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**HUMAN RESOURCE MANAGEMENT: A STUDY OF TWO ENGLISH DISTRICT  
HEALTH AUTHORITIES.**

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**A thesis submitted to the University of Warwick for the degree of  
Doctor of Philosophy in Industrial and Business Studies.**

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## Abbreviations

A&E	Accidents and Emergency
AHA	Area Health Authority
BMA	British Medical Association
CHC(s)	Community Health Council(s)
CIPs	Cost Improvement Programmes
CMG	Corporate Management Group
CNA	Chief Nursing Adviser
DGM	District General Manager
DHA(s)	District Health Authority(Authorities)
DHSS	Department of Health and Social Security
DMAB	District Management Advisory Board
DMT(s)	District Management Team(s)
EETPU	Electrical, Electronic Telecommunication and Plumbing Union
EOP	Equal Opportunity Policies
FPC	Family Practitioners Committee
GP(s)	General Practitioner(s)
HRM	Human Resource Management
IDS	Incomes Data Services
IPRs	Individual Performance Reviews
IR	Industrial Relations
JSCC	Joint Staff Consultative Committee
NAHSPO	National Association of Health Service Personnel Officers
NHS	National Health Service
NSQC	National Society of Quality Circles
O&G	Obstetrics and Gynaecology
PM	Personnel Management
PSBR	Public Sector Borrowing Requirement.
QA	Quality Assurance
QC(s)	Quality Circle(s)
QWL	Quality of Working Life
RAWP	Resource Allocation Working Party
RCGP	Royal College of General Practitioners
RCM	Royal College of Midwifery
RCN	Royal College of Nursing
RGM	Regional General Manager
RHA(s)	Regional Health Authority(Authorities)
UGM(s)	Unit General Manager(s)
UPM(s)	Unit Personnel Manager(s)
UMB	Unit Management Board
WHO	World Health Organization



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## Summary

The thesis is primarily about personnel management in the National Health Service (NHS). It uses managerial strategy theory to examine the arguments about the changing style of personnel management and the emergence of human resource management (HRM). Some scholars have argued that the adoption of HRM results in an increasing role of line managers in the formulation and implementation of personnel issues. It is further argued that HRM results in increased ambiguity in personnel issues, and consequently poses a threat to personnel management.

Using a case study qualitative approach involving the analysis of documents and in-depth, semi-structured interviews, the thesis examined the implications of the integration of the personnel strategy of quality circles into the organizational strategy of quality assurance in two English district health authorities in the Post-Griffiths period.

The research revealed that both quality assurance and quality circles initiatives are responses to the potential deterioration in health service delivery as a result of the cuts in health care expenditure. They are, thus, opportunistic and reactive approaches for managing under financial constraints and as such cannot be considered as HRM. The empirical evidence indicates that personnel managers did not play any significant role in the quality initiative programmes; as such both programmes did not pose any major threat to personnel management although they encourage line management involvement in personnel issues. This heightens the ambiguity between line and staff functions and relationships in personnel.

This research is significant in showing how higher level managerial decisions, a response to environmental pressures provide a link between organizational policies and the employment practices at the lower levels within an organization. It has shed some light also on the supposed effects of employees commitment programmes on personnel management thus contributing to the debate on the supposed 'transformation' of personnel management into HRM.

## CHAPTER 1

RESEARCH PROBLEMS, METHODS AND METHODOLOGY

This introductory chapter deals with two main issues. The first section gives the background of the research problems and also specifies it. In this respect it provides a brief overview of the major issues which will be the subject of discussion in the subsequent chapters.

The second section considers the research methods adopted for the study. It explains the origins of the research; the reasons for the choice of the empirical focus; the reasons for the development of case-study qualitative methodology; and a brief discussion of the usefulness of qualitative as opposed to quantitative methodology in field work research. A brief discussion of the potential contribution of the research is also carried out. This section ends with a summary of the structure of the thesis.

Background to the Research Problem

In recent years the emergence of human resource management (HRM) has renewed interest in the study of personnel and employment practices in organizations. Reflecting this development, much research has dealt with new models of the management of human resource, in particular, managerial strategy and human resource policy (see, for instance, Gospel, 1983a, 1983b; Purcell and Sisson, 1983; Sisson and Sullivan, 1987; Thurley and Wood, 1983; Kochan et al., 1984, 1986).

The concept of managerial strategy has been employed to show how higher level managerial decisions, perhaps a response to key environmental pressures, provide a link between organizational policies and the employment practices at lower levels within an organization. Some of these analysts have specifically focused on the changing style of personnel management (PM) or, put another way, its supposed metamorphosis into HRM. Thus the debate on the continued



evolution of PM confronts a variety of old issues with a recent one; the emergence of HRM. This supposed 'transformation' of PM has generated debates about the factors responsible for the origins of HRM and the role of line management in the process. Although the concepts of managerial strategy and HRM are vaguely defined many have attempted to explain their origins and implications in organizations. Guest (1987, 1988) and Storey (1987), for instance, point out that the adoption of HRM implies an increasing role of line managers in the formulation and implementation of personnel policies. This view suggests that the management of human resources in organizations is too essential to be handled solely by personnel managers. Thus the literature seems to indicate that the adoption of the HRM approach in organizations could potentially undermine or diminish the role of personnel specialists in personnel matters. Moreover the involvement of line managers in personnel issues could potentially result in increased ambiguity in the personnel function. These together fundamentally undercut the efforts of personnel specialists to establish a monopoly of competence in the management of human resources in organizations. These views raise the issue of whether HRM is a force which PM has to resist or whether PM itself is moving towards HRM.

After analysing some HRM initiatives in the U.K., both Storey and Guest conclude that in spite of the claim that PM is moving towards HRM, many organizations in the U.K. perhaps do not fully practice HRM. They argue further that although some organizations have introduced employees involvement programmes, such as quality circles (QCs), it is not clear whether these QCs can be considered as HRM per se, or part of the broader trend towards HRM.

This finding notwithstanding, there has been a proliferation of QCs in the public sector in the U.K. in recent years. In the NHS the QCs are part of the broader management strategies, particularly at the district level, to respond to changes in the management of health services since the Griffiths restructuring which introduced general management in the NHS. Although NHS decisions are made in a complex political environment within the various levels - national, regional, and district - strategic decisions are made - albeit in a limited scope



at each level. General management provides opportunities for the formulation of strategic initiatives at the district level. These include strategies on quality, for example, quality assurance (QA).

The objective of the implementation of these strategies is to link the managerial strategies with the personnel strategies. It is believed that this can create a potentially conducive atmosphere for the growth of HRM. If HRM implies an increased involvement of line managers in personnel issues then it raises the issues of how personnel work is divided between line and staff and how PM justifies its existence. It is not clear whether these issues have been sufficiently tackled or resolved in the current debates. Similarly the role of choice in the emergence of managerial strategies remains unresolved in the literature. Whilst some argue that managerial strategies are primarily a response to environmental constraints others argue that managers have a choice in the formulation of strategies regardless of the environmental constraints.

The thesis is primarily about PM in the National Health Service (NHS) and as such it deals with the issues raised above. It brings together current debates on the emergence of managerial strategies, changes in the personnel function and the emergence of commitment programmes along the lines of HRM. Having reviewed the literature, it applies some of the insights, and explores some of the unanswered questions, in two case-study district health authorities (DHAs) in the NHS in England. Specifically it uses the concept of QCs to examine the various aspects of PM practice in the case-studies. This is done by examining the implications of the integration of the personnel strategy of QCs into the managerial strategy of QA. Here, the main objective is to determine whether PM in the case study authorities is changing into HRM. It, thus, attempts to throw some light on the contemporary arguments about the changes in the personnel function in organizations and the role of personnel in the move towards HRM.



### Specifying the Research Problem

The preceding section points to some incomplete debates in PM. It has also shed some light on the interest in studying the links between managerial strategies and personnel practices in organizations. The main research problems of this study are thus as follows:

1. To explore and explain the factors responsible for the emergence of the managerial strategies of quality assurance (QA) and quality circles (QCs) in the post- Griffiths period in the two case-study district health authorities (DHAs) in England.
2. To explore and explain how managerial strategies formulated at the upper levels of the organization (district) are implemented at the lower level (unit) in the case-study DHAs. This invariably involves a discussion of the effects of national strategies on the DHAs.
3. To determine: (1) the role of line managers as well as personnel specialists in the evolution and subsequent implementation of the managerial strategies; (2) the effects, if any, of the implementation of the managerial strategies, particularly the QCs on the personnel function; (3) whether the implementation of QCs in any way indicate a shift towards HRM and; (4) whether personnel management plays any strategic role in the move towards HRM.

The research will deal mainly with the changes in PM at the workplace level in the NHS after the Griffiths restructuring, but excluding the developments arising from the Conservative government's 1989 White Paper on the NHS. For reasons of anonymity the two case-study DHAs which provide the specific location of the research will be referred to as Metropolis and Countryside and their corresponding Regional Health Authorities (RHAs) will be known as Inner London RHA and Midlands RHA respectively.

The next section of this chapter deals with the research methods and the methodological issues.

## Methods and Methodology

This research began actively a few days after I arrived in the U.K. in August 1987. My original research plan was to do a comparative analysis of health services industrial relations (IR) in Canada and Britain. This research, however, did not materialise for a couple of reasons. First, as a self-financing overseas student it became apparent upon my arrival in the U.K., that I could not finance a long fieldwork research visit in Canada in addition to the one in the U.K. Second, my visa status in the U.K. was unresolved at the time and it was anticipated that it may make it impractical to leave the country for fieldwork overseas. In view of these problems I decided to pursue a U.K. based research. These issues therefore gave birth to this research.

Having chosen the research area a decision was made to explore the links between managerial strategies and personnel practices in organizations. This was in line with research in the late 1980s. At this stage the literature review dealt with new models of management roles in IR and PM, in particular the shift towards the exploration of management structure and strategies in IR and PM research, the changes in PM and the various debates on HRM. In view of the on-going changes in the management of the NHS it was realised that it could be an interesting research site for exploring the application of managerial strategies to PM. In other words, it provided the opportunity for exploring the links between managerial strategies and human resource strategies.

The health care sector was chosen as the empirical focus for several reasons. First, PM in the NHS has recently been confronted by a broader reorganization of management based on 'commercial' management principles in a period of intense resource constraints in Britain. Second, the changes in the NHS since the management reorganization-Griffiths restructuring-offered the opportunity to conduct an empirical investigation of the link between strategic management decisions and the development of employment relations policies and practices designed to ensure the achievement of some organizational objective. It makes it possible to bring together in an



integrated manner, issues of managerial strategies, quality initiatives, changes in PM and the rise of HRM. Third, the NHS is the largest employer in the U.K., and indeed in Western Europe. It contains a complex structure of employment ranging from powerful professional groups, aspiring professionals and vocational specialists, clerical and ancillary employees; therefore, any changes or innovations in PM practices are themselves worth examining.

Fourth, a significant part of the literature on managerial strategies, changes in PM and the emergence of HRM (that is, the theoretical framework and analytical models), have originated in the U.S. Moreover, in both the U.K. and the U.S, researchers have focused on the application of the theoretical and analytical models to private sector organizations, thus essentially ignoring public sector ones. It was thought that a case study on a public sector organization in the U.K. would help to clarify the applicability of the theoretical framework and models to the public sector.

Having arrived at the decision to focus the research on the NHS it was necessary to decide on the specific context. It was decided that a case-study of two DHAs-one in an urban setting and the other in a rural area-would perhaps yield contrasting results in the application of managerial strategy to human resources. This was based on the belief that the factors influencing the development of managerial strategies might differ from one DHA to another.

Two main research methods were used to gather data in the case-study DHAs. These were interviews and analysis of publicly-available and confidential documentary material. The library research yielded a rich secondary literature on a variety of issues relating to the management of health services. This research was concentrated mostly at the King's Fund Centre in London and also at the Health Services Management Centre's library at Birmingham University. These two libraries together yielded most of the NHS literature on Griffiths restructuring, general management, QA, QCs and the changes in the PM role. Furthermore, the interest in QA and QCs required a general review of the QA and QCs literature including their application in the health care sector.

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and research contacts were used to gain access in the case-study DHAs. A letter was written to the district general managers of each DHA seeking fieldwork research access. The letters indicated through whom these contacts were chosen. A brief research outline indicating my personal background, the purpose and nature of the research, the research interests and fieldwork plans was added to each of the letters. The District General Manager (DGM) for Metropolis responded to the request, agreed to cooperate and assured me of full research access. In Countryside, it was the Chief Nurse Adviser (CNA) who responded to the request. He gave the approval for the research. These two officials subsequently introduced me to other managers and helped to establish further contacts in each DHA.

In both DHAs, the people interviewed ranged from members of the management boards (including personnel managers) at both the district and unit levels to middle managers, non-managerial staff and members of the staff-side. Some interviews were conducted with the relevant personnel at the regional level. In all, 86 people were interviewed. Some were interviewed individually whilst others, such as QC members, were interviewed in small groups of 5-8 people.

The research also involved attendance at QC meetings, training sessions or sub-committee meetings. The main purpose here was to observe the meeting and to interview the participants later. Such meetings also allowed me to become acquainted with some of the management board members and others involved in QA and QCs initiatives. They were invaluable sources of contacts which were subsequently tapped for interviews. While at the meetings notes were taken to facilitate subsequent interviews. As indicated earlier, attendance at those meetings was purely to get acquainted with potential interviewees. For this reason, observation of meetings is not treated as a distinct research method.

The in-depth, semi-structured interview method was used. This was considered desirable as the research was aimed at exploring the relationship between managerial strategies and personnel policies and practices, but did not have any firm ideas about what to expect in the way of links. The semi-structured interview, based on flexible interview schedules helped in eliciting from the interviewees the



important issues relating to the investigation. Moreover, it made it possible to explore and clarify pertinent issues as they arose. In response to many questions, the interviewees raised many issues which more often than not merited further pursuit, and this was done accordingly. Every possible effort was made to avoid asking leading questions. It was also possible to probe issues that were important but not mentioned in the interviewees' narrative accounts.

The group interviews were quite informative. As indicated by Lofland (1971:88), they gave the members of the group the opportunity to discuss the issues together, to reflect and recall experiences. This made it possible for the members to reflect on initial accounts and to revise them in light of any contradictions. It also offered the opportunity for interchange between contrasting perspectives. In almost all the interviews, the interviewees were very open and willing to talk; thus most interviews gradually became guided conversations. Some of the interviewees' including those introduced by management, gave critical views on the managerial strategies. Each interview lasted between one and two hours.

A notebook and pencil were used throughout the fieldwork to record the interviews. A tape recorder was not used because it was thought that it might inhibit responses from the interviewees. Moreover it might take too long to transcribe tape recorded interviews. Without a tape recorder, notes were effectively taken at the interviews, and were transcribed as quickly as possible, but never later than two days after the interview.

Another research method used was the examination of documents. Many of the questions raised at the interviews culminated in a verbal response and a document for further study. These documents included, among others, RHAs and DHAs strategic plans, personnel policies, consultation documents, QA strategy papers, QC documents, etc. These documents were examined to find out more about the DHAs' policies and values on such issues as quality, personnel, etc. Most of the fieldwork was conducted intensively in three periods: (1) between the beginning of April and end of August 1988; (2) early December 1988 to end of January 1989 and; in the summer of 1989. The latter was essentially a follow up of the fieldwork data gathering.



The choice of research methods was a crucial issue in this research. Whilst the fieldwork is based on a U.K. organization, most of the theoretical framework, and the analytical models are U.S. in origin, (eg. managerial strategy, strategic choice, HRM, QA and QCs). Therefore a significant reference is made to the U.S. literature. It is particularly noteworthy that whilst U.K. IR and PM researchers have tended to adopt a qualitative approach, their U.S. counterparts have preferred the quantitative approach. As shown in Chapter three, the use of qualitative methodology in IR research has often received hostile reviews. Yet after careful consideration of the research objectives, it was decided that a case study with qualitative methodology would be the most appropriate for this research, since it seeks to explore and explain developments in management strategies and personnel policies in the context of the changes occurring in the NHS. Thus Batstone's (1984:292) view that the importance of case studies lies less in their typicality than in the insights they provide into process of change becomes relevant here.

Just as in Poon's (1987) research, the qualitative case study methodology can help to clarify the various, and often divergent models and themes identified in the managerial strategy and PM and HRM research. A case study, perhaps offers the best opportunity at this stage to strengthen the theoretical framework before it can be subjected to rigorous assessment in the form of a large scale survey or quantitative analysis in the U.K.

When research is aimed at generating data to assess a theoretical framework to generate a hypothesis, or to develop a theory, Glaser and Strauss (1965) contend, qualitative research is often the most adequate and efficient method of obtaining the type of information required. Similarly, Foreman (1948) argues that qualitative case studies can be useful tools for illustrating a theoretical perspective and for concept development, and by so doing strengthen the theoretical base-as it clarifies the concepts as well. Qualitative research, then, according to Glaser and Strauss is a preliminary exploratory effort to quantitative research.

Stacey (1969), and Burton and Lazarsfeld (1961) agree with this view. These authors also point out that qualitative research can



yield much data out of which concepts and hypothesis can be developed. Stacey indicates the impossibility of developing clear hypotheses for testing in a new area where adequate data have not been collected. In Stacey's words,

Hypotheses which are worth testing can only be developed in areas about which a good deal is known i.e. where a great deal of empirical data has already been collected. Before this stage most research is an exploratory nature (p.6)

Stacey agrees with Glaser and Strauss that after adequate empirical data have been collected then precise hypotheses can be formulated for testing or a theory can be derived inductively.

In discussing the utility of qualitative research methodology, Babbie (1979:105) further adds that quantitative methodology in its structured form often overlooks relationships not anticipated by formal hypotheses, and that qualitative research often is more fruitful than that with hypotheses. As indicated earlier, this research is an attempt to extend and apply the theoretical and analytical concepts of managerial strategy and HRM to a relatively unresearched area—the public sector. In this respect Babbie deems the qualitative case study as a valuable research methodology. Following these authors, therefore a qualitative case-study method was adopted for the empirical research. In this case the qualitative research method allowed investigation without defined hypotheses to be tested. The aim of this research at this stage is to understand an on-going process that is difficult to specify in advance. The objective of this research thus includes making initial observations, developing general conclusions and possibly suggesting areas of further research.

Whilst not criticizing quantitative research methods or justifying the use of qualitative research methods here, this discussion is important because the use of qualitative research methodology by Kochan et al. (1984, 1986) has come under heavy criticism by Lewin (1987). As explained in Chapter two, Lewin attacks the qualitative research methodology of U.K. researchers on managerial strategy, changes in IR and PM and the emergence of HRM. Lewin seems



to believe that qualitative research is inferior to quantitative research, and that research is not scientific unless it has a clearly defined hypothesis which can be tested. Stacey argues, rightly so, that this is too narrow a view. Zito (1975) agrees and contends that some research, especially that dealing with micro-social phenomena which defy simple quantification, are best served by qualitative methods. On the other hand, research involving large numbers of individuals, populations, surveys, and theories involving probabilistic occurrences are best handled quantitatively after the data have been collected.

This qualitative-quantitative controversy is discussed further in Chapter two in relation to Lewin's views on the managerial strategy/strategic choice literature. However, this discussion of methodological issues has been necessary in view of the fact that virtually all the literature utilized in this research used the qualitative approach.

Guest (1987) and Kochan and Chalykoff (1986), among other researchers, maintain that there is as yet no comprehensive HRM theory and there is no theory that fully explains the changes in PM either. In spite of these, however, the use of managerial strategy and strategic choice theory as an attempt in theory building in IR and HRM has come under increasing criticism. It is expected that the qualitative case study methodology utilized by this research will help in clarifying the utility of managerial strategy theory, provide adequate explanation for the emergence of managerial strategies and changes in the personnel function and contribute to the development of HRM theory. It is, however, realized that this methodology, being qualitative rather than quantitative, seldom yields precise definitive conclusions, thus limiting the extent of its generalizability. For this reason the conclusions drawn from this research can more realistically be considered as suggestive rather than definitive. They may provide the basis for a more rigorous survey using statistical analysis in further research which may then yield more precise conclusions.

The rest of this chapter presents the sequential structure of this thesis. It is divided into eleven chapters. Chapters two and



three provide an overview of the theoretical and analytical background of the study. Chapter two reviews and assesses the application of managerial strategy to IR and PM research. In contrast to the organizational contingency perspective which sees organizational environment as the primary determinant of organizational outcomes and therefore no need for strategic formulation, strategy is seen here as a consciously formulated plan devised by managers to respond to environmental pressures facing organizations. The main argument of the authors reviewed in this chapter is that in the face of environmental constraints managers still have a choice in shaping organizational outcomes; and that they do not simply react to environmental pressures. The final section of the chapter attempts to apply the concept of managerial strategy to the case-study DHAs.

Chapter three brings together the various discussions on the changing nature and style of PM and the emergence of HRM. It begins with an exploration of the origins as well as the practice of PM in the U.K. and reviews the differences between PM and HRM as part of the attempt to define HRM. The role of managerial strategy is emphasized in the discussion of the factors contributing to the emergence of HRM. Here, it is argued by some authors that it is the interaction of certain environmental pressures and managerial strategies that determines the context of human resource policies and precipitates the emergence of HRM initiatives such as QCs. The discussion underscores the increasing role of line managers in personnel issues and raises the question whether QCs can be regarded as HRM or not. In the wake of the dual existence of HRM and IR in some organizations the discussion questions the importance of HRM in the U.K. In raising and discussing such issues the chapter provides the basis for analysing the emergence of managerial strategies and their effects on the management of human resources in the case-study DHAs.

Chapter four provides a broad overview of the environmental factors, particularly government policies, which have fostered the development of managerial strategies in the management of health care in general as well as in the management of human resources. In this respect it explores the Conservative government's economic philosophy and its role in the attempts to shift employee relations from



collectivism to individualism. It also discusses past and contemporary management practices in the NHS, including recent attempts to introduce private sector management practices to the NHS. Accordingly, it reviews the origins of the NHS and the factors responsible for the emergence of general management. The main focus of this chapter is the simultaneous pursuit of centralization and decentralization policies in the NHS. The Griffiths restructuring was supposed to encourage decentralization but the government's public expenditure constraint policies have effectively increased centralization in the NHS. This, coupled with the fact that the chairmen of health authorities and their general managers are appointed on short-term contracts, against a backdrop of performance related pay for the latter, has ensured that these officials adhere to government policies. The chapter thus examines the government's policies which influence the development of managerial strategies in the NHS. These strategies and their implications are explored in the empirical sections of the study. This is the first of the three chapters which attempt to link the theoretical and analytical issues with the empirical research.

The fifth chapter focuses on the PM function in the NHS. To the extent that this research involves changes in the personnel function, this chapter traces the evolution and development of PM in the NHS. It argues that the ambiguity in the personnel function is partly due to the arbitrary manner in which the function was introduced and subsequently developed. It attempts to show the links between the Conservative government's policies on the one hand and the changes and developments in the PM function on the other. These include the development of managerial strategies for the management of human resources and the attempts to integrate human resources strategies to organizational strategies. The increasing role of line managers in personnel issues in the post-Griffiths period and the institutional attempts to strengthen PM in the NHS are also discussed. The chapter essentially provides a discussion of the major issues to be explored in the case-study DHAs.

Chapter six focuses on the emergence of QA and QCs programmes in the health services sector. Having discussed the problematic definition and meaning of quality, it moves on to analyse the reasons



for the resurgence of interest in quality in the NHS. This discussion involves an analysis of the environmental pressures which have influenced the adoption of QA as a managerial strategy. The chapter also reviews the evolution of QCs in Japan and their recent popularity in the West. QCs are discussed in relation to the broader concept of quality of working life (QWL). The supposed reasons for the development of QCs, the trade unions' and middle management perceptions of the programme are also discussed. The chapter highlights the links between QA as a managerial strategy and QCs as a human resource strategy. Having analysed the characteristics of QCs and HRM it raises the question whether QCs can be considered as a HRM initiative. This chapter provides the background for the analysis of the emergence of QA and QCs initiatives in the case-study DHAs.

Chapters seven, eight, nine and ten focus on the case-study empirical material. Chapters seven and eight deal with the development and implementation of QA and QCs programmes in Metropolis and Countryside health authorities respectively. The background characteristics as well as the structure of QA and QCs programmes in both case-study DHAs are discussed. Both chapters analyse the evolution of the managerial strategies and mention the influential role of both national and regional strategic priorities on local strategies. Similarly the role of line managers and management consultants in the development and implementation of the managerial strategies are discussed. Some attention is devoted to the relationship between QA and QCs. After reviewing some of the QC projects undertaken in both DHAs, the chapters examine the attempts by the management of both DHAs to bypass the trade unions in the development of the QCs. Both chapters briefly evaluate the QA and QCs initiatives. Here, the focus is on the examination of the reasons for the failure of some of the QCs.

It is argued that QA developed as a strategy in response to certain environmental factors and that the QC programme is an attempt to integrate the human resource strategy into the organizational strategy. It is further argued that the QC programme is essentially an attempt by management to change the culture of the organization—that is, to sensitize the employees to quality issues.



Chapter nine assesses the QA and QC programmes in both case study authorities. The first section of the chapter focuses on the debates about the need to evaluate QA and QC programmes. In spite of the recommendation in the literature to evaluate QA and QCs neither authority has developed a formal and systematic evaluation programme. It is, thus, argued that this undermines management motives for the development of the QA and QCs strategies. The second section of the chapter addresses management motives and objectives for the introduction of the QA and QCs innovations as well as management style in handling labour-management relations. Here, it is argued the QCs are a means to foster direct relations between management and employees and by so doing bypass the trade unions. The QCs are therefore meant to undermine the existing consultative arrangement.

It is also argued that the QA and QCs initiatives were introduced in both authorities by senior managers primarily as a response to environmental pressures. They are meant to improve management delivery of health care within financial constraints. The QA and QCs programmes satisfy the self-interest of managers but they are of little benefit to employees. They do not allow any meaningful employees participation in decision making and do not seriously address work reorganization. As a managerial strategy it is argued that the QCs are only marginally successful.

Chapter ten traces the development of PM in the case-study DHAs. It examines the post-Griffiths PM function and some of the main issues that PM had to deal with in 1980s. In particular, it explores the Griffiths recommendations on strengthening line management role in personnel issues whilst at the same time strengthening the personnel function. It is argued that this recommendation is contradictory and has had some effects on the personnel function, notably an increase in line management involvement in personnel issues. In view of this encroachment of line managers in personnel issues in recent years, the chapter attempts to assess the PM role in the formulation and implementation of the QA and QC programmes. It is further argued that the increasing line management involvement in personnel issues heightens the inherent ambiguities in the personnel function.

This chapter also examines the PM/HRM interface and attempts to



investigate whether or not PM is moving towards HRM in any of the two case studies. The research did not find any significant evidence that PM in the case study authorities is changing into HRM. Similarly the chapter attempts to determine whether the QCs can be considered as strategic initiatives. On this issue the evidence from the case studies supports the view that the QCs are reactive, rather than a proactive and strategic responses to the changes in the DHAs' environment. This also implies that the QCs are not strategic initiatives and therefore cannot be considered as significant HRM initiatives.

Chapter eleven is the final chapter and it provides the summary and conclusions for the study. After reviewing the main arguments of the various chapters, the chapter shifts its attention to the discussion of some substantial issues arising from the study. Evidence from the case studies shows that environmental constraints severely limit the choice of strategies by senior managers in the management of the NHS. In view of this finding it is argued that the formulation and implementation of the QA and QCs programmes can be explained more appropriately by the organizational contingency perspective rather than the managerial strategy perspective.

The chapter also examines the usefulness of Kochan et al. and Kochan and Chalykoff frameworks as analytical tools for explaining the emergence of managerial strategies and HRM in a public sector organization heavily constrained by political considerations. Evidence from the authorities indicates that the frameworks do not provide much insights on the origins of the QA, QCs and HRM. The contribution of the theoretical and analytical frameworks as well as the qualitative case study methodology in clarifying some of the debates on the application of managerial strategies to the 'management of people' in organizations is also discussed. Finally, some attention is devoted to the policy implications of the research .

## CHAPTER 2

MANAGERIAL STRATEGY AND HUMAN RESOURCE MANAGEMENT

This chapter addresses three main issues. Section one presents a review of the concept of strategy as it has been used in the management, IR and PM literature. In section two, the major literature on managerial strategy and strategic choice is reviewed. This discussion begins with the U.K. literature on managerial strategy and strategic choice and extends to the U.S. literature, emphasizing, in particular, the Kochan et al. framework of strategic choice as an IR variable. The final section of this chapter assesses the essential elements of the managerial strategy perspective.

The Concept of Strategy

In recent years some IR and PM researchers have focussed on management strategy and personnel policy. These writers have considered the various managerial approaches to IR and PM. Some have traced the development of various managerial strategies and strategic choices towards employees and have subsequently developed frameworks for explaining management's approach to IR and PM.

Whilst most of the empirical applications of managerial strategy to IR and PM have focused on the U.S., interest in the topic is no less keen in the U.K. In Britain a number of writers have argued for the need to study the links between managerial strategies on the one hand and IR and PM practices on the other. The proponents of this view in the U.K. include Thurley and Wood, and Gospel. In the U.S. the leading proponents are Kochan et al. In order to understand the effects of managerial strategic decisions on PM, there is the need to explain the concepts of strategy and strategic choice.

During the past quarter of a century or so, writes Lewin (1987), the concept of business strategy has gained wide currency and attracted a veritable legion of researchers. Kochan et al., for instance, have explored managerial strategic decisions and their



effects over an extended period of time on IR and personnel practice. They utilise organizational behaviour theory in the analysis of IR and HRM. Other organizational behaviourists have also used the strategy framework to analyse the personnel and HRM function and some of its subfunctions, such as performance evaluation, employee training and development, recruitment and staffing and compensation systems (Dyer 1984; Milkovich and Glueck 1985). Some literature on firm level manpower planning and modelling is also based on strategic planning (Walker 1969; Patten 1971). Lewin concludes that it appears IR, and for that matter PM researchers are jumping on the strategy bandwagon.

In spite of the large body of literature on managerial strategy, the concept of strategy is still vaguely defined and remains ambiguous. According to Hyman (1987), the notion of strategy has become increasingly popular in the management literature, yet its meaning is often elusive and imprecise. Many authors neither define nor attempt to explain the concept, but rather leave their readers to assume the meaning from the context, or perhaps assume that the readers already understand the concept. Still, other writers, such as Thurley and Wood (1983), Kochan et al. (1984; 1986), Chandler (1962), and Hyman (1987), among others have attempted to define and explain the concept of strategy.

What, then, is meant by the concept of strategy? The term is derived from the Greek word *Strategia*, which denotes the role of a military commander or general, but as Hyman (p.27) humorously puts it, the Greeks provided no clear job description. In military terms, the word is used to imply the planning and organization of a campaign; therefore, it is contrasted with tactics, which means, literally, the arrangement of forces for a single battle. Hyman raises the question of how the categories of ancient warfare are to be translated in the context of modern business management.

A translation is provided in the work of Chandler (1962). Chandler, in acknowledging the importance of strategy in the management of the modern business enterprise, differentiates between strategic and tactical decisions. The former are concerned with the long term health of the enterprise, whilst the latter deal with the day-to-day activities necessary for its efficient and smooth



operation.

Chandler explains that both tactical and strategic decisions usually require implementation by an allocation, or reallocation, of resources - funds, equipment and personnel. Even more critically, Chandler admits, a strategic plan can be formulated from below, but its implementation will be difficult, since it requires resources which only people at the top can provide. It is implicit here that Chandler is referring to unequal power relations in organizations. He maintains that executives who actually allocate available resources are the key people in any enterprise; these people make the strategic decisions. The low ranking executives at the lower levels carry out tactical decisions. Chandler, thus, defines strategy as:

the determination of the basic long-run goals and objectives of an enterprise, and the adoption of courses of actions and the allocation of resources necessary for carrying out these goals. Decisions to expand the volume of activities, to set up distant plants, and offices, to move into new economic functions, or become diversified along many lines of business involve the defining of new basic goals. New courses of action must be devised and resources allocated and reallocated in order to achieve these goals and to maintain and expand the firm's activities in the new areas in response to shifting demands, new technological developments, and the actions of competitors. As the adoption of a new strategy may add new types of personnel and facilities, and alter the business horizons of the men responsible for the enterprise, it can have a profound effect on the form of its organization (Chandler 1962: 16)

Chandler implies, in his analysis, that structure follows strategy.

In their discussion of strategy, Thurley and Wood make passing reference to the military origins of the concept. According to them, many writers dealing with managerial business decision-making have used the term strategy to describe a particular set of choices made over time for a given objective. In an organizational setting, this implies that there is a hierarchy of decisional choices, so that one decision will result in a memorandum of guidelines laying down policy to direct the more specific decisions taken by operational managers who have to deal with a myriad of short-term problems and issues. A strategy, the authors continue, means a consistent approach over time



which is intended to yield results in the medium and long term for a specific problem.

Thurley and Wood maintain that a strategic approach assumes that it is possible to review the overall situation facing decision-makers in the way that a general reviews a battle situation before actual hostilities break out. When they do break out, tactical decisions will have to be made for temporary advantage, but it is hoped that decisions, on overall strategy will help prevent short-term decisions, made in the heat of battle, from cancelling each other out. Thurley and Wood (p. 2) explain that the idea of a strategy does seem to imply an external force or forces which must be anticipated and dealt with; strategic thinking thus arises from the need to cope with such pressures. Equally, IR-PM strategies are also developed as an integral part of the corporate strategy to cope with the external pressures.

On the other hand, Kochan et al. do not provide a specific definition for strategy or strategic choice; they tend to use both words interchangeably. They do not distinguish clearly between strategy and strategic choice, and even seem to imply that there is no difference between the two concepts. For instance, Kochan et al. state:

the purpose of this paper is to add a more dynamic component to IR theory by developing the concept of strategy or strategic choice (Kochan et al. 1984: 16).

They make particular reference to the work of Chandler (1962), Bain (1968), Porter (1980), Cyert and March (1963), Simon (1957), Braybrooke and Lindblom (1970) on strategy. They also maintain that their approach to strategic choice in IR is defined by two conditions: first, strategic decisions can occur only where the parties have discretion over their decisions, that is, when environmental constraints do not severely curtail the parties' choice of alternatives. Second, within the set of decisions over which the parties have discretion, strategic decisions are those that alter a party's role or its relationship with others in the IR system. It is evident from this short review that some writers have adopted an eclectic approach to the concept of strategy.



Kochan et al., among others, see strategy as a rationally and consciously articulated plan. According to this view all organizations consciously develop strategies. Strategy here implies that organizations have to anticipate external forces and come to terms with them. Other writers including Thurley and Wood, Weick (1979), March and Olsen (1984) and Gospel (1989a), however, caution that the effects of strategic decisions may be evident only in the long run, may appear only indirectly and may not even be the result of a rationally preconceived plan. They indicate that managerial strategy may be irrelevant if the direction of an organization is by and large constrained by its environment. According to this view management has no choice and cannot formulate strategies when economic laws are the prime determinants of organizational direction, giving both its objectives and the best practices. In the end, however, almost all the authors on strategy place greater emphasis on strategy as a consciously articulated plan.

In view of this, Thurley and Wood point out that the concept of strategy is useful in the explanation of managerial decisions because they show managerial discretion in the face of environmental constraints. It also makes it possible to compare the different strategies developed by different firms in the same industry in response to similar environmental constraints. The major problem with the theory, however, is the tendency to impute rationality, or consciousness and intentions, to managerial decisions. Thurley and Wood warn that organizational decisions may not necessarily follow any rational approach but may represent a response to pressure and problems rather than proactive decisions. Strategic choice theory, however, refutes this view.

In their discussion of strategy as a conscious element, Thurley and Wood refer to the work of Wood (1980) and Child (1972) on strategic choice. They incorporate the concept of strategic choice in their discussion and make reference to managerial strategy as a reflection of power, control and political processes in organizations but they do not mention that Child developed the concept as a counterweight to the contingency approach. The contingency theory projects the view that organizational characteristics have to be



shaped to meet situational circumstances. The extent to which any organization secures a 'goodness of fit' between situational and structural characteristics will determine the level of organizational performance. Enter strategic choice.

Aldrich in tracing the entry of strategic choice into managerial strategy literature, maintains that:

Organization theorizing and research in the past decade has, more or less by default, gradually reduced the role of persons as significant decision makers in organizations. Various external constraints have been identified as sharply limiting the role that participants play in selecting organizations' structures and activities. Organization size and technology treated as imposing structural imperatives on organizations, joined environmental constraints as a trilogy of forces hypothesized to circumscribe prospects for purposively directed change. Child's (1972) ringing rebuttal to these pessimistic arguments drafted in 1970, defended the concept of choice and introduced a new term - strategic choice - into the literature (Aldrich, 1979: p. 136).

According to this view, strategic choice raises three major arguments to counter the claim that environmental influence is an overwhelming constraint on the ability of participants to influence the course of organizational change. These arguments are: (1) decision makers have more autonomy than inferred by those arguing for dominance of environmental, technological or other forces; (2) organizations occasionally have the power to manipulate and control their environments; and (3) perceptions and evaluations of events are an important intervening link between environments and organization's action. (Aldrich p. 138)

In Child's view, then, strategic choice stresses an element of choice that may be at the disposal of management in shaping organizational objectives and policies and in adapting to external forces. Child focuses on the decision-making within organizations that has determined why a particular structure was adopted. He also examines critically patterns of association among contextual and organizational variables. According to Child, models which have been derived from this association depict organizational structure as determined primarily by economic constraints which contextual



variables impose. He argues that such models lack adequate explanations, since they do not take into consideration the process whereby managers within organizations decide upon courses of strategic action.

Chandler (1962) also uses the concept of strategy to refer to the exercise of choice by a dominant coalition as the major source of organizational variation. Strategic choice is thus a critical variable in organization theory. Dimmock and Sethi (1986: 749) similarly view strategic choice as the process whereby a decision-maker proceed to plan, shape and/or exploit (either systematically or opportunistically) circumstances or events within the environment in ways that are perceived as bringing it nearer to its aim. The element of choice lies in determining what circumstances or events to exploit. Shifting attention towards the role of choice leads to the explanation of IR and PM behaviour through reference to its source rather than its supposed consequences.

The notion of strategy as a conscious managerial activity implies the systematic planning of personnel and IR in organizations and injecting the concerns of personnel and IR into executive managerial decisions covering all aspects of organization. Such organizational decisions are often made within the overall framework of the organization's corporate strategy. According to this view corporate strategy is rationally connected to certain environmental factors, such as product market objectives, the prevailing social, political and economic conditions at the location of the enterprise, such as government policy and legislation. The environmental factors often constrain managerial choice of strategy and structure. Furthermore, they may influence the link between corporate strategy and other sub-strategies such as personnel and IR.

The organizational strategy perspective indicates that an organization's overall strategy often incorporates a policy stating the organization's human resource strategy which guides management in the operation of the organization. This human resource strategy thus defines the organization's long-term objectives with regard to human resource issues. It forms an integral part of the total strategy with which it pursues its business objectives. The role of management in



the formulation and implementation of this strategy is shown in the discussion of strategic choice.

### Strategic Choice and the Management of Human Resources.

In introducing strategic choice theory into IR and PM, Kochan et al. (1984, 1986) observe that a more realistic model of IR should recognize the active role played by management in shaping IR, as opposed to the traditional view which sees management as reactive, responding to union pressure. They report on changes in managerial values and strategies in the U.S. which have in turn resulted in changes in the personnel function. These changes have been accompanied by other changes in the collective bargaining environment in the form of reduced rates of bargained pay and benefits settlements, employment security concessions often referred to as 'concessions bargains', rapid decline in trade union membership in the 1980s and some decline in strike activity. In line with these changes management has instituted employee involvement programmes and job design schemes intended to enhance worker cooperation at the workplace as well as commitment to the firm in the unionized sector. These programmes have been dubbed the 'New Industrial Relations' (Kochan et al. 1986).

At just about the same period, a shift has taken place at the highest level of corporate decision-making, where basic policies regarding human resources, technology and the status of unions are formulated. Kochan et al. argue emphatically that the transformation of U.S. IR is the result of environmental pressures that had been building up gradually, as well as organizational strategies that had been evolving quietly for a number of years. They attempt to develop a more strategic perspective of U.S. IR and show that future patterns are not ultimately predetermined by economic, technological or some other forces in the American environment. Their main argument, therefore, is that:

IR practices and outcomes are shaped by the interaction of environmental forces along with the strategic choices and values of American managers, union leaders, workers, and public policy makers (Kochan et al. 1986: 5).



The motivation for the development of Kochan et al.'s theoretical framework which emphasizes the role of strategic choice in IR and PM was derived partly from the inability of both middle range and systems theories to explain some anomalies in American IR. The framework was, thus, aimed at improving the explanatory power of Dunlop's systems theory.

The basic assumption of the Dunlopian IR systems model is that the actors - labour, management and government-share an underlying consensus that defines and legitimizes their role. This shared ideology supposedly lends stability to the system. Dunlop's original statement on ideology, however, allows for the possibility of the absence of a shared ideology; Dunlop notes that in such a case conflict will arise over the very structure or organization of the IR system.

Kochan et al. (1984, 1986) argue that it is the absence of a shared ideology that helps to explain changes in the U.S. IR system over time. These changes result in environmental turbulence and remove the element of stability; therefore, it becomes difficult for systems theory to explain the dynamic aspects of the IR system. The authors insist that the adoption of the concept of strategy, or strategic choice, will add a more dynamic component to systems theory, and in so doing will help explain the changing patterns and anomalies in U.S. IR. policy.

The strategic choice perspective which is considered by Kochan et al. as a new theoretical framework takes the view that a shared ideology may exist only at the collective bargaining level; however, decisions are made at levels other than the collective bargaining level, where a shared ideology does not necessarily exist. This may for instance be the case at the top levels of organizations where strategic decisions are formulated. Having incorporated the concept of strategic choice into the systems model, the authors focus primarily on management, which in recent years has made the most important strategic decisions.

Kochan et al. provide empirical evidence to support their view that U.S. management has recently re-adopted union-free values, or

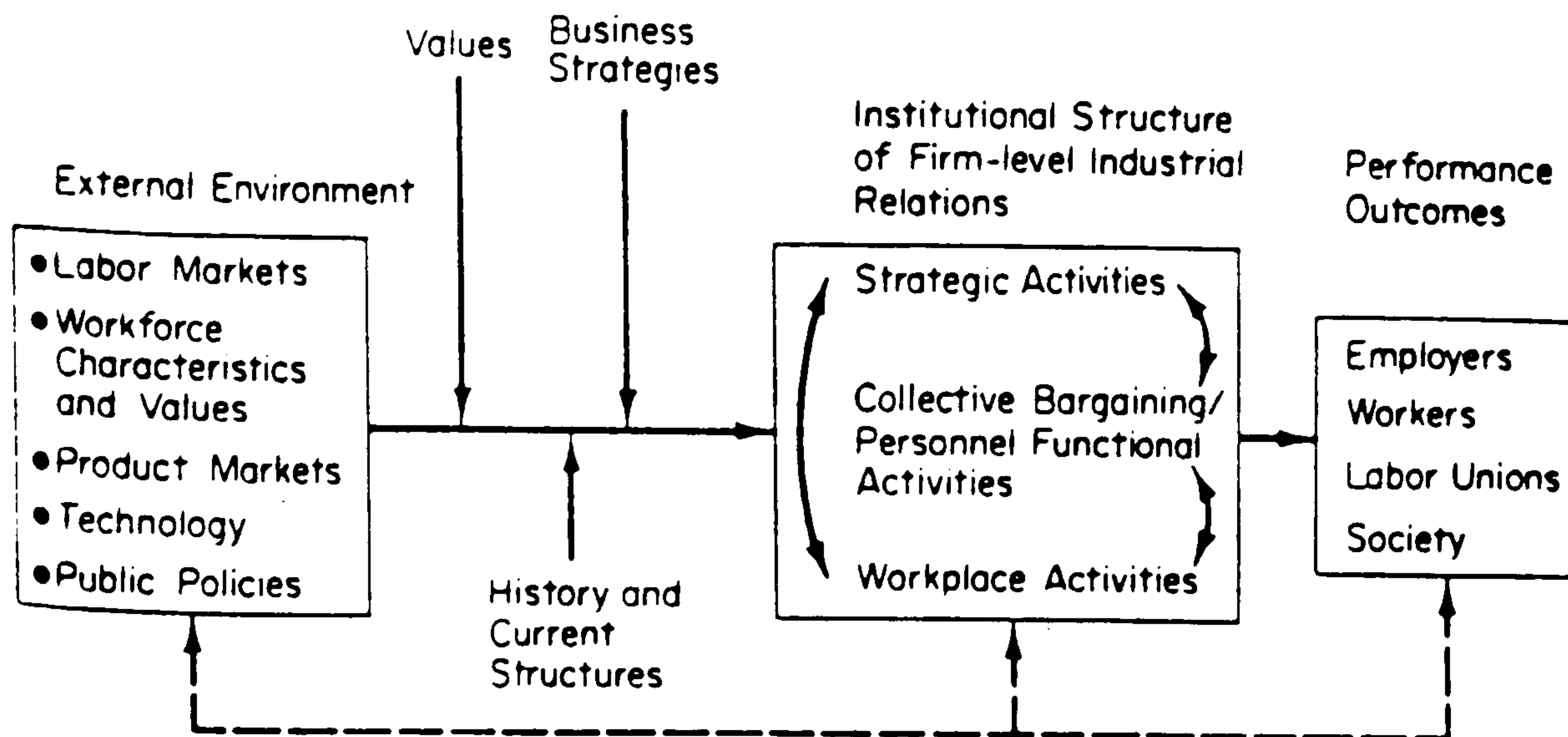


union containment policies, thus shattering the pluralist assumptions of IR researchers that American managers have since the passage of the 1930s labour legislation accepted the legitimacy of unions. This change in managerial values has in their view tilted the balance of power in organisations from IR staff to human resources staff. The power of the latter group arises from the managerial opposition to unionism which has resulted in the adoption of union-free or union-avoidance strategies in the 1980s. Consequently, the traditional IR professional, whose primary responsibility in the past was to achieve stable and peaceful labour relations, has lost power to both the HRM professional and line managers.

This is even more apparent in organizations where the top executives have demanded greater organizational innovation in managing employees than could be provided by many traditional labour relations managers at the workplace level. The innovative programmes, which include various forms of worker participation, such as QWL and QCs, are introduced often with the active support of the local unions. These initiatives often represent alternatives, or sometimes supplements, to collective bargaining. They are meant to replace adversarial relations with more cooperative relationships.

Evidence provided by Kochan et al. shows that the traditional role of the U.S. government as the regulator of the process of rule setting, but not of the outcomes, has also changed in recent years. Between 1960 and 1980, U.S. government regulations covering the terms and conditions of employment expanded rapidly. The authors mention that the assumption of power by the Reagan Administration marked a sharp reversal in that approach, and to some extent in the government's role as a neutral third party in regulating the process of bargaining. These changes in policy, they suggest, require a reassessment of the government's role in U.S. IR.

Kochan et al. (1986) present in a diagrammatic form (Figure 2.1), the broad theoretical framework guiding their analysis.

Figure 2.1General Framework for Analyzing Industrial Relations Issues

Source: Kochan et al. (1986: 11).

The model is derived from the traditional IR theories and the literature on corporate strategy, structure and decision-making. It makes explicit the roles of government, values, business strategies, institutional structures and the history of the organization in the analysis of IR processes and outcomes. The principal research thrust here is to gain greater understanding of the institutional interaction. The following quotation from Kochan et al. (1986) captures the essence of this model.

Like traditional IR theory, our model starts with consideration of the relevant forces in the external environment that affect employment relationships. Changes in the external environment induce employers to make adjustments in their competitive business strategies. In making these adjustments, the range of options considered are filtered and constrained so as to be consistent with the values, beliefs, or philosophies ingrained in the minds of key decision makers (p. 12) .

Just as management strategy and values play an important role in explaining IR outcomes, so too do the values and strategies that influence the behaviour and policies of unions and government. The



framework thus shows that IR and PM processes and outcomes are determined by a continuously evolving interaction of environmental pressures and the responses (i.e. the choice and discretion) of employers, unions, and government.

In the American case, choice is constrained by management values which more often manifest themselves as a deep-seated antipathy toward unions. Kochan et al. lament that researchers in IR and related fields have been unwilling to acknowledge the existence and power of this managerial belief system.

Table 2.1

*Three Levels of Industrial Relations Activity*

<i>Level</i>	<i>Employers</i>	<i>Unions</i>	<i>Government</i>
Long-Term Strategy and Policy Making	Business Strategies Investment Strategies Human Resource Strategies	Political Strategies Representation Strategies Organizing Strategies	Macroeconomic and Social Policies
Collective Bargaining and Personnel Policy	Personnel Policies Negotiations Strategies	Collective Bargaining Strategies	Labor Law and Administration
Workplace and Individual/Organization Relationships	Supervisory Style Worker Participation Job Design and Work Organization	Contract Administration Worker Participation Job Design and Work Organization	Labor Standards Worker Participation Individual Rights

Source: Kochan et al. (1986: 17)

The new theoretical framework recognizes the different levels of decision making that occur within business, labour and government organizations and their independent effects on IR and PM outcomes. Kochan et al.'s three-tier framework which is shown in Table 2.1 recognizes these levels. It illustrates the location of strategic decision making in a firm. The columns of the matrix represent the three key actors who make strategic decisions - employers, labour organizations and the government. The rows represent the levels at which these decisions are made. The effects of these decisions,

however, may appear at levels other than those where the decisions are made. The authors focus their analysis on strategic choices made by management, particularly those decisions made at the top-tier. They are primarily interested in explaining employers', or management's, IR activity. The belief is that the recent transformation in U.S. IR was set in motion mainly by managerial strategic decisions.

While Table 2.1 seems to suggest that strategic choices are made only at the top level of IR activity, Kochan et al. show otherwise. For example, strategic choices at the workplace level are mainly those associated with workers, as individuals, or work groups and their relation with their immediate work environment. Strategic choices made here are most directly associated with the organization of work, the structuring of worker rights, and the management and motivation of individuals or work groups. This includes job design, work organization, work rules, worker-supervisor relations, and the public policy relating to individual rights at the workplace - for example, occupational health and safety or equal opportunity laws. Kochan et al. (1986:18) maintain that since they are part of the on-going, day-to-day worker-employer relationship, the activities that occur at this level normally are not under the direct control of the collective bargaining process, since formal personnel policies and negotiated agreements are decided at higher levels of the organization.

The middle or functional tier is where collective bargaining and personnel policies are negotiated or designed and implemented. Strategic choice made at the top tier represents a new frontier in U.S. IR research and practice. It is at this highest level that business decisions in the area of managerial prerogatives are made. It calls for the need to analyse the relationship between broad business strategies and IR and PM practices within a firm. Decisions made at this level affect IR and PM at lower levels of the organization and therefore are central to the analysis of IR and PM. Kochan et al.'s analysis, thus, emphasizes the changes within management in the locus of decision-making power and authority over employment issues in recent years.

Kochan et al. use this three-tier framework to highlight some developments at the workplace level which need to be explained. The



first involves experimentation with QWL programmes and other employee involvement in problem-solving activities. The second is the increase in management initiatives to introduce greater flexibility in the organization of work and the allocation of human resources. The authors argue that an adequate theory of IR should be capable of reasonably explaining why these developments are occurring and, most important, how to relate them to the rest of the IR system. Kochan et al. (1984:35) maintain that strategic choice is not meant as a complete substitute for explaining environment changes, bargaining structure, and organizational characteristics, but is an important additional and intervening variable that contributes to an understanding of the transformations of the U.S. IR system.

It is the view of the authors, therefore, that IR and PM researchers can build on existing research on business strategy and policy for an understanding of the evolution of an organization's IR and PM policies or strategies. Having said this, it will be worthwhile to assess managerial strategy and strategic choice theory as a whole. The next subsection is devoted to this task.

#### Management Strategy and IR and PM Analysis.

As the preceding section shows, in the view of Kochan et al. it may be useful to consider the three-tiers, environmental pressures and strategic choices in the analysis of contemporary U.S. IR and PM practices. They maintain that although the three-tier framework is not a fully developed theory of IR it shows the inter-relationships among activities at different levels of the system. It is also a useful tool for analysing the impact of various strategic decisions on the different actors in the system. It also encourages the systematic investigation of the roles that labour, management and government play in each other's domain and activities.

McCormick and Quinn Mills (1985:285) observe that the usefulness of Kochan et al.'s research is twofold. First, it attempts to link exhaustive field research on current practice to the development of new theory of the functions of an IR system. The research therefore attempts to bridge the gap between theory and practice. Second, the



authors' notion of a three-tier system of IR draws attention to the links between the three levels, instead of studying them in isolation. This enhances our understanding of all levels of the labour-management interaction and linkages.

In spite of the apparent usefulness of strategic choice theory Lewin (p. 31-32) criticizes the strategic choice literature, in particular its characterization of QWL processes as 'strategic choices' of the parties, that flowed from the business strategy. He comments that:

No definition of business strategy or IR strategy is offered in this narrative; no alternative strategic choices are considered, and no single concept or construct of strategy is operationalized or measured (Lewin 1987:31-32).

Used in this way, there is clearly a lack of consistent, clear or distinctive definition of strategy or strategic choice. Judging from the way in which the term strategy is used in the literature, Lewin (p. 35) concludes that Rumett's (1979) observation that the term is used idiosyncratically in the business strategy literature seems for the present to apply to its use in the IR strategy literature as well. Having arrived at this conclusion, Lewin moves on quickly to question the extent to which the concept of strategic choice can provide a linchpin to the theoretical developments of IR. Since Kochan et al.'s strategic choice theory is meant to improve the explanatory power of systems theory in the transformation of U.S. IR, Lewin begins his attack on Kochan et al. from Dunlop's (1958) claim to a theory. He dismisses Dunlop's IR systems as a theory because it could not be tested in a formal way.

Lewin's critique of Dunlop is reminiscent of Winchester's (1983a:102) comment that the debate on Dunlop's IR system theory has generally been characterised by confusion, repetition and ambiguity. Lewin observes that for the advocates of the strategic choice perspective, operationalization has taken the form of gathering, analysing and attempting to integrate into the conceptual framework a wide variety of primary and secondary qualitative and quantitative data. Thus, the additive evidence produced does not support the



theoretical construct of IR as a strategic variable or the accompanying notion of management as the prime mover of modern IR activity. Lewin finding Kochan et al.'s evidence unconvincing, insists that:

It may be plausibly proposed that employers recent union-avoidance activities are as (more)consistent with the reactive behaviour model as with (than) a strategic choice model of IR. Because Kochan et al. and other scholars have not as yet conducted the type of research which permits one to reject this alternative explanation, or null-hypothesis, the validity of the claim that union avoidance and disinvestment behaviour of management supports the notion of the IR as a strategic variable must be questioned (Lewin p.16).

Lewin's over-emphasis on quantitative research methodology is not limited to U.S. based research. Turning his attention to Purcell and Sisson (1983), Lewin (p. 21) challenges their conception of management strategy as the driving force behind the restructuring of bargaining in the UK. In Lewin's view this claim lacks empirical validation, if not theoretical justification.

Lewin (p. 22) also reviews Kochan et al.'s (1986) findings on labour-management cooperation and worker participation. He (p. 24) argues that this research evidence does not necessarily support the view that new initiatives in labour-management cooperation reflect the strategic choices of management and labour. On the contrary, Lewin (p. 23) argues, the introduction of new IR policies and practices into the workplace is a reaction of the parties to external environmental pressures and a search for new 'solutions' to labour relations problems. He observes that with so heavy a reliance on ex-post facto deduction, few specific hypothesis about strategic choice among various labour-management cooperation schemes have been posed and tested. Instead, what is available are certain industry case studies which have been interpreted by their authors to support the strategic-choice model of IR, but which can just as readily be interpreted to provide contrary evidence and support rival hypotheses.

Lewin contends that IR researchers have not as yet produced evidence to support a distinctively strategic choice theory of IR as otherwise available evidence can just as readily be interpreted to



suggest that labour and management in the U.S. and elsewhere have been reacting to major environmental changes that occurred during the 1970s and early 1980s. Thus Lewin suggests that the cooperative programmes in U.S. auto industry are reactive rather than strategic in origin. Automakers, despite their well developed business planning processes and substantial planning staff, writes Lewin, have basically been reacting to, not anticipating, changes in consumer tastes, demographic trends, and increased competition. Consequently, the introduction of QCs and other cooperative programmes has the basic objective of achieving greater flexibility in, and higher performance from, the use of labour and equipment. To elaborate on this point Lewin contends that even where quantitative methods have been employed in strategic choice research the findings fall far short of supporting a strategic choice theory of IR.

Whilst Lewin attacks Kochan et al.'s research methodology, McCormick and Quinn Mills applaud the wide variety of research methodologies used - including statistical analyses, case studies, interviews, and discussions with unions and management participants in the IR system.

It appears that Lewin has a unilinear view of research methodology, and every research work which does not follow his expected type of quantitative research methodology is not valid. This view particularly applies to Lewin's comment on Purcell and Sisson's study.

After a careful review of the managerial strategy literature it is perhaps correct to suggest that apart from the inconsistencies in the usage of the concept of strategy. Kochan et al. effectively discuss strategic choice as an explanatory variable in the 'transformation' of U.S. IR although strategic choice is not a complete theory with testable hypothesis. Lewin is perhaps right in saying that Kochan et al.'s model is an overarching framework. Its contribution, however, is to organize people's perceptions and understanding of PM processes and outcomes. The three-tier framework can produce testable hypothesis, however, Kochan et al's emphasis is on historical developments in IR and PM practices in the U.S. and the factors responsible for changes in the system. It is therefore little



wonder that Kochan et al. did not set themselves the task of producing testable hypothesis. Their objective is to build a theoretical model to explain the 'transformation' of U.S. IR and PM. This theory building objective is far from a methodological exercise in theory testing. The testing can be done after the theory has been fully developed. Their critics, particularly Lewin, are perhaps not clear about this objective and have principally concerned themselves with the research methodology that Kochan et al. should have adopted rather than with assessing the usefulness of their research.

In spite of the criticisms of the concept of managerial strategy (and for that matter strategic choice), its introduction as a strategic variable is an enormous contribution to PM research. Firstly, it points to a new perspective in PM research by indicating that management has been the initiator of changes in IR and PM practices in organizations. It points out that managerial initiatives play a crucial role in the formulation and implementation of strategies to respond to changes in an organization's environment; whether it is changes in the market or public policy, managers develop strategies for coping with the opportunities and constraints of the external environment. The managerial strategy perspective poses a challenge to conventional IR especially in the U.S., which takes the view that management reacts to changes initiated by unions. In a sense, it points out that perhaps organizations do not just respond to environmental pressures but rather, PM practices and outcomes are influenced by the interaction of environmental pressures along with the managerial values and strategies. Seen along these lines choice and discretion on the part of management affect the practice of PM.

Secondly, the theory has shown that in the 1980s in both the U.K and U.S. the increasing tendency to link organizational strategies with human resource strategies has produced important outcomes at the workplace level. For instance it has resulted in changes in the practice of PM in organizations creating a conducive atmosphere for the growth of HRM initiatives and consequently allowing line managers to assume increasing responsibility for the management of human resources.

This discussion essentially points out that both managerial



strategy and strategic choice share some common elements. Both strategic choice and managerial strategy involve an element of choice exercised by the management of an organization in formulating and implementing decisions to cope with environmental pressures. Managerial strategy and strategic choice theorists argue that in the face of environmental constraints there is often a diversity of possible strategies for an organization at any particular point in time. The element of choice lies in managers determining what circumstances or events to exploit. Thus managerial strategy and strategic choice emphasize the element of choice that may be at the disposal of the management in shaping organizational objectives and policies and in adapting to external forces. The successful manipulation and control of the environment depends on the management's perception and evaluation of events. Managerial strategy and strategic choice, then, essentially carry the same message: the power of managers to formulate and implement strategic decisions. This indicates that strategic choice is part of the broader concept of strategy. If strategic choice is part of the broader concept of strategy, then, there is the need to harmonize the usage of both terms. This thesis will therefore use the concept of managerial strategy instead of strategic choice. Unlike Kochan et al. (1984) the two concepts will not be used interchangeably.

Management Strategy and Management of Human Resource in the  
District Health Authorities in the U. K.

It is perhaps appropriate at this stage to ask: what can be taken from the above discussion to apply to this research? It is worthwhile noting that in spite of the criticisms of managerial strategy it is still an interesting concept and it can be used to understand this research. Following Dimmock and Sethi, therefore, strategy in this thesis refers to the process in which the management of an organization proceeds to plan, shape and systematically exploit circumstances or events within the environment in ways that are perceived to bring it nearer to its aim.

This thesis attempts to modify the Kochan et al. framework and



apply it to a U.K. organization. It is not clear whether it can be applied in different countries with different IR and PM traditions. However, this is going to be explored to determine how useful and how relevant it will be in the NHS - a U. K. public sector, multi-level organization which is heavily influenced by political considerations. It thus raises the question: can the concept of managerial strategy discussed above be used to explain the recent innovations in the management of human resources in the NHS?

In both the U.K. and U.S. most of the discussion on managerial strategy concentrate on the private (manufacturing) sector. Moreover strategy in the private sector is often a response to product market constraints and opportunities. Because the NHS is a public sector organization, the greatest pressure comes from the political environment (government), rather than the product market as indicated by Kochan et al. In the NHS, central government public policy often exerts pressures on the management of the service, and initiate changes in the NHS environment. In recent years the changes result from the desire to improve the managerial efficiency of the NHS. This was the reason behind the Griffiths Inquiry. Once the Griffiths report was accepted by the government, attempts were made to implement it in the NHS. This required the design of new organizational structures and the adoption of managerial strategies to cope with the new demands of the external environment. One such demand, was the need to pay particular attention to quality in the NHS. The Griffiths report and subsequent restructuring thus initiated changes in managerial values on quality and resulted in the adoption of managerial strategies taking into consideration the history of the NHS and the organizational structure.

It is therefore in this respect that the three-tier framework becomes relevant. This can be analysed in relation to the different levels in the NHS. The three-tier levels of analysis is perhaps comparable to the three levels in the NHS. The top-tier represents the national level (i.e. the NHS Supervisory and Management Boards). The middle tier represents the RHAs, and the bottom-tier represents the DHAs. The management of the NHS is so complex that it may not be feasible to use the Kochan et al. framework this way to analyse the



management of human resources in the NHS. It may perhaps, be better to apply a modified version to the DHA level and consider the NHS Boards and the RHAs as part of the external constraints.

Both the RHAs and the DHAs face the consequences of initiatives from the NHS Management Board which, in turn, is responsible to the NHS Supervisory Board. In this case the national (government/NHS boards) and RHA levels are essentially environmental constraints since they are the strategic actors. In terms of the control of resources, then, one could argue that the government, as represented by the NHS Supervisory Board, is an external constraint. The NHS Supervisory Board and the NHS Management Board are mainly responsible for strategic initiatives in the NHS. This being the case, the government has used its decentralization and centralization approaches, as well as its role as the provider of funds in the NHS, to exercise a degree of initiative and control. The government has used this political and financial power to influence the adoption of strategies, for instance, QA strategies and initiatives in the DHAs. These national strategies are passed on to the RHAs which in turn passes them on to the DHAs. Thus the regions are required to make sure that the districts develop and implement the QA initiatives. In view of this the managers at the district level have attempted to develop QA and QC strategies. However, strategy formulation and implementation in the DHAs are constrained by NHS national priorities and financial constraints.

This then raises the question: who is running the NHS? Nairne (1985:122) argues that, an answer to this question is not a simple one and is certainly not to be provided by the analogy, for example, of parent and subsidiary companies in the private sector. NHS general managers in a particular health authority have to deal with the DHA and with multidisciplinary teams in addition to the constraints imposed by the policy and political aspects of a national service.

Arguing along the same lines, Smith (1984:5) maintains that the NHS is made up of three loosely coupled systems and domains namely: policy or political domain, management domain and service or professional domain. The policy domain is the level at which the government sets policies for the NHS. The policy domain deals with rational business management, focussing on organizational efficiency



and effectiveness. The service domain comprises professionals who consider themselves capable of self-governance, who protect professional standards and non-conformist individuality, and who perceive themselves as experts focusing on individual clients. Thus the clinical autonomy aspect of the NHS together with its union features and lack of managerial influence over reward systems essentially sets it apart from a commercial enterprise. The complexity of the NHS affects the management of the service. It dilutes management principles of hierarchy and control. It also blurs organizational goals and results in internal competition for resources. For instance, it may be difficult to reconcile management value of organizational efficiency with the professional norm of clinical excellence, if the attempt to achieve organizational efficiency (e.g. cutting staff levels) interferes with clinical practice. What this amounts to is that:

The management of the NHS does not have the sole right to regulate the organization. In most other types of enterprise the management system has primacy: the authority to determine and direct all the organization's activities. In the NHS this is not so. (Smith 1984: 4)

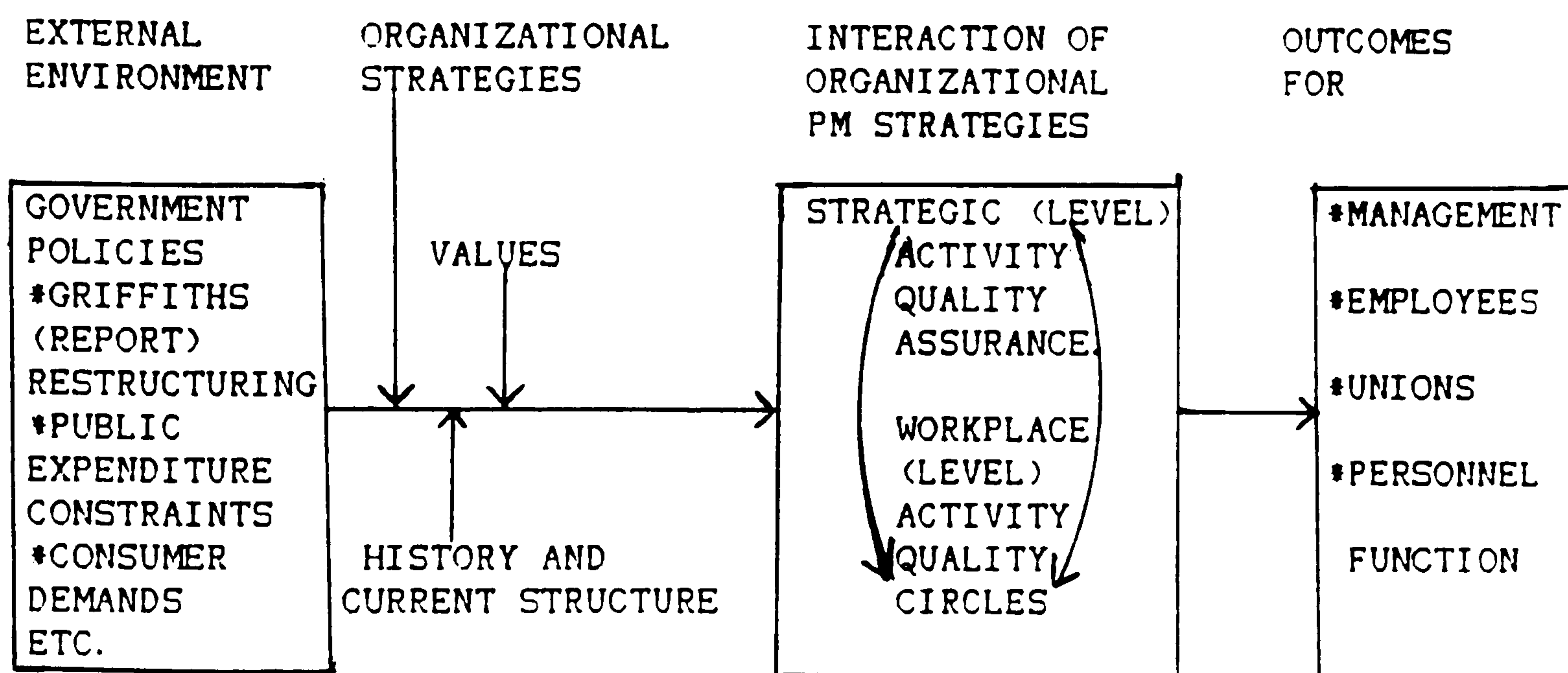
Faced with such environmental constraints it is not clear whether the management of any particular DHA still has a choice in adopting managerial strategies although some DHAs have implemented such initiatives as face-to-face communications, team briefing, customer care, and QCs. This thesis will explore whether management strategy in the DHAs contains choice within constraints. In discussing the formulation and implementation of managerial strategy at the DHA level, Kochan et al.'s (1986: 11) general framework for analysing IR and PM issues is important because the framework explicitly shows the role that the environment, values, business strategies, institutional structures and history play in the analysis of PM processes and outcomes. The framework also incorporates the three-tier model in the institutional structures section. Here the framework depicts on the one hand a direct relationship between the strategic (top) level and the workplace (bottom) level. This direct relationship bypasses the middle level. On the other hand, there is a direct relationship



between the top-tier and the middle tier and then between the middle tier and the bottom tier. This framework, thus, allows the possibility of adopting one of the two interactions in an analysis. With some modifications, however, the Kochan et al. framework can be applied to some of the recent developments in the NHS. Figure 2.2 below is a modified version of Kochan et al.'s framework which could perhaps allow analysis within a DHA.

Figure 2.2

**A Modified Framework for Analysing HRM Issues in the District Health Authorities**



This framework will be used to analyse the factors responsible for the emergence of managerial strategy in the two case-study DHAs; its impact on the personnel function and the emergence of HRM initiatives.

Within the DHAs, however, the district level can be considered as the top-tier/strategic level whilst the unit levels can be considered bottom-tier. (This analysis considers only the interactions under the employers row of the Kochan et al. three-tier framework). Since general managers have responsibility for strategic management it is plausible that at the DHA level, managerial strategies are developed at the top-tier (strategic level), and directly applied to the bottom-tier (workplace level). This research will therefore deal with the direct relationship between the top-tier and the bottom-tier at the



DHA level in the NHS. It will explore the environmental constraints and opportunities that managers face in the formulation and implementation of the managerial strategies. It will also attempt to answer the question whether these managerial strategies in any significant way alter the existing arrangements at the middle-tier.

This research will thus deal with the effects of managerial strategies adopted at the top-tier on PM practices at the bottom-tier. In other words, how managerial strategies at the top-tier influence or affect PM processes and practices at the bottom-tier. The emphasis is on management because in so far as the Griffiths restructuring is concerned, it is mainly management that has been the initiator of change in the DHAs. It will determine whether the unions have played any significant role in the formulation and implementation of strategies to cope with the pressures emanating from the Griffiths restructuring. An exploration of these issues would perhaps allow the framework to be revised substantially.

### Conclusion

This chapter has discussed the concept of strategy and its application to PM research. It has also discussed the salient aspects of both Thurley and Wood and Kochan et al.'s discussion of strategy and strategic choice. An attempt has been made to reconcile the concepts of strategy and strategic choice. Thus strategic choice is considered as part of the larger concept of strategy. The chapter also assesses the managerial strategy theory noting in particular Lewin's critique. In spite of the criticisms of managerial strategy theory it has been shown that it can be applied to this research. As indicated earlier the greatest contribution of the managerial strategy theorists is the view that the integration of managerial strategies with human resource strategies result in an increasing role of line managers in personnel issues. The managerial strategy literature also point out that the adoption of managerial strategies precipitate the emergence of HRM. Chapter three therefore deals with the theoretical discussions regarding the changes in PM and the emergence of HRM notably in U.K. organizations in recent years.

## Chapter 3

FROM PERSONNEL TO HUMAN RESOURCE MANAGEMENT?

The preceding chapter discussed the concept of strategy which is an important variable in understanding employment relations in an organization. This chapter explores the changing nature and style of PM in the U.K. In pursuit of this objective section one will discuss, among others, the traditions which form the basis of the personnel function in the U.K., the practice of PM in the U.K. and the changes in the personnel role as a result of the recent emphasis on the human resource approach.

This discussion will be followed in section two by an examination of the roots and emergence of HRM, as well as problems in its definition. It addresses the various aspects of the debate over the differences between PM and HRM, and attempts to distinguish between HRM and 'strategic HRM'. The third section is concerned with the Guest's attempt to develop a coherent HRM theory. It also presents the essential components of Kochan and Chalykoff's model, explaining the emergence and persistence of HRM. This involves a discussion of the role of managerial strategy in the formulation of HRM policies.

Section four addresses the relationship between HRM and IR, and emphasizes in particular, the unitarist assumptions and individualistic focus of HRM which tends to downgrade the role of unions. This discussion is followed by some brief observations on the relevance of HRM in the U.K. The concluding section of the chapter raises some issues which will be explored in the empirical section of the thesis.

The Changing Nature and Style of PM

In recent years the focus of IR and PM researchers on the role of management has yielded numerous studies on the changes in PM and the subsequent rise of HRM. A discussion of these changes can begin with



the work of Kochan and Cappelli (1984) who have conducted an extensive analysis of the changes in the U.S. It is important to mention the U.S. literature, since the changes began earlier in the U.S. and are more advanced than in the U.K. Moreover many U.K. organizations which have adopted HRM initiatives take their cues from U.S. organizations.

Kochan and Cappelli make use of a broad conceptual framework to interpret the historical evolution and changing role and power of IR-personnel units within large U.S. organizations. Their analysis focus on four historical periods: (1) 1900-1935, when personnel and IR units first began to emerge as a professional staff function in major firms; (2) 1935-1960, when IR rose to the dominant power position within personnel and IR departments; (3) 1960-1980, when IR units generally maintained their power, or experienced a gradual, but generally unnoticed, decline in power, whilst the personnel-HRM specialists regained power and influence; and (4) the early 1980s, in which the roles of personnel and IR were undergoing fundamental restructuring and change.

Following Baron et al. (1986, 1988) and Harris (1982) who have traced the evolution of PM in the U.S., Kochan and Cappelli mention the influential role of the state in the origin and development of PM in the US, in particular, President Roosevelt's New Deal and the subsequent passage of the National Labour Relations Act in 1935. This facilitated the growth of IR departments within organizations. In line with the increasing state regulation of employment, the period between 1960-1980 witnessed an increase in the use of legislation. In many cases personnel departments were expanded to include responsibility for monitoring compliance with government legislation such as safety regulations, pension programmes and affirmative action.

The early 1980s however, witnessed a lack of enforcement in legislation. This, together with the decline in union pressure, gave managers the opportunity to move away from a collectivist to an individualist approach to personnel. This approach seeks to bypass or substitute for the union, and establish direct communications between management and workers. It is aimed at ensuring closer integration between human resources and organizational strategy. The spread of these programmes in the U.S. generally contributed to the



decline in power of the traditional IR management, and the emergence of HRM.

In recent years some organizations in the U.K. are also following the example of some U.S. organizations and have attempted to incorporate the human resources approach in their IR and PM practices. Sisson (1989), however, argues, that the actual practice of PM in the U.K. is deeply rooted in specific contexts. In view of this, the discussion of PM in the U.K. should necessarily make reference to its historical origins.

Niven (1967) and Anthony and Crichton (1969) have traced the origin and development of PM in the U.K. In the account of these authors PM in the U.K. developed out of welfare work. According to Niven, Thomason (1981), Tyson and Fell (1986) and Tyson (1987) the welfare tradition in turn had its origin in the industrial betterment movement of the late nineteenth century. Thus the earliest specialists in the employment relationships were primarily concerned with the welfare of individual workers, especially women, and with balancing the search for profit with the betterment of the individual worker (McGivering, 1970). It was out of this welfare work that the Industrial Welfare Society, the forerunner to the Institute of Personnel Management (IPM), was formed in 1913.

Following the welfare tradition emerged the employment management or manpower control function which concentrated on controls and how to obtain compliance. Here, personnel departments seem to have been established in response to the growth in numbers of people employed in organizations in the 1920s and 1930s, to the complexity of the business, and to a felt need for the formalization of procedures in PM. This tradition was followed by the 'professional tradition' which arose mainly because of the desire of personnel managers to gain status in organizations after 1945.

This tradition emphasized the possession of specialist knowledge and expertise in personnel techniques and employment laws. It also encouraged the development of personnel departments which are well integrated into the organization and valued by line management. The personnel specialists demonstrate competence in pay, IR, recruitment and selection and training. The IPM led the struggle to



professionalize PM, and in view of the influential role it played in this process it acquired the reputation of a 'qualifying' association.

Armstrong (1984, 1986) gives an account of this struggle by personnel managers to achieve professional status and to move away from its welfare origins. In his account the transformation of welfare work into PM was facilitated by the adoption of strategies for dealing with issues for which the personnel specialists purport to offer solutions. Examples of such issues are rate-fixing, interviewing, selection and record-keeping. They claimed that they possessed specialized knowledge for the performance of these functions. In view of this, the personnel association opposed the employers' belief that everyone could do the job and attempted to persuade them to employ only trained personnel specialists.

Adopting this perspective, soon after World War I, personnel specialists increasingly appropriated the training of first line supervisors and middle managers. Moreover personnel specialists developed and administered personnel policies (Cuthbert and Hawking 1973). In spite of these activities by personnel specialists and the IPM, the development, institutionalization and professionalization of PM was advanced less by the efforts of personnel specialists themselves than by the activities of the state, particularly through the enactment of legislation in the 1970s. This, then, brings us to the fourth tradition.

The fourth tradition, which is the IR tradition, arose in the 1960s and 1970s in line with the increasing importance of workplace bargaining and the enactment of legislation. Batstone (1980) and Guest (1982) mention the influential role of the Donovan and Bullock Reports, the Industrial Training Act of 1964, and other legislation at the national level which helped further the growth of PM and IR. Along the same lines, Tyson (1983) discusses state interventions through laws and their enforcement agencies as a factor in the development of PM in both the public and private sectors in the U. K.

This legislation was on trade unions and collective bargaining, discipline and dismissal, pensions, redundancy, health and safety, contracts of employment and equal opportunities (Cowan 1985). In an attempt to achieve harmonious relations with trade unions and to



adhere to the legislation, many personnel specialists were hired for the establishment, interpretation and negotiation of trade union agreements and other personnel policies. As the new laws were aimed mostly at limiting managerial prerogatives it became necessary for the personnel specialists to advise managers on what they could do and what they could not do. Thus in the 1970s the power and influence of personnel managers in organizations were tremendously increased (Cowan, P. 2). These traditions have influenced the diverse nature of the practice of PM in the U. K.

Purcell (1987), Purcell and Sisson (1983) and Sisson (1989a: 9-10), in discussing the practice of PM in the U.K., argue that management style in handling employee relations is dependent on whether or not trade unions are recognized for the purpose of collective bargaining. Where management does not recognize a trade union, it is likely to emphasize the relationship with the individual; where it recognizes unions it is likely to emphasize the relationship with trade unions and relations with individuals are relegated to the background. Based on this differentiation Sisson has come up with four models of management style namely: traditional, constitutional, sophisticated human relations, and consultative.

Under the traditional model, unionization is opposed and there is emphasis on employee subordination. Moreover, employees are viewed as a factor of production. The constitutional model recognizes unions and management's employee relations objectives are to achieve stability, control and the institutionalization of conflict. Management prerogative is, thus, fiercely defended through highly specific collective agreements which are carefully administered.

The sophisticated human relations model sees employees as the organizations most valuable resource. Emphasis is placed on flexible reward structures, above-average pay, internal labour market structures with promotion ladders, employee appraisal systems linked to merit awards, internal grievance, disciplinary and consultative procedures, and extensive networks and methods of communication. The objective of such policies is to foster employee loyalty, commitment and dependency so as to discourage unionization.

Organizations following the consultative tradition recognize



unions. Management hold discussion and provide information to the unions on a broad range of decisions and plans, including some aspects of strategic decisions, although the final decision rests in the realm of management. Emphasis is also placed on techniques designed to enhance individual employee commitment to the organization and the need to accept change. These techniques include QCs, briefing or information systems and joint working parties.

These are, in fact, ideal-types and it is conceivable that many organizations in the U.K. do not conform to any of them. In more realistic terms, the practice of PM in the U.K. is a mixture of what is referred to by Thurley (1981) as 'ad hocery' and Purcell and Sisson (1983) as pragmatism and opportunism. This to some extent has been the basis of the ambiguous role of personnel specialists and their lack of authority. As Sisson (1989a) argues, the numerous discussion in the personnel literature (see, for instance Legge (1978) Legge and Exley (1975), Watson (1977), Purcell and Gray (1986) and Marsh (1983)) on the ambiguity of PM as a specialist function in the U.K. can be attributed to the particular development of the function.

The ambiguous nature of the personnel task revolves around the performance of the PM role in organization. In order to explore this issue it will be necessary to discuss the line and specialist personnel functions in organizations. Tyson and Fell (1986:7) agree with Watson (p.1) that it is a truism that all managers are personnel managers, but maintain that there is a distinction between PM as an element of line management and PM as a specialist function. In most organizations, however, the distinction is not all that clear-cut.

In view of this some authors have attributed the ambiguity in the PM task to the lack of clarity in the definition of the personnel function. The main argument here is that management has no clear definition of, or expectation for, and that personnel function, and the personnel managers themselves often cannot explain what their role should be, thus creating ambiguity between the personnel and line management roles. Herman (1968) seems to agree with this assessment. Following Ritzer and Trice (1969) and Herman, Legge and Exley argue that the confusion over the personnel function arises in part from problems of definition, and write:



The terms 'personnel department' and the 'personnel function' are often used and regarded as synonyms for each other. In practice of course, the 'personnel department' and the 'personnel function' although not co-terminous are not fully discrete either. If we accept the usual broad definition of what comprises the personnel function (i.e. the optimum utilization of human resources in the pursuit of organizational goals) its activities must necessarily spread beyond the personnel department i.e. the function's institutionalized presence in the organization and involve managers in every other function whether production, marketing, finance, and so on (Legge and Exley, 1975:54).

The authors continue that not only is the boundary between the personnel department and the personnel function confused, but so is that between the personnel function and other management activities. The confusion between the role of the personnel department and personnel function, as well as that between the personnel function and line management, results in difficulty in differentiating the specialist personnel function from the general personnel function, which is more often carried out by line management. Legge (1978) has discussed the apparent confusion and inconsistencies in the definition of PM, and consequently has attempted to draw a clear line between the general (functional) and specialist perspectives.

The functional definition of PM emphasizes the optimal use of employees to achieve organizational aims and objectives. This includes planning, organizing, directing and controlling the functions of procuring, developing, maintaining and utilizing human resources with the objective of satisfying organizational goals. To refer to Tyson and Fell, then, it is the function which they see as every manager's responsibility - the function that transcends the personnel department.

The specialist perspective on the other hand considers the specialist personnel task performed by those who specialize in the personnel function. In the view of Tyson and Fell the specialist personnel manager is concerned with the management of the employment relationship. His/her purpose is to propose, coordinate and implement agreed policies in such areas as IR, reward structures, management development, training, recruitment and promotion, redundancy,



redeployment and on the conditions of service.

This perspective deemphasizes the line management aspects of the personnel function and emphasizes those activities undertaken by the specialist personnel department, or restricted, so to speak, to the personnel department. It is clear, however, that some of these specialist personnel functions are undertaken with the assistance of line managers, for instance, training. In spite of this distinction between the line and specialist aspects of PM, the fact still remains that the indeterminate nature of the personnel task makes any such distinction superficial.

One aspect of the ambiguous nature of the PM task is reflected in the decline in the influence of personnel managers in organizations in the 1980s. The reliance of line managers on the expertise of personnel specialists has been changing tremendously in the 1980s. Thomason attributes this fading professional image of personnel specialists to their skills and techniques. In his view the profession's techniques of human relations and social skills are too indeterminate to form a sufficiently exclusive and distinct basis on which to claim a monopoly of competence. Along the same lines Torrington and Hall (1987:5), following Legge (1978), argue that it is difficult for personnel specialists to demonstrate a closer relationship between their activities and organizational success.

Referring to the work of Knight et al. (1985) on this issue, Armstrong insists that personnel specialists can prosper in an organization only when the issues they address are, or can be made to appear, sufficiently grave a problem not to be handled incidentally by other managers. Thus, the logic of the personnel specialists' position in his view, demands that the control of labour, at both the individual and collective level, should continue to pose a problem, albeit one containable by the specialists techniques possessed by them. Unfortunately, it has been less easy for personnel specialists to demonstrate this effectiveness in recent years.

Cowan adds that personnel specialists are losing their influence in organizations because unlike in the past, line managers are now much more familiar with employment law, and although they still require some advice, they tend to need it less often. Cowan (p. 3)



maintains further that:

In addition, the law is so complex that professional legal advice is often needed. The result is that the personnel department is less a centre of advice and expertise than a filter passing the issue on to others... In the past, by contrast, there were many areas in which personnel people were able to give authoritative advice, and thus to strengthen their claim to having their own specialized body of knowledge.

These changes in the personnel role are associated with the human resource approach -the roots of HRM. In view of the increasing interest in HRM in recent years, the question that arises is what is meant by HRM? This the subject of discussion in the next section.

#### Human Resource Management

HRM has recently become a popular term but its meaning is quite imprecise. This is probably due to its diverse origins. Armstrong (1987) traces the roots of HRM to the 1950s, when Drucker (1954) advocated good, visionary, goal-directed leadership and McGregor (1960) emphasized the importance of integrating an organization's human resource strategy into the organizational strategy. According to these perspectives, human resource policies and programmes must also aim to get everyone involved in the achievement of the organizational objectives and plans. Out of this perspective emerged the view that human resources are the most important asset an organization possesses, and that their effective management is the key to its success and in seeking competitive advantage.

If HRM has diverse origins then it is necessary to discuss the various factors which have given birth to these views. Some factors which have influenced the development of HRM are the discovery of corporate culture and its influence on organizations and, the resurgence of interest in excellence (effective utilization of human resources) advocated by Peters and Waterman (1982) and Kanter (1984).

Others argue that the decline of trade union pressure on management as a result of the changing economic and political environment, and the move away from adversarial issues associated with



traditional IR towards individual, cooperative issues, have given rise to HRM. Taking this view a step further, Storey (1987:1) maintains that HRM is a response by organizations to environmental changes to improve viability and effectiveness. It is also a response to the intensified interest in customer-orientation, innovation, enterprise and competitiveness. The resultant interest in the management of human resources, with emphasis on individual as opposed to collective relations, has influenced the development of direct forms of employee involvement and communication, such as QCs and team briefings. These in turn, have influenced the developments in integrated reward systems, the linking of remuneration to performance, harmonization and flexibility. These changes are increasingly being associated with the adoption of HRM approach.

Similarly, Hendry et al. (1988:37) argue that those firms that have adopted HRM initiatives have done so under competitive (i.e., economic) pressures. According to this view, a complex set of business environment changes have led to a series of generic, strategic responses. The authors further identify some interdependent responses that have driven and dictated developments in HRM. These include: competitive restructuring, decentralization, internationalization, acquisition and mergers, 'total quality process', technological change, and new concepts of services management.

In view of the diverse factors attributable to the development of HRM, Ross (1981) maintains that a definition of the field of HRM remains elusive. Guest (1987) notes that HRM is a term widely used but very loosely defined. The term HRM, like the concept of strategy, lacks definitional precision. It is, thus, very ambiguous. In an attempt to clarify the ambiguity and imprecision in the usage of the term, Guest (1987:506) and Legge (1989:19-29) review the various ways in which it has been used. The first use is a mere name change from PM to HRM without any change in role. Thus HRM is used as a substitute name for PM or IR management. Following Legge (1978), therefore, Guest notes that the term HRM is not new, and it is possible to find examples over the last twenty years of HRM being used as a generic term in preference to PM. A quotation from Armstrong



epitomizes such use of the term. In Armstrong's words,

Why waste emotional energy trying to convince those who will not be convinced that what they mean by HRM is what you mean by PM? (Armstrong 1987:31).

The second approach has been the use of HRM to reconceptualize the personnel role and describe the work of personnel departments. This reflects in part the conceptual framework developed by Beer et al. (1985) at the Harvard Business School. According to this view, HRM often emerges as a set of staff activities lacking a coherent structure or central purpose imprinted by general managers. Beer et al. further propose that many diverse personnel and IR activities may be subsumed under the four main policy areas which define HRM tasks that general managers must follow in managing employees. These four policy areas are: employee influence, human resource flow, reward systems and work systems. These policies are pursued to ensure the maximum utilization of employees, and the policies may not be directly linked to the overall organizational strategy. Often the intended purpose of these policies is to discourage unionization. Thus HRM according to this conceptualization excludes IR strategies and is practised most often in non-union organizations (Tichy et al. 1982). This exemplifies what has been referred to as the 'soft' or 'loose' version of HRM by Storey (1987;1989) and Guest (1987) respectively. The other dimension is referred to as 'hard' or 'tight'. This categorization depends on whether the definition of HRM is general or precise. Consequently the 'soft' or 'loose' version denotes that version of HRM which is general and does not emphasize strategic integration,

This brings us to the third use of the term HRM which argues that it is distinctively different from PM, as it offers a new managerial approach; one which embraces, for example, a closely integrated strategic series of interventions in the way people are managed. Many of the writers on human resource strategy employ this approach. They include, among others, Walker (1978); Tichy et al. (1982); Devenna et al. (1981); Skinner (1981); Hendry and Pettigrew (1986,1987) and Miller (1989). The claim to distinctiveness lies in the integration



of the human resource strategy into the organizational strategy. In other words, strategic HRM entails integrating HRM policies and practices such as selection, training and remuneration into the organizational strategy. It thus emphasizes full and effective utilization of human resources

According to Hendry and Pettigrew (1986), strategic HRM has two overlapping themes: the first is contained in the term strategic, and the second in the idea or philosophy of human resources. The latter follows Drucker's (1954) view that people are a valued resource, a critical investment in the organization's current performance and future growth. It is people oriented, with an ethic of respect for the individual; a maximization of individual talents. The term strategic, on the other hand, Hendry and Pettigrew continue, has both established and new meanings which include the following: (1) using a coherent approach to the design and management of personnel systems based on the employment policy and manpower strategy and often underpinned by a philosophy; (2) matching HRM activities and policies to some explicit business strategy; and (3) seeing people in the organization as a strategic resource for achieving a competitive advantage.

Armstrong adds that strategic HRM generally deals with human resource planning and the achievement of organizational plans through recruitment and training, performance and reward management, career development, communications, involvement and commitment, building cooperative relationships with trade unions, productivity management, and being goal directed and forward looking. Here, unionized organizations attempt to incorporate the human resources approach to their traditional IR and PM practices. In a sense they imitate the approach of non-union organizations which pursue HRM through highly developed practices aimed at securing the commitment and involvement of the individual employees through training and development, counselling and appraisal (Foulkes 1980).

Human resource specialists perform their duty with the advice of personnel managers who provide the services required to implement the strategic plan. Moreover the human resource policies and activities usually fit the culture of the organization (Fowler, 1987). This conceptualization of HRM, unlike that of Tichy et al., does not delete



IR as a central strategic issue and therefore it is possible to practice HRM in any organization including those where trade unions are powerful. Again this is what has been referred to as the 'hard' or 'tight' version of HRM by Storey and Guest respectively. This, then, sums up the two dimensions of HRM namely: strategic and non-strategic HRM.

In spite of the major differences in orientation, the term HRM is used almost indiscriminately or, interchangeably, to represent strategic HRM. It appears that at one level both HRM and strategic HRM put emphasis on people as the most important resource of an organization; however, strategic HRM emphasizes the strategic planning of human resources. Both forms of HRM aim at achieving the loyalty and commitment of employees. HRM, then, can mean different things to different people: a retitling of the personnel function in an attempt to raise the status of the personnel specialist; to emphasize a reorganization of the approach of PM; to indicate a more strategic and integrated perspective in the management of employees. It is evident from the above that a review of the HRM literature does not yield any precise meaning of the term. But as Edwards and Sisson (n.d.:3) point out, HRM should properly denote a package embracing a strategic and integrated approach to 'people management'; the integration of employees on the basis of commitment and not mere compliance with instructions; and an organic and devolved business structure, as against a bureaucratic and centralized one.

Quite apart from the inconsistencies in the use of the term HRM the literature is not very clear about the differences between HRM and PM. It seems to indicate, however, that at one level HRM deals with long-term, proactive, strategic/integrated issues whilst PM generally deals with short-term, reactive, ad hoc and marginal issues. PM unlike HRM does not emphasize the management of people as an important aspect of the organization. Whilst PM emphasizes compliance, HRM emphasizes commitment and involvement of employees. PM relies on external controls whilst HRM uses self-control. On employee relations, PM has a pluralist, collective, low trust focus as opposed to the unitarist, individual and high trust focus of HRM. The roles are also different, PM often relies on specialist/professional competence whilst in HRM



the roles are largely integrated into the line management function. PM is often supported by bureaucratic/ mechanistic, centralized structures with formally defined roles whilst HRM is often supported by organic, devolved and flexible structures (Guest, 1987: 507).

These differences notwithstanding, both Guest, and Tyson and Fell, see the HRM model as a variant of conventional PM. Moreover, Guest suggests that there can be overlaps between the HRM and conventional PM and that the HRM approach is only one of the diverse approaches to managing people in organizations in the U.K. Guest (1989: 50) thus cautions that the HRM is by no means the dominant model, and for some companies it may not be the most viable.

As HRM aims at securing individual commitment and loyalty to the organization it also undermines the collective basis on which some personnel policies are based. In view of the emphasis on management of people, line managers assume some responsibility for PM, thus pushing the specialist personnel manager away from the forefront of people management. Thus, the emergence of individualist policies also heralds the emergence of line managers in personnel issues. Here, PM and IR issues are relegated to the margins whilst there is tremendous emphasis on HRM.

The increasing involvement of line managers in personnel issues has consequently given rise to academic discussions on the changes in PM and the role of senior line managers in the process. In a number of detailed case studies, Manning (1983), Purcell (1985), Purcell and Gray (1986), and Storey (1987) have argued that the changes in the political and economic environment in the U.K. have to some extent eroded the PM role in organizations. Such erosion in the personnel role has presumably occurred mostly in organizations which have incorporated the human resource approach to their traditional IR and PM practices. For those who see an erosion in the personnel role, the initiative in personnel issues has shifted from personnel managers to line managers with first line managers assuming responsibility for traditional personnel issues as absenteeism, appraisal, discipline, grievance etc. Here, line managers in many cases participate in the formulation and implementation of HRM policies with personnel advice. Moreover, line managers and even the chief executive often identify



with involvement programmes such as QCs (Storey, 1987).

Sisson (1989b) argues that the changes in the role of personnel managers, if they have occurred at all, have had little to do with the economic and political context, and much more to do with some of the underlying trends and developments in the nature of personnel work. In his view the changes in the personnel role may be due to the complex and fragmented nature of personnel work which is double edged in its implications:

To begin with, it manifests itself in a growth in the demand for experts - in compensation, communications, management development, pensions administrations and relocation, as well as some of the more traditional specialisms such as selection, training and employee relations... The corollary of this greater specialization however, is that it often ceases to be cost-effective for the individual organization to employ such specialists directly, and so the use of outside consultants, which has always been extensive in personnel work, is growing (Sisson 1989b: 37).

This often results in an intrusion of line managers and consultants in personnel issues. Consequently it results in ambiguity in the personnel function. Tyson lamenting the assault on personnel by line managers and the concomitant changes in the personnel role writes:

Personnel work can be seen to be subject to conflicting and powerful pressures which are leading to the balkanization of the personnel role. The territory which could have been delineated as personnel country, is being invaded, sold-off, subdivided and put under lease to consultants, sub-specialists and line managers, whose cross-cutting alliances do not correspond to a coherent separate function (Tyson 1987: 530).

These changes arise from the emergence of HRM because, in Guest's view, HRM is considered too essential to be handled solely by personnel managers. He writes:

If personnel managers want HRM to be taken seriously they have to give it away... Human resource issues were taken much more seriously... when managed at the top by line management committees, with personnel managers playing a supporting role (Guest, 1988: 5).

Guest is sceptical of any pro-active role of personnel managers



in HRM, since personnel's contribution to strategic management tends to be minimal. He points out that personnel managers might be expected to seek or promote HRM, but even if they were interested and had sufficient influence to do so, they would face a dilemma. They may want personnel issues discussed seriously at the board level, but HRM implies giving personnel away to line management. Guest (1988:5) thus concludes that for their own sake, personnel managers needed to sell or give away HRM to the line.

Such a view has precipitated a debate in the PM literature on the effects of the changing nature and style of PM on the role and status of personnel managers in organizations. Two camps can be discerned in this debate. The first of these includes Torrington and Hall, (1987: 14-180), Torrington et al. (1985), Mackay and Torrington (1986:75-80) who are more inclined towards the generalist or professional approach to PM, and see the HRM approach as a threat to PM. On the other hand, Millward and Stevens (1986) and Marginson et al. (1986,1988) have produced evidence from surveys to challenge the earlier assertion about the decline of the personnel function. They see no major threat to PM. They maintain that there has been relatively little change in the personnel role apart from a decline in board level influence as well as trade union representation. Moreover personnel managers have maintained their influence in the narrow area of labour-management relations. Others like, Brewster and Connock (1985:160-162), Tyson and Fell (1986) Tyson (1987), and Armstrong (1987) who regard the PM function to be more diverse and complex, see the changes as bringing potential opportunities to PM.

According to this view personnel managers should not give PM away but must align themselves with HRM or welcome it. These writers claim that HRM can help the development of personnel by introducing a more coherent and strategic approach to personnel work. For instance HRM may integrate a range of often disparate functions-recruitment, selection, appraisal, reward, development, etc.-into organizational strategy so as to position HRM input at the top level. Furthermore it may help personnel specialists learn new skills in identifying organizational missions and the kind of human contributions required to reach that goal. (Storey 1987).



Having discussed the various views and characteristics of HRM the next section explores the attempts to develop a theory of HRM.

### A Theory of Human Resource Management?

Kochan and Chalykoff (1986) and Guest, for instance, lament the lack of systematic HRM theory although there is implicit theory lying behind many of the writings of HRM. Moreover some scholars, including Beer et al., have made attempts at theory formulation. This lack of a systematic HRM theory has to a greater extent been attributed to the lack of clarity in the definition of HRM. Kochan and Chalykoff (p. 10-11) correctly point out:

In no other field of the social and behavioural sciences than HRM has organizational practice, management consulting, prescriptive academic and textbook writing or teaching so far outstripped theory and hard empirical data. The lack of a sound theoretical foundation in the face of a growing demand for information by practitioners has led to the proliferation of popular literature that focuses on process rather than content issues.

They argue that the development of a systematic theory of human resource policy will allow predictions about HRM. Guest thus sets himself the task of developing a theory of HRM. He begins by examining Beer et al.'s prescriptive Harvard framework. He argues that it cannot be a theory in view of the range of stakeholder interests and situational factors which require policy choices rather than clear prescriptions. Another weakness of this framework is that although employee influence in organizations is likely to vary according to situational factors such as the characteristics of the work force, Beer et al. do not take this view into consideration.

Guest turns to a review of the contributions of other behavioural scientists, such as Maslow (1943), Argyris (1964) and Herzberg (1968) on motivation and work-life improvements. HRM is derived from theories of commitment and motivation and it is a subtle blend of some of the best elements of scientific management and human relations. Although superficially similar to McGregor's (1960) theory Y, the focus on the individual worker, on goals, and on careful selection and



training are all closer to scientific management associated with theory X.

In spite of this, HRM utilises the assumptions of McGregor's (1960) theories X and Y concerning human behaviour and motivation, and Miles's (1965) differentiation between human relations and human resources. McGregor's theory Y and Miles's human resources together form the basic assumptions about HRM. Both McGregor and Miles base their theories mainly on Maslow's (1943) theories of human need.

Guest (1987) mentions the improvement in theories of motivation in recent years by referring in particular to expectancy theory, higher order needs (Hackman and Oldham, 1980), and achievement motivation (Steers, 1981) as individual variables which influence policy, especially job design. This has permitted the shift in the application of general motivation theory to all workers to more specific theories suggesting that some workers will seek out and respond to work environments that provide challenge, autonomy, learning opportunities and self-control.

In view of this, a micro-theory about specific aspects of work behaviour has been utilised to develop an outline for a theory of HRM, and this indicates ways of selecting, training and rewarding those exhibiting appropriate motivational orientations and therefore will not tap responses from all workers. Following Blackburn and Mann, (1979), Guest thus cautions that the general advocacy of HRM for all workers in all settings is probably not feasible. HRM based on these assumptions about employee motivation will therefore be viable in organizations employing employees with these orientations or able to recruit and select such employees.

Guest builds upon these assumptions to propose a theory of HRM. His aim is to develop a set of testable propositions and finally to arrive at a set of prescriptive policies. He identifies four immediate policy goals: (1) the goal of integration, (2) the goal of employee commitment, (3) the goal of flexibility/adaptability, and (4) the goal of quality. In addition to these goals, Guest maintains that HRM outcomes are achieved through the consistent, sophisticated application of policy issues such as job design, the management of change, recruitment and selection, socialization, appraisal, training



and development, manpower flows, rewards systems and communication systems. These should be directed by clear policy objectives driven from the top, strategically planned and managed through the organization's culture. The attributes of successful HRM initiatives according to this perspective include high job performance, problem-solving, change, innovation, cost-effectiveness, low levels of turnover, absence and grievance.

The first goal of HRM is the concept of integration. Guest (1987:512) identifies four aspects of integration. The first is the integration of human resource strategy with organizational strategy. This perspective advocates that in order to ensure successful implementation of strategic plans, human resources must become an integral part of the strategic planning process.

The second aspect of integration is the necessity for human resource policies to cohere with other policies, and be consistent. Policies on selection, rewards, employee relations, etc. must complement each other and help in the achievement of strategic goals.

The third aspect focuses on the need for line managers to recognize the importance of human resources and to accept their responsibility to practise HRM, although they may rely on specialist resources to assist in policy development, problem solving, training, etc.

The fourth aspect of integration follows Beer et al.'s concept of congruence, and suggests that all employees should be as fully integrated as possible into the organization so that employee interest will merge with that of the organization. According to this perspective, when these factors are satisfied, the organization's strategic plan is more likely to be successfully implemented, since there will be greater willingness to accept change and fewer delays and barriers caused by conflicting understanding and priorities.

Besides the integration goal there is also the need for the development of a feeling of commitment of individual employees to their organizations. Beer et al. contend that commitment can produce loyalty, better performance and higher productivity in addition to self-worth, dignity, psychological involvement and identity for individuals. Commitment here refers to organizational and job



commitment. It may include individual involvement and identification with a particular organization, acceptance of and belief in an organization's goals and values, willingness to exert effort and the desire to maintain membership in the organization (Mowday et al., 1982).

The practice of HRM requires the ability to implement strategic plans and to manage planned organizational change, as well as to be adaptive and responsive to unanticipated environmental pressures. An adaptive organization avoids rigid, hierarchical and bureaucratic structures, prevents powerful, entrenched interest groups from developing and has no inhibitive demarcation among groups of workers or between individual roles. This tends to create problems for traditional personnel activities such as the development of detailed job specification and job evaluation. HRM therefore calls for decentralization and delegation of control as well as careful design of jobs, and managers who have skills to manage change effectively.

It also calls for the 'flexible firm' model (see Atkinson, 1984, Atkinson and Meager, 1986; Atkinson and Gregory, 1986) which suggests that the organization is 'flexible' in terms of its adaptability to expansion, contraction, or change in the product market. This in turn depends on whether the organization's workers are able to offer two kinds of 'flexibility'. As Pollert (1987; 1988) explains, the first category: 'functional flexibility' involves the crossing of occupational boundaries, multi-skilling and also flexibility by time, in terms of willingness to adjust to production demands. It is provided by a 'core' of stable, skilled employees who enjoy relatively secure employment.

The second category, 'numerical flexibility', which involves part-time and temporary work and sub-contracting, allows the firm to adjust labour force levels rapidly. Such 'flexibility' is provided by a 'periphery' of workers who may be insecurely or irregularly employed, or may not have a direct relationship with the firm at all, being for example, sub-contracted or self-employed. In general the workers in the 'periphery' are relatively easily disposable and face considerable insecurity. Here, it is the insecurity in the employment relationship which provides the employer with a numerically variable



workforce. ( Quite a number of conceptual problems have been identified with the 'flexible firm' model and some of its claims are considered to be an exaggeration. See for instance Pollert (1987) and Sisson (1989b) ). Thus HRM requires workers who exhibit flexible skills and are willing to move freely between tasks. Guest insists that many bureaucratic organizations are partly incapable of meeting these conditions, thus effectively limiting their ability to pursue human resource policies. In view of this he argues that a general advocacy of human resource framework as both a descriptive and prescriptive approach is unwise.

Like the goal of integration, the goal of quality has multiple aspects. The first deals with the quality of staff, and the need to recruit, develop and retain staff with high levels of ability, skill and adaptability. Another area is the quality of performance and the importance of setting and maintaining high standards. The establishment of appropriate grievance systems is essential to ensure the trust of employees in management policy and practice. The maintenance of high quality requires appropriate recruitment, selection and training techniques, goal setting and job design.

Guest (1987:516) follows the four prescriptive human resource goals with another prescriptive framework for identifying human resource policy. He shows that it is not simply a matter of advocating good selection or job design, but rather of prescribing 'enriched' jobs and selection of individuals of high quality who exhibit high commitment and motivation. Training needs to contribute to flexibility. Communications need to be goal-directed rather than primarily concerned with process. These are intended to achieve HRM policy goals which in turn often results in positive outcome.

Guest (1989:50) points out that not every organization can pursue HRM and prescribes the conditions necessary for its success. These include: (1) corporate leadership support for values inherent in HRM; (2) the existence of a strategic view shared by managers in the organizations which see HRM as a key component of the corporate strategy; (3) the ability to put HRM policies in place and; (4) the recognition that employees with instrumental orientation, established trade unionism and corresponding management attitudes can hinder the



pursuit of HRM.

Whilst Guest has developed a useful ideal-typical model of the goals of HRM as part of the general effort towards the discussion of HRM, it is perhaps not clear why organizations adopt HRM. In other words, what factors are responsible for the emergence of HRM? In this respect, Kochan and Chalykoff apply the Kochan et al.'s three-tier framework (i.e. managerial strategy framework) to a high technology firm in the U.S. in an attempt to empirically develop a theory of HRM. It is in a sense, an attempt to empirically determine the emergence and persistence of HRM. Kochan and Chalykoff (p. 10-14) summarise the essential features of the model. According to this model, decisions affecting HRM are made by the top management including the chief executive at the top-tier (strategic) level in the organization. Human resource staff who play influential roles in decision making are also located at the top level. The human resource planning process and its linkage with the organization's human resource policies and business strategies take place at this top level.

At the middle or functional level are policies based on employment stabilization for the core employees and flexible contracts for others. Compensation and benefits are set at or above labour market median rates. There are, however, in some cases, contingent compensation practices. In addition there is promotion from within and extensive training and career development policies.

At the workplace level are policies aimed at maximizing the dual objectives of flexibility in the utilization and development of workers and a high degree of commitment, loyalty, participation and motivation on the part of individual employees and work groups (Walton, 1980). The organization endeavours to incorporate individuals into the decision-making process surrounding their jobs in order to better motivate individual employees and in addition to improve productivity and product quality through more decentralized organization decision-making and communications. This is manifest in QCs, quality of work life, employee involvement and employee participation schemes.

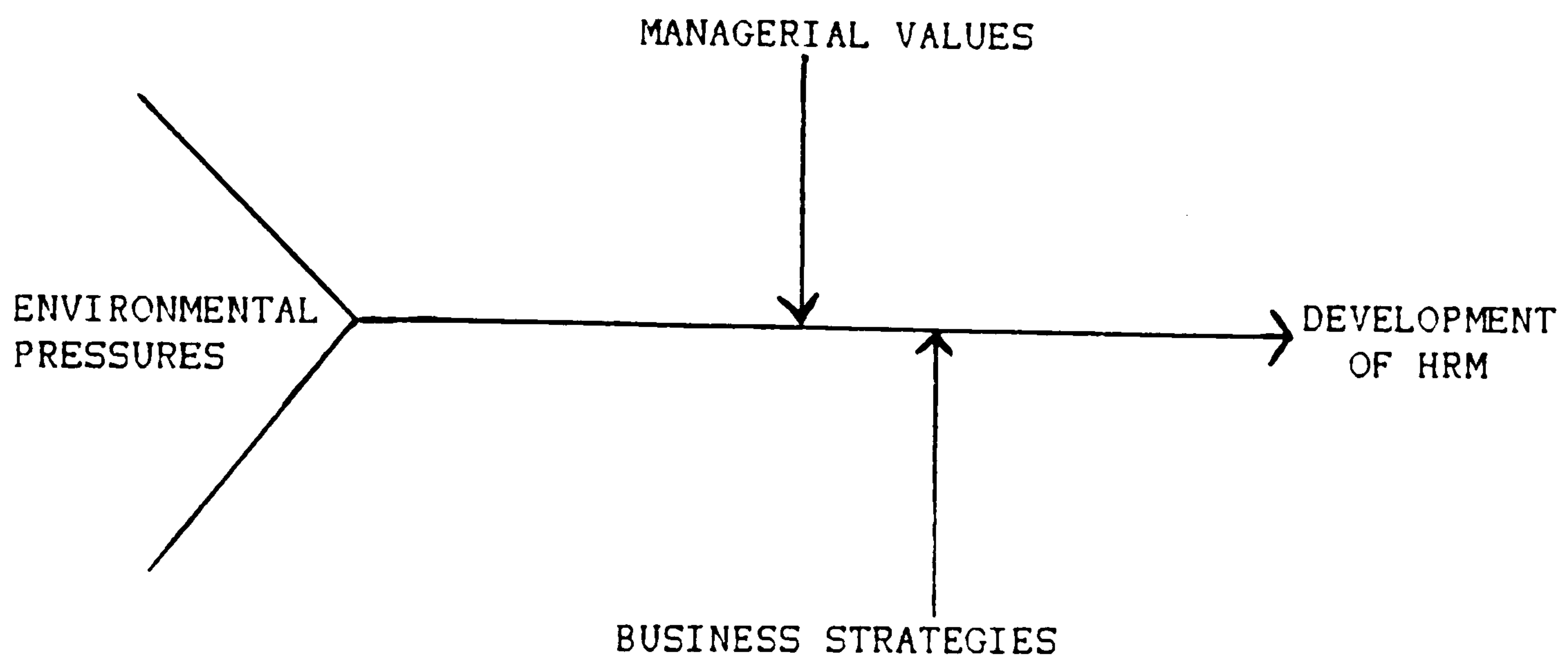
Kochan and Chalykoff discuss the factors which cause the new HRM system to emerge and those that will influence its future dynamics.



These include environmental changes, business strategies, management values, and organizational structures. The authors caution that no single causal force or variable dominates or provides a parsimonious explanation for all the characteristics of the new system. Thus there is the need to introduce the role of each of these variables as a causal force. As figure 3.1 shows it is the confluence or interaction of these forces working in the same direction that in the authors' view accounts for the emergence and innovation in HRM.

Figure 3.1

A Modified Version of the Kochan and Chalykoff Model for Analysing  
the Development of HRM



Source: adapted from Kochan and Chalykoff (1986: 10-17).

In Figure 3.1 the determining forces of HRM innovations are shown with the key variables and their interaction. The model begins with environmental pressures facing the organization. These include government policies, business strategies; organizational values play mediating roles in determining how similar environmental pressures influence organizational policies in specific organizations. The authors maintain that these mediating variables introduce a range of discretion into the policy making and consequently account for the strategic choice model (Kochan et al.'s). The main assumption of this model is that it is the interaction of certain environmental pressures



and managerial strategies that determines the content of human resource policies.

Similarly Storey's case study evidence on both public and private sector organizations points out that managerial strategies developed in response to environmental changes and the need to improve the viability and effectiveness of organizations. Taken together, the interaction of the managerial strategies and environmental pressures give birth to HRM initiatives such as QCs. It is clear from the above that managerial strategy theory can be used to determine the origins of HRM and discuss its implications.

#### The Relevance of Human Resource Management in the U.K.

It has been argued earlier that HRM unlike strategic HRM tends to downplay the role of unions and IR in general as an important aspect of management. This is accordingly due to the unitarist and individualistic focus of HRM policies (Guest, 1989). In the US, for instance, HRM has come to be associated with a management strategy for union avoidance. Unions are perceived as unnecessary and irrelevant. Even in cases in which unions have supported commitment and involvement programmes, their role has been marginal (Walton, 1985). However, Armstrong argues that in spite of its unitarist and individualistic focus some versions of HRM, particularly strategic HRM, allows the integration of IR strategy into organizational strategy. Moreover union involvement in HRM is not encouraged.

This is perhaps what is happening in some organizations in the U.K. In recent years as some public sector organizations have attempted to combine the consultative approach with the sophisticated human relations approach the question of the anti-union nature of HRM has been brought to the fore. Such organizations are already unionized and therefore it might be argued that even if they do not intend to withdraw recognition from the trade unions, the effects of HRM policies will be to undermine the collective basis of trade unions. Research evidence indicates that in such organizations in the U.K., unions have not played any significant role in HRM (Storey, 1987).



In those U.K. organizations in which the role of unions in HRM initiatives has been marginal, there has emerged a dualism in management's approach to the workforce. Storey (ibid:9) thus raises the question of whether HRM can transform IR into a cooperative, commitment-inducing process. He argues that if this cannot be done then organizations need to address the relationship between HRM initiatives and the co-existing IR machinery. Storey discusses some of the strategies adopted by management to avoid dealing with the issue. In Storey's words:

A common device has been to avoid tackling or resolving the question of the relationship between new initiatives and traditional IR practices, by creating the one to run parallel with, and interfere as little as possible with, the other. A number of organizations have even established HRM managers and departments quite distinct and separate from their existing IR departments. The obvious potential for rivalry and inconsistency is usually reduced by virtue of the fact that, in the main, IR continues to be almost totally responsible for the whole gamut of personnel functions directed at the blue collar work-force while HRM restrict itself (or is restricted) to the white collar staff. In the latter, the various integrated elements of development, reward, target-setting and so on, may indeed be even more specifically targeted just to the managerial cadre - and indeed perhaps to only a small section of that. (Storey 1987:9).

In spite of such avoidance strategies, Storey points out that U.K. organizations pursuing HRM will have to clarify their IR and union policies to forestall any suspicion that HRM is aimed at undermining the union. Storey applies Kochan et al.'s three-tier system to the U.K. In the U.S., unlike in the U.K., unions are actively cooperating with management on HRM initiatives at the top. In his view the U.K. management ambivalence towards the union has prevented such cooperation therefore HRM initiatives are limited to the workplace level. It is worthwhile noting that the U.S. situation has evolved over time and began in the same way as is now occurring in the U.K.

Evidence from the U.S. indicates that in the 1970s, worker involvement programmes and collective bargaining were kept separate (Kochan et. al. 1986). This was similar to the dualism which exists in the U.K. at present. The participation schemes were instituted at the



bottom-tier to deal with worker-supervisor relations as a solution to economic pressures. However, these cooperative ventures and other workplace and IR activities proved artificial, and it therefore became necessary to include the union officials in cooperative ventures. Kochan et al. (1986:159) contend that:

The economic troubles of the American auto industry after 1979 have led to significant changes in the conduct of labour-management relations. These changes have included the initiation of quality circles at the shop-floor level and enhanced communication between workers and management through other less formal channels. To preserve jobs, a number of plants have modified local agreements and work-rule practices. In the process, the role of union officials has changed drastically. Union officials in many plants now communicate frequently with management outside of normal collective bargaining channels and receive information regarding business plans, new technologies and supplier relations - information on subjects earlier deemed to be exclusive managerial prerogatives.

In the U.K. the dual existence of HRM and IR provides the union no role in the formulation of business strategy, making it difficult for U.K. organizations to adopt the 'New IR' existing in the U.S. This has raised the issue of the relevance of HRM in the U.K. Some scholars, including Guest (1987:518), argue that since HRM is American in origin it may be less relevant in the U.K. for a number of contextual reasons: a well established 'professional' structure of PM, the relatively strong position of unions, the different orientations of workers, and perhaps most importantly, the pluralism and the range of entrenched interest groups within industry and society in general. This accordingly may be the reason why Goldsmith and Clutterbuck's (1984) study of excellence in the U.K. did not highlight any consistent practice of HRM. Guest contends that very few U.K. organizations appear to practice a distinctive form of HRM, although many are moving slowly in that direction through the implementation of employee involvement and communication programmes, but these have been opportunistic rather than strategic as these organizations have not altered their personnel practices such as recruitment and selection to match their HRM strategies.. Guest (1988:5) believes there is not much HRM to speak of in the U.K., for the following



reasons:

Companies adopted little bits of the theory in a piecemeal way, but never the whole. Procedures or systems would be adopted as fads, such as quality circles (QCs) or 'two-way communication', but without any clear policy goals or reasons.

Furthermore, research evidence in the U.K. indicate that flexibility, decentralization, labour relations and employee involvement initiatives (Batstone, 1984; Edwards, 1987a, 1987b; Millward and Stevens 1986) have not followed a systematic change or shift towards HRM, since they do not integrate human resource strategy into organization strategy. Guest thus argues that in only a few cases can these initiatives represent what Walton (1985) characterizes as the 'transitional' stage between control and commitment strategies in the management of human resources.

A number of studies support this view. For instance Cross (1988) mentions the lack of an integrated and coherent employment policy. Moreover, several organizations can only vaguely describe their employment policy and there is often no correlation between endorsement of a particular policy and actual practice (Marginson et al., 1988). Furthermore, many U.K. organizations do not pay much attention to training and development, an important element of HRM (Sparrow and Pettigrew 1987). Many organizations consider training as a cost rather an investment (Coopers and Lybrand, 1985).

Storey (1987:2) seems to agree with this observation, maintaining that the pressure on the IR system of some U.K. organizations as a result of organizational restructuring has resulted in the implementation of HRM initiatives. Accordingly, there is a departure from a centralized, formalized and standardized IR pattern towards a devolved pattern containing many of the characteristic features of HRM. He insists, however, that it is important to study the wide range of initiatives occurring in U.K. organizations to see whether they can actually be judged as forming part of the phenomenon that can be labelled HRM or not.

This view becomes all the more important when viewed in relation to Guest's suggestion that there are some factors limiting the



practice of HRM in the U.K. organizations, not least is the need for cost-effective strategies for change. It is thus suggested that in view of these limitations it is reasonable for organizations to maintain existing personnel and IR practices and to take only minor initiatives to increase involvement until an opportunity for change arises, most likely at a green-field site (Guest, 1989). On this, Guest (1987: 518) writes:

The opportunity seems most likely to arise when a new chief executive is appointed, when a major crisis arises which creates opportunity for change or at a greenfield site. The challenge for management if it wishes to move in this direction is to do so through planned organizational change.

The Griffiths reorganization—a planned change—has given birth to QCs initiatives in the NHS in the U.K. Many DHAs have implemented QA and QCs strategies in order to make quality awareness part of the culture of the organizations. This is perhaps an attempt to create a human resource approach to co-exist with the consultative approach. This raises questions about the role of the unions in the QA and QCs programmes. Furthermore it raises the issue whether the implementation of the QA and QCs programmes has resulted in the marginalization of IR. In a sense it questions the importance of the QA and QCs initiatives in the DHAs. It is therefore against this background that an attempt will be made to examine the the QCs, currently taking place in the NHS in the U.K. to determine whether they can be classified as HRM or not.

### Conclusion

This chapter has reviewed the literature on the differences between PM and HRM on the one hand and HRM and strategic HRM on the other. The inconclusive nature of these supposed differences are attributed to the lack of a coherent and explicit theoretical underpinning. It has also shown that HRM is a relatively new debate and the term is used in different ways. The literature on both PM and HRM is often prescriptive and lacks convincing empirical basis. As Sisson (1989a: 6) points out, whilst this prescriptive approach tells us what personnel



practice is or what personnel managers do, the theories implicitly underpinning this approach, do not tell us how HRM can be put into practice or the problems managers face in their attempts to practice HRM.

In view of the inadequacy of current HRM theory, Guest attempts to develop a set of testable propositions, but it is not clear that he succeeded. However, his ideal-typical model of the goals of HRM offer criteria against which actual cases can be compared. The ideal-type can highlight the differences in organizational practice, and hence throw some light on the variability of HRM across different sectors. For instance, Guest points out that under certain conditions the conventional PM practice with emphasis on the professional aspects may be more useful than HRM. This may be the case with bureaucratic public organizations. Ostensibly, bureaucratic organizations are too rigid to respond to HRM initiatives. This may be the reason why the literature on HRM with a few exceptions (for instance, Storey, 1987), almost entirely ignores practices in the public sector choosing to highlight only those in the private sector. This study which is focused on the public sector attempts to empirically explore the feasibility of HRM in the case-study DHAs. It raises the question: can there be a theory of HRM which cuts across both the private and public sectors? In a sense it raises the issue of the usefulness of the HRM frameworks in different sectors. This will consequently provide some way of evaluating what HRM means in the NHS.

Since the introduction of general management in the NHS, several DHAs have adopted various managerial strategies which have had tremendous impact on the management of human resource in their organizations. The Griffiths restructuring has given general managers, as well as lower level line managers, an influential role in the formulation and implementation of personnel and HRM policies and practices. In line with this development there has been an attempt to blend the consultative model with the human resource model. Some DHAs have instituted QA programmes as an integral part of the organizations' overall strategy on quality. Once this grand strategy has been developed, the organizations have also developed other human resource strategies to achieve their overall objectives; for example,



QCs. Both QA and QCs initiatives have been adopted as a means of achieving the organizations' objective of making improvements in the quality of health care provision. The adoption of managerial strategies raise the issue of the effects of the implementation of these strategies on personnel practice in the organizations concerned.

As indicated earlier both Guest, and Tyson and Fell, see the HRM model as a variant of conventional PM, and in some cases there can be overlaps between the HRM approach and conventional PM. If we accept this view, it is possible that some organizations are still in the process of moving from PM to HRM. This is probably what Walton calls the 'transition stage'. If this is the case, then how and why does the movement occur? If, on the other hand, the overlap is permanent, does it imply that HRM and other PM can coexist simultaneously? If the answer to the latter question is affirmative, then it negates the claim of HRM's distinctiveness, and probably makes the search for a distinctive HRM theory futile.

With regard to the case-study DHAs, it raises the question whether there is a trend towards HRM. If yes, is there a consistency in HRM practice or is it a mixture of ad hocery, or pragmatic and opportunistic approaches to PM? Are the employees involvement programmes strategic or opportunistic? What is the role of unions in this process? These questions will be explored in the case-study DHAs.

One key issue amongst all the changes in PM and the emergence of HRM is the line management/PM interface- that is the reassertion of line management authority as a result of the emergence of HRM. The essence of this thesis is not to study the changes in the PM role in organizations for their own sake, but to examine the factors responsible for the changes and the emergence of HRM; how the emergence of a HRM initiatives, for instance QCs, allow line managers to get involved in personnel decisions; the implications of this on the personnel function and specifically to what extent these changes have influenced the 'balkanization' of PM.

The Kochan and Chalykoff's model will be used as the theoretical basis for exploring these issues in the case study DHAs. Furthermore this will make it possible to analyse in subsequent



chapters how state policies and changes in the political and economic environment have influenced these changes. Given that the study will comment on the changes in PM and the adoption of managerial strategies in the NHS, the next three chapters will deal with the management of the NHS, the evolution of PM and QA and QCs in the health services sector with particular emphasis on the U.K.



## CHAPTER 4

THE STRUCTURE AND MANAGEMENT OF THE NHS.

The aim of this chapter is to show how policies initiated by the government influence the management of human resources. The main argument is that the government creates opportunities and constraints that encourage employers (managers) to respond with changes in their PM and IR practices. The chapter begins with an examination of the origins and structure of the NHS from its inception until 1984. It also discusses the factors which precipitated the various changes in its structure and organization during this period. This is followed by a section on the advent of the post-1984 NHS structure and management arrangements; in particular, the factors which gave rise to its emergence, and some of the major recommendations, of the Griffiths Inquiry.

The next section addresses the management of health authorities with particular reference to the DHA and its main functions. It surveys the general development of management in the NHS since its inception. It also considers the emergence of managerial division of labour, managerial specialization, and attempts to introduce private sector management practices to the NHS. Furthermore it traces the evolution of general management in the NHS.

The fourth section discusses the Conservative government's public sector policies in the context of Thatcherism -the doctrine of laissez-faire. The influence of the Thatcher government in trying to shift values from collectivism to individualism is also discussed. Here, the emphasis is on the government's desire to reduce the size of the public sector and the level of expenditure. This section also discusses the government's policies in the area of health care. In addition it examines some of the government's policies which have had substantial influence on the adoption of new managerial strategies in the management of human resources in the NHS. The concluding section



attempts to link this discussion with the analysis of managerial strategy and HRM outlined in chapters two and three.

### The Structure and Management of the NHS up to 1984.

The creation of the NHS was greatly influenced by World War II which impelled the British government to review hospital resources and facilities and to consider the national provision of health care. With increasing public concern about the need for an integrated health service, the publication of the Beveridge Report in 1942, and the 1944 NHS White Paper, accelerated negotiations between the government, local authorities, health service professional bodies and political parties. These negotiations culminated in the passage of the 1946 NHS Act which gave birth to the NHS in 1948.

Before the creation of the NHS, provision of health care was mainly in the hands of the local authorities and charitable organizations, which were responsible for running the municipal and voluntary hospitals, respectively. The provision of primary care, including general practitioner services, was uneven, supported by a combination of different forms of financing. Half the population subscribed to the 1912 National Health Insurance scheme, and the other half of the population either paid for their health cost or became members of voluntary sick clubs. This, then, was the background which gave birth to the 1946 NHS Act.

According to the 1946 NHS Act, the responsibility of the Minister of Health was to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of people of England and Wales and prevention, diagnosis and treatment of illness, and for that purpose to provide a secure, effective provision of services. The creation of the NHS brought together both the public and private health care agencies under one central tripartite structure of hospitals, community services and general practice. The hospitals were managed in a three-tier system made up of the Ministry of Health, Regional Hospital Boards and Hospital Management Committees. Almost all hospitals came under public ownership and were arranged into



administrative regions. A number of hospitals in each region were managed by Hospital Management Committees, accountable to Regional Hospital Boards which were, in turn, accountable to the Minister. The various Boards and Management Committees were non-elected lay bodies on which a number of doctors served, though not in a formally representative capacity.

The local authorities were responsible, through a Statutory Health Committee, for community services, such as home nursing and midwifery, health visiting, ambulance services and public health. In the area of general practice, the desire of the medical practitioners to work independently resulted in their being employed under contract to the NHS through local administrative regulating bodies - Executive Councils on which they were strongly represented (Barnard and Harrison, 1986:1215). This system survived until the 1960s, when the NHS structure came under strong criticism.

In the 1960s, and especially after the amalgamation of the Ministries of Health and Social Security into the Department of Health and Social Security (DHSS) in 1968, the 1948 NHS structure was considered a hindrance to the coordination of services. Consequently, after many years of public debate and the production of a number of consultative documents by different ministries and different governments, the NHS was reorganized in 1974 to coincide with a reorganization of local government.

The 1974 reorganization of the NHS resulted in a four-tier management structure. The structure provided for the retention of the supervisory regional tier - RHAs -which succeeded Regional Hospital Boards. The RHAs covered 14 English regions. The day-to-day work at the regional level was conducted by a team of officers known as Regional Teams of Officers (RTOs). The second tier consisted of 90 Area Health Authorities (AHAs) with the same boundaries as elected local Authorities. These two statutory tiers of regions and areas absorbed the functions of the previous hospital and local authority health services, including community services.

The third tier of the structure consisted of 205 Health Districts which were responsible for providing operational services to local communities. Nearly two-thirds of the AHAs were far too large for



operational management of health services, and therefore were subdivided into Health Districts, each nominally centred around a district general hospital.

The operational management of the services in the Health Districts was carried out by multi-disciplinary District Management Teams (DMTs) accountable to the AHA. These teams were made up of six members, one for each of the functional areas of administration, finance, nursing and community medicine, together with one representative each from the consultant medical staff and the general practitioners in the district. The administrator, finance and nursing officers, were also responsible for the line management of the staff. There was no chief executive system, since teams were set up as groups of equals. In practice, the role of the chief executive was often filled by the administrator, known as the Group Secretary. Decision making was based on 'consensus' management among team members on a proposed course of action (Mitchell, 1986/87:20). As Trainor (1982) shows, in spite of consensus management, the administrator, because of his secretarial and coordinating role, exercised considerable influence over his management team colleagues. The Chair of the DMT was usually determined by election or by rotation. Some DMTs, however, did not have chairs and in such cases the administrator acted as a surrogate chair (p.17).

Under the 1974 reorganization, membership of AHAs provided for lay representation for various interest groups, nominees of the Secretary of State and local authorities filling the majority of places. The Chairman of the AHA was nominated by the Secretary of State. The membership requirements allowed two medical and one nursing representative nominated by the trade union movement. The required number of lay representatives was not specified under the regulations. The main employing authority for the NHS staff was the AHA, with a minority of staff directly employed by the RHAs. Most staff actually worked within the Health Districts.

The next tier in the structure was responsible for the administrative functions relating to the services of the medical practitioners (independent contractors). These functions were performed by the Family Practitioners Committee (FPC), which received



its budget directly from the DHSS. The FPC covered the same areas as the AHA. Although there were some built-in organizational links between FPC and AHA, the FPC in most instances acted in an almost autonomous capacity. Thus, in Barnard and Pendreigh's (1984) view, the underlying purpose of the 1974 NHS reorganization - to create a unitary health authority at the local level - was thwarted at the outset.

The separation made it essential for the establishment of a statutory machinery, a Joint Consultative Committee (JCC), at the local level to foster collaboration between the two agencies in joint planning and the coordination and integration of operational services. As a consequence, more elaborate arrangements were instituted to bring together the administrators and the operational staffs of the two agencies functioning as Joint Care Planning Teams (JCPT) under the aegis of the JCC. The JCC was merely a liaison body since decisions on resource allocation and investment were made by the AHA and the FPC.

Soon after the 1974 reorganization the shortcomings of the structure became apparent. Nairne (1985) reports that between 1975 and 1982, the NHS was in a state of unhappy convalescence since its organization and management were considered inefficient. There were numerous debates in Parliament and within the NHS concerning the structure of the service. As a result, a Royal Commission under the Chairmanship of Sir Alec Merrison was appointed to study the problem. The Royal Commission in turn commissioned Professor Maurice Kogan to study the 1974 reorganized service. Kogan reported:

...a great deal of anger and frustration at what many regard as a seriously over-elaborate system of government, administration and decision-making. The multiplicity of levels, the over-elaboration of consultative machinery, the inability to get decision-making completed nearer to the point of delivery of services, and what some describe as unacceptable wasteful use of manpower resources... (Quoted in Nairne 1985: 121).

In 1979, after three years of study, the Royal Commission on the NHS reported on the structure and management of the service. This was followed in December 1979 by a consultative paper and then in July



1980 by a substantive reorganization circular. These documents culminated in the Conservative government's reorganization of the NHS in 1982.

The 1982 reorganization was aimed at simplifying the structure of the NHS and delegating and improving the quality of decision-making. The regions and RHAs were retained, but the AHAs were replaced by statutory DHAs. The functions of the DHAs were similar to those of AHAs and they were accountable to RHAs for the management of operational services. The abolition of the Area-tier broke the link between a health authority and one matching elected local authority. The 1982 reorganization retained the DMTs in principle, although attempts were made to devolve decision-making to the operational level by introducing unit teams within each district.

Since 1984 the NHS has experienced some changes in management structure. The desire of the government to introduce 'commercial' management practices to a public sector organization resulted in the altering of the 1982 structure to reflect the Griffiths recommendations in 1984. The 1984 restructuring introduced general management into the NHS. This, then, is the topic for discussion in the next section of the chapter.

#### The Post - 1984 NHS Management Structure.

The 1982 reorganization did not end the criticisms that the service was undermanaged and over-administered. Critics cited the pressures of cuts and cash limits and the wider policy objectives of shifting resources to more deprived areas of England and to less emphasized categories of patients, such as those suffering from mental illness. The inadequate management of hospital estate and catering supplies was also cited.

The Parliamentary Committee of Public Accounts was particularly vocal in this respect. As Nairne (p. 121) reports, the then Chairman of the Public Accounts Committee, Sir Edward du Cann, argued that if ever there was a case in which it is necessary to see that the nation obtain value for money, surely it was the NHS. All these factors, in Nairne's view, shifted the emphasis from structural change to



managerial improvement. Enter Griffiths.

In February 1983, Norman Fowler, Secretary of State for Health and Social Security, announced the establishment of an inquiry into the NHS management policies in England. The inquiry was placed under the Chairmanship of Roy Griffiths (managing director of Sainsbury's); and most of the other members of the inquiry team were businessmen. Their brief was to:

review current initiatives, to improve the efficiency of the Health Service in England, and to advise on the management action needed to secure the best value for money and the best possible service to patients (cited in Stewart, 1986: 15).

The inquiry team completed its task within eight months and in October 1983 presented its report to the Secretary of State for the DHSS (Griffiths, 1983). The report was accepted and, after a brief period of consultation, implemented by the Conservative government in 1984.

The government's decision to commission the inquiry was partly due to its dislike of the open-endedness of NHS spending which, as Patchey (1986: 87) shows, had already given rise to a series of piecemeal cost-containing initiatives. These included the privatization and contracting out of some ancillary services, such as catering, laundry and cleaning; the encouragement of private medical insurance for private medical provision; increases in NHS fees and charges for prescriptions, spectacles etc, and the establishment of 'Rayner efficiency reviews' - named after Lord Rayner, Chairman of Marks and Spencer - on the costs of non-ambulance transport and of NHS recruitment.

The commission of inquiry was also precipitated by the widespread dissatisfaction with 'consensus-management' - the pre-Griffiths managerial structure introduced in the NHS by the 1974 reorganization. The Griffiths inquiry was to advise on a new managerial structure, since the existing one was thought to be cumbersome and time-consuming, resulting in institutional stagnation and lack of managerial accountability.

The Griffiths report was highly critical of the NHS management at all levels. It identified the failure of management as the central



problem of the NHS (Mitchell and Vousden, 1985). In this respect, it criticized consensus management mentioning the lack of a clearly defined general management function throughout the NHS. By general management they meant the responsibility drawn together in one person, at different levels of the organization for planning, implementing, and control of performance. It also includes the lack of identifiable individuals to accept personal responsibility for real continuous evaluation of performance against such criteria as level of service, quality, budgets control, cost improvement, productivity, motivating and rewarding staff (Bowman 1986:40).

The Griffiths report made the following principal recommendations: (1) the establishment of the general management function through the appointment in each unit, district health authority, and regional health authority of a general manager responsible for planning and implementing plans; and control of performance without prejudice to the responsibility of professional staff for professional advice; (2) the closer involvement of clinicians in management, especially unit management; and (3) the creation within the DHSS of two new boards - The Health Service Supervisory Board, chaired by the Secretary of State, responsible for the strategic policies and priorities and resource allocation, and the NHS Management Board, to be responsible for the national planning of the service and the oversight of performance at the departmental level (Nairne, p. 121)

The establishment of the general management structure was recommended in view of the deficiencies under 'consensus management'. The general management structure is supposed to provide the necessary leadership to capitalize on the existing high levels of dedication and expertise, to stimulate initiative, urgency and vitality to bring about a constant search for improvement and cost reduction, and to secure proper motivation of staff (Bowman, p.41). The general manager need not necessarily come from the NHS; he/she could be appointed from outside the NHS. General management implied a single individual to supersede the consensus team of decision makers who would deal with strategic management, policy execution, the improvement of health service performance and, not least, a greater awareness of customer



needs and preferences (Barnard and Harrison p.1216). General managers were expected to expedite the decision-making process when disagreement arose, and on implementation to be personally responsible for policies and to monitor and review their efficiency and effectiveness.

These general managers are on fixed term contracts of between three to five years, renewable for a further period of two years. They are subjected to performance related pay (merit pay) increases, with no annual increase for poor performers. The 1984 reorganization according to Halpern (1984:696), was a victory for those who wanted to see the NHS properly managed with the aspirations of the clinical profession relegated to becoming part of the corporate management process.

The Griffiths Report is part of the trend towards managerial enlightenment. As Schofields (1985:7) aptly puts it, its basic message is very simple, namely: that there should be clear and quantified objectives for NHS management and for services to patients; that progress towards these objectives should be monitored; that management arrangements should be designed to assist in the achievement of these objectives and; that the views of the consumer should systematically be sought and used in the evaluation of services. Figure 4.1 below outlines the Post-1984 (Griffiths) NHS structure.

At the top of this structure is the Health Services Supervisory Board, chaired by the Secretary of State, concerned with national strategic issues and NHS objectives. Below it is a full-time NHS Management Board within the DHSS which is responsible for NHS head office management function at the national level. At the regional, district and unit levels general managers have been appointed to undertake the general management function.

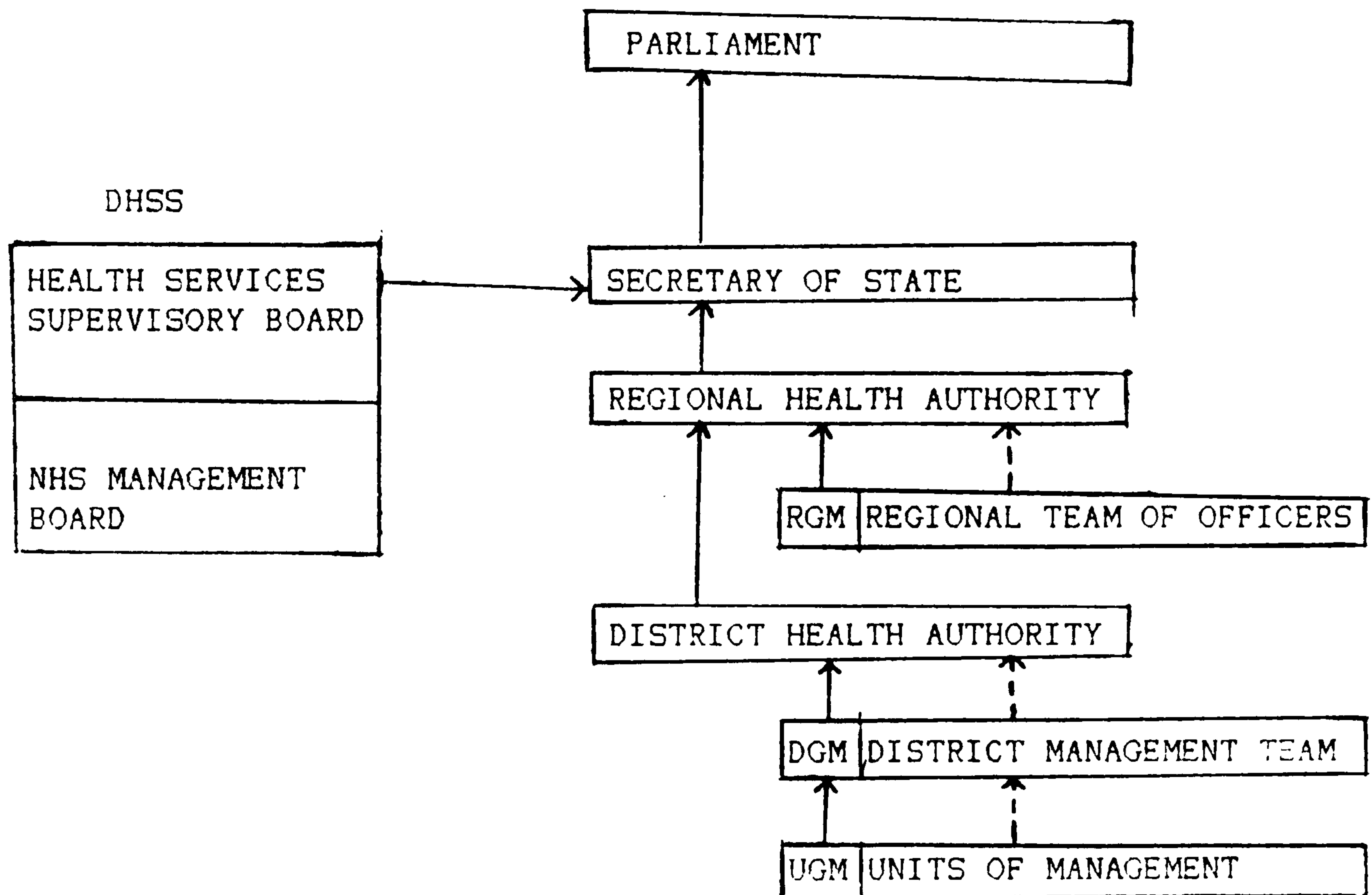
As indicated earlier, the NHS Supervisory Board is concerned with the determination of national strategic issues and the setting of NHS objectives and direction. It is also responsible for reviewing the overall operations of the NHS and for monitoring performance. This means that the board reviews, from time to time, the work of the NHS Management Board. The Supervisory Board also approves the overall budget and resource allocation for the NHS. The Secretary of State



for the DHSS is the chairman of the Supervisory Board. Other members include the Minister of Health, the Permanent Secretary, the Chief Medical Officer, the Chairman of the NHS Management Board, and two or three non-executive members with business experience.

Figure 4.1.

The Post-1984 NHS Management Structure.



Solid lines indicate management accountability

Dotted lines indicate professional accountability

Source: Halpern 1984: 696.

Immediately below the Supervisory Board is the NHS Management Board. This board has the overall responsibility for managing the NHS. Levitt and Wall (1984) summarize the main responsibilities of the Management Board as follows:



The Management Board would be the executive arm of the Supervisory Board having particular responsibility for the implementation of policies, for giving leadership to the NHS, for controlling performance and for achieving consistency and drive over the long term. The Chairman of the Management Board would be vested with executive authority derived from the Secretary of State. He would be responsible for consultation particularly with Regional Chairmen (p.28).

The Management Board is accountable to the Supervisory Board and its duties include laying the foundation of the managerial framework and style in the NHS. In Victor Paige's (1985:205) view, it offers a focal point for both the NHS and the DHSS, a point where the important issues affecting the management of the NHS can be made explicit, brought together in a coherent way, and resolved. The existence of the Board clarifies the functions and relationships between the Board and the regions, and between regions and districts. The Management Board holds meetings and discussions with regional chairmen and general managers to involve them, and subsequently through them, other NHS employees, in policy formulation and decision-making. The Management Board has developed its relationship along lines of accountability that run from the Secretary of State through regional and district authorities.

The Management Board coordinates the planning and review of activities throughout the NHS. In this regard the strategic plans set out the ten-year, long-term objectives for the health authorities. The current strategic plans run up to 1993. The short-term programmes set out specific actions to be pursued in the following financial year. The Management Board examines these plans with particular reference to the following: financial viability, internal coherence, adherence to national policy guidelines, the feasibility of the plan's proposal and the management workload involved.

The Management Board, together with the regions, identifies in each plan the salient points which require action for the plan to succeed. In the light of these discussions regarding regional plans, the Management Board determines what action it needs to take centrally, and to prepare for the next round of strategic plans. The Management Board thus provides guidelines for the strategic plans and



examines the format and role of short-term programmes. In this the Board has two objectives: first, to specify what is to be done in the year ahead and what is to be achieved; second, to link the proposals for the immediate year with the long-term proposals set out in the regional strategic plan, and to assess the progress proposed for the immediate future in terms of the longer term aim (Fairey, 1985:5). The Board further translates long-term plans into short-term action. It also monitors the progress of short-term programmes in the achievement of the key aims identified in the strategic plans and attempts to unify the framework of short-term programmes.

The Management Board produces a corporate strategic plan for the NHS by drawing on both the regional strategic plans and its own identification of vital long-term objectives. This gives the regional health authorities the projected overall picture in the coming years and allows them to agree together on what is expected of them. Thus an accountability tool is provided for both the regions and the centre (Paige, p.208).

The Board has identified a more rational framework for integrating planning and review processes. Performance reviews have been instituted which will assess each region's short-term delivery of long-term goals and the management process involved. Performance indicators have also been introduced and targets have been set to improve and monitor performance. The review system also more broadly examines whether the actions proposed have actually occurred and whether they have achieved the expected results.

In 1985, the Management Board used for the first time a management accounting framework to assess the impact of regional proposals on the number and types of patients treated. This framework was subsequently modified for use in setting out regional and district proposals for 1987/88.

Planning and review systems depend on reliable and adequate information, and for this reason, the Management Board has implemented many of the proposals of the Korner Steering group on health service information. In addition, an informal advisory group, chaired by a Management Board member and made up of representatives from district and regional health authorities, has produced a document for



consultation on a national strategic framework for information. The objective is to derive information systems from the main objectives of top management. The framework also identifies the key requirements in information systems, together with the proposed central work programme, in preparing, discussing and agreeing on national standards (Fairey 1985:5). The membership of the NHS Management Board includes those responsible for other functions such as personnel, finance, procurement, estate and planning. It has other members drawn from business, the NHS and the Civil Service.

The creation of both the NHS Supervisory Board and the Management Board is designed to facilitate coherent policy making at the national level, with fewer uncoordinated central initiatives and a clear national focus for NHS Management. As Kinston (1986) summarizes, the NHS Management Board's strategic initiatives include:

Such matters as providing for the long-term NHS manpower needs, development of medical and health services research, ... allocation of finance to regions, provisions of arrangements to ensure, cooperation of health services with local authority services; pay and industrial relations, and so on (p. 20).

These issues do not directly concern the actual delivery of services, a function which is delegated to the district.

The Griffiths Report led to the introduction of general managers at the regional level and abolished the Regional Team of Officers (for a detailed analysis of regions and districts, see Levitt and Wall 1984). The Griffiths Report stated that districts, hospitals, and units are capable of managing the service and recommended they be held to proper account for performance and achievement.

The RHA's functions include those of setting regional strategies, strategic planning, allocating resources, monitoring the performance of the districts, and providing specialist services to districts in a cross-or multi-district manner. Such overlapping district services include management, legal work, education and training, supplies, personnel, the management of operational services such as ambulance service, blood transfusion services, and computer centres. The RHAs further attempt to integrate the planning and annual review processes



(Coe 1985:1232). The RHA also sets priorities in national initiatives and reviews the district's strategic plans and operational programmes. In addition it plans major hospital developments in the region.

The Griffiths Report allowed flexibility in the development of organizational structures. Each region or district (including units) was permitted to evolve its own management structure. Whilst there is no such thing as a typical structure, most regions are organized around the following departments: (1) finance; (2) manpower and personnel management; (3) planning, resource allocation and planning review; and (4) specialist services to districts. In such an organization, the directors of these departments together with the Regional General Manager (RGM) and the professional heads for medicine and nursing, form the management executive board. The RGM is the chairperson of the board.

The members of the management board at the region often consult with the members of the NHS Management Board. Although there is no direct line of responsibility between the general manager and the management executive board at the district and their counterparts at the regional level, the RGM provides liaison and monitors district progress through the District General Manager (DGM). The management executive board, as well as the employees at the regional level, all work for the RHA and are answerable to the RHA. The members of the RHA are appointed by the Secretary of State for DHSS and consists of people from across the region. The RHA is managed in roughly the same way as the DHA which is discussed in some detail below.

Griffiths introduced general managers also at the district level where planning and annual review, including reviews of management in the units within the district, form the backbone of the management task. The district develops its own strategic objectives, in accordance with regional and national guidelines. Districts have control over the operational objectives and the strategic plans once the programmes have been approved by the region. The district is responsible for implementing service delivery strategies. The district, however, delegates the operational management of services to the general managers of the units. This allows top management at the district level to deal with long-term issues rather than short-term



problems.

It is clear from the above that district functions essentially exist to provide support to the units. Budgetary systems at the district level are designed to ensure that the best clinical practices are encouraged and facilitated. The management structures are designed around key management tasks, and officers are appointed mainly according to their skills, not their professional origin. The Unit General Manager (UGM) is accountable to the DGM, but all the other staff at the unit are responsible to the UGM.

The UGM is responsible for decision-making at the lowest level. The unit focuses primarily on delivery of services to patients/clients. The manager's main concern is the quality and effectiveness of the services as well as their efficiency. This means that care groups or speciality-based units have been established.

At the unit level, the UGM is assisted by a management executive board made up of the heads of the relevant departments. This may include, for instance, the Unit Personnel Manager (UPM) and the administrative services manager, to name but a few. The UGM reports to the DGM, but there is a high degree of delegation of responsibilities to unit managers within clear guidelines and objectives established and monitored by the district.

Knowles (1985) discusses the post-Griffiths general management arrangement at both the unit and district levels. He points out that just as the management executive board established at the unit level assists the UGM in fulfilling the delegated responsibilities of operational management, so does management executive (advisory) board at the district level assist the DGM in the task and responsibilities of that role. The district management executive board assists district-wide policies, particularly relating to resource allocation, and focuses on strategies and forward planning issues. It meets frequently to discuss the operational delivery of health care. It also monitors progress and performance in all the main areas of the authority's work. Its membership comprises the DGM, the UGMs, and the directors of (1) personnel and administration; (2) planning; (3) estates; (4) medical services; (5) community services; and (6) QA and nurse advise and public relations. Other members include



representatives of consultants and general practitioners (G.Ps.). The DGM is the head of the board.

Taking the personnel function to illustrate the levels of responsibility, the UPM is responsible to the UGM, although he/she may seek professional advice from the Director of Personnel at the district headquarters. Similarly, the Director of Personnel at the district is responsible to the DGM but may seek professional advice from the Director of Personnel at the region. The Director of Personnel at the region is responsible to the RGM but may seek advice from the NHS Director of Personnel on the NHS Management Board.

It is important to consider the relationship between the general manager and his/her management executive board and the DHA. The emphasis is on the DHA because of its importance for the focus of the fieldwork research. West (1988) describes how the DHA is managed. The DHA is the highest policy making body at the operational level in the NHS. The membership comprises appointed individuals, some representing local bodies such as the local council and the Community Health Council (CHC). The others, West (p. 94) points out, are drawn from the reserve army of men and women of goodwill prepared to spare time for the public good. The chairman is appointed by the Secretary of State and typically works about two days a week on part-time basis, thus receiving a part-time salary. The DGM, the members of the management executive board, and indeed all the employees in the health district, work for the DHA.

The DGM reports to the Chairman of the DHA. The management executive board reports to the DHA, usually at monthly public meetings, but the public may be excluded from some of the discussions. Shortlisting for management jobs or wider policy issues, such as a possible hospital closure, for example, are discussed in private. The DHA uses sub-committees of members to discuss issues without the public present. The DHA makes policy decisions on strategic issues formulated by the general manager and the management executive board. The board, therefore, spends much time on the preparation and analysis of strategic plans, and on discussion of the plans with the DHA sub-committees and with full DHA in public meetings. The DHA approves the district strategic plans and the operational plans. The district also



sends a copy of the strategic plan to the region. Operational management is controlled by senior managers rather than by the DHA members. Although the DHA members may sit on sub-committees or visit hospitals to examine standards, they usually leave the day-to-day running of the hospitals to the managers.

Levitt and Wall (1984) have summarized the main functions of the DHA as follows:

Each DHA was to be responsible for the planning, development, management of health service in its district within national and regional strategic guidelines... Specifically, DHAs had to make sure they had integrated plans for the provision and development of primary care, general hospital services, maternity and child health services and also for services for the mentally handicapped, the mentally ill and the elderly (p.64).

The DHA's budget is allocated by the RHA which receives an annual allocation from the DHSS and, in turn, allocates the money to the various districts in the region.

Having discussed the general post-Griffiths management arrangement in the NHS, the structure and practice of decision-making at the district level in the case-study authorities will be explored in some detail in Chapter six and seven, based on the fieldwork research.

#### The Development of Management in the NHS

According to Harrison (1986:7), the recognition of the importance of formal organizational structure, and the attempt to introduce to the NHS private sector practices, date back to the 1960s. Barnard and Harrison, in relating the development of management in the NHS to the general development of management in the U.K., mention that from the 1960s until the mid-1970s there was some emphasis on 'scientific management'. In the NHS this led to the introduction of work study techniques to increase operational efficiency and to introduce incentive bonus schemes for lowly paid manual employees.

Another dimension was the employment of capital investment planners and administrative doctors on hospital boards after 1962.



Thus from the mid-1960s until the late 1970s planning methodologies were applied to hospitals and service development. Harrison maintains that the need to secure the formal involvement of hospital consultants in management was the subject of three 'Cogwheel' reports commencing in 1967.

In 1976, the government's interest in Planning, Programming and Budgeting Systems (PPBS) led to the introduction of a complex rational-comprehensive planning system (Barnard et al. 1984). In 1977, the Resource Allocation Working Party (RAWP) system introduced geographical distribution of funds, previously based on historical patterns in the NHS. These developments were preceded by managerial specialization and the emergence of functional management of ancillary services such as catering, laundry and domestic work between the late 1960s and the early 1970s.

This development is attributed to the increasing specialization of nurses, which led to the divestment of housekeeping responsibilities which were not directly related to their clinical professional task. The early 1970s was also the period when the NHS was being encouraged to set up specialist finance, personnel, supplies and planning posts. Nursing also adopted a more formal management hierarchy pattern after the implementation of the Salmon and Mayston Reports of 1966 and 1968 respectively, and subsequently the model was extended to other professions, including chiropody, physiotherapy and occupational therapy.

Specialization occurred largely on professional and functional lines and, since hierarchies were created within each function there was a need for co-ordination between the functions or professions. This objective was at the centre of the 1974 reorganization, which emphasized the co-ordination of all sections of the NHS and other relevant sectors, such as local authority and social services. The 1974 reorganization encouraged further formalization of management. It also recognized consensus decision-making by multidisciplinary management teams. Highly controversial decisions which could not be resolved in this way were passed to the authority and the government bodies.

Harrison (p. 7) maintains that although the 1982 reorganization



somewhat simplified the organizational formalities, and in particular, attempted to procure additional delegation of decision-making within the health authorities, the basic philosophy remained unchanged. According to Harrison:

This basic philosophy seems to have been underpinned by the assumption that, by improving inputs into management, improved results would occur. Thus all the changes which were made were of benefit to managers in that they provided greater status and promotion opportunities, and indeed some of the changes were explicitly directed towards this purpose. This philosophy co-existed, somewhat paradoxically, with a view of management as a process of facilitating the work of professionals, a view most evidently expressed in the 'Grey Book' and 'Patient First' (p.7).

This view changed in the early 1980s, when the emphasis in management shifted to improving performance in the NHS. The Conservative government's desire to apply the discipline of commercial enterprise management to the NHS resulted in the implementation of the Griffiths report. One of its main objectives was to facilitate policy execution and the implementation of decisions in order to achieve efficiency and cost-containment. The Griffiths restructuring therefore was aimed at improving efficiency in the NHS by strengthening the management function.

Since the implementation of the Griffiths recommendations there has been a great deal of interest in the management of the NHS. Since 1984, general managers have been expected to play a strategic role, whilst operational management is usually the responsibility of junior managers and the clinical support services managers.

It is believed that strategic management will make it possible for general managers to anticipate change and provide direction and control for the organization. Strategic management will also make it possible for the organization to make its decisions based on long term forecasts -not reacting to day-to-day issues in a fire-fighting manner.

As Pettigrew et al. (1988) have shown, strategic management in the NHS represents an attempt to import ideas from the private to the public sector, but this is done in a way which is sensitive to the



nature of managing the political environment. Pettigrew et al. observe that:

Under strategic management, the role of senior management is to develop a coherent style which can develop strategies for change not only in services but in attitudes and capabilities throughout the organization (p. 36).

Some DHAs have relied on the strategic management approach as a means of designing more change-oriented organizations (Liddell, 1987).

In Glueck's (1985) view strategic management is:

a unified, comprehensive, and integrated plan relating the strategic advantages of the firm to the challenges of the environment. It is designed to ensure that the basic objectives of the enterprise are achieved (p. 9).

According to this view strategic management decisions include the analysis and diagnosis of environmental problems and opportunities and the assessment of information needs to solve the problem or take advantage of the opportunities. It also includes developing strategies to solve the problem, the designing of structures to implement the strategy, evaluating the strategy through feedback to determine whether the strategy is appropriate and taking steps to correct any deficiencies. Strategic management is thus a fluid and continuous process.

Since 1974 strategic plans have been prepared in the NHS in an attempt to help identify and analyse problems and indicate the alternatives to ameliorate them. Best (1985), however, points out that the systems of forward planning and cash control in the NHS are inexorably intertwined, to the detriment of both. Plans are therefore viewed as specifications of future resources use which indicate the ways and means for an authority to stay within cash limits. As a consequence, Best maintains that:

The concept of strategy within the NHS has a very restricted managerial meaning, having come to be equated with long-term spending initiatives (p. 20).

In the NHS, reductions in Districts' budget and inadequate resources



to support services have forced some DHAs to adopt survival strategies. When survival is the crucial issue, what needs to be achieved and how to achieve it become blurred (Berman and Maxwell 1986; Parston 1986). For this reason it is difficult to achieve a unified and coherent approach to strategic management in the NHS. There is often a tendency to plan separately for the various strategies or a specified strategy.

In spite of this apparent drawback there is now an emphasis on strategic change in HRM in the NHS. This is aimed at getting employees committed and involved in the organizational values and objectives. It is towards the achievement of this objective that the DHAs have adopted both the QA and QCs strategies. Strategic change involves the creation and nurturing of the necessary climate for change in an organization. Rathwell (1986:56) identifies three stages through which the process passes. The first is the setting up and instituting of the strategy. It is here that the main objectives and policies are formulated to ensure successful implementation of the strategy. This involves the generation and fostering of commitment in the organization. Commitment, in Martin and Nicholls' (1985) view, is a sense of excitement in the job, a sense of belonging to the organization, and a confidence in management leadership.

The second stage involves the setting of timetables for what needs to be done and identifying initial tasks which are allocated in accordance with the organizational structure. The third stage is the continuity of managing change. This would be supported by good decisive management leadership at all levels of the organization capable of motivating staff and colleagues alike. Strategic change thus mainly involves the fostering of commitment and involvement. It requires an appropriate managerial structure to facilitate the implementation of change.

The general belief is that the acceptance and application of strategic management in the NHS will assist in the management of change. The strategic management approach may be used by general managers to design strategy, influence attitudes and styles of working, set standards and promote excellence. General management's task is to make desirable change occur. Unlike strategic management



in the private sector, where the predominant emphasis is on the response to market forces, in the NHS environment the dominant influence is political; thus, managerial strategies are mainly a response to political decisions. Consequently general managers seek to maximize the quantity and quality of service in an environment of tremendous political uncertainty. Their main objective, therefore, is the management of the interface between the organization and its environment. This, according to Berman and Maxwell (p.248), involves not only the perceptions of appropriate objectives but also the development of the internal capability to respond to changing circumstances. The development of this internal capability rests with the general managers.

Such an internal capability is needed to change the culture of the organization. Each organization has its own distinctive culture, and sub-units may often develop their own sub-cultures as well. According to Baird et al. (1983), an organization's culture:

...is the total body of values, ideology and goals shared by the organization's members. The culture is manifest in the organization's management practices and policies...The organization's culture will be a major influence in determining what the human resources strategy should be. (p. 19)

The culture of an organization is essentially a system of shared values and beliefs that produce norms of behaviour. In this respect Peters and Waterman (pp.75-78) have discussed the importance of culture in reinforcing the idea of excellence. They argue that since culture develops over many years, changing the culture of an organization requires a strong managerial initiative (pp.103-106). It is something that should be carefully planned and managed. Barnard and Harrison (p. 1216) emphasize that in an attempt to change the culture of the NHS, management (especially HRM), has come to occupy a central place in the service. Along the same lines Pettigrew et al. write that:



... practical managers are now tackling explicit change agendas matched by objective setting, time action plans and individual performance review. The ability of managers to plan for and achieve organizational change, to respond to and manage external changes impacting on their organizations and to guide others through change is seen as a proper part of the modern manager's brief... Managers in the NHS are being confronted by an ever-accelerating pace of social change. (p. 7-8)

As the external environment changes it imposes some opportunities and constraints. It is the manager's task to anticipate, prepare and plan, adapt and interpret these political, economic and legislative changes within individual organizations. As the introduction of general management was designed to bring about a constant search for major change and cost improvement, many general managers have adopted strategies to help them to cope with these changes. In Ferlie and McKees' (1988) view, the factors accounting for this change in the NHS include the growth of the consumer movement, cash limits on welfare expenditure, the growth of public demand for services and the dwindling resources to finance these services, changing government priorities, privatization and manpower issues. If many of the changes occurring in the NHS result from the pressures emanating from the government, particularly cuts in public expenditure, then it is necessary to discuss the effects of resource constraints on the management of the NHS under the Conservative government.

#### Government Public Sector Policies in the 1980s.

In chapter two, the influential role of the state in the evolution and institutionalization of PM practices in organizations was discussed. As Fredman and Morris (1989:25) correctly point out, state employment practices in many respects serve as an example to the



private sector of what the state considers as 'appropriate' practice. The government thus assumes the role of a 'model' employer. For nearly 60 years beginning from 1918, the U.K. government actively encouraged trade union organization, supported collective bargaining and offered a high degree of job security in the public sector. It was hoped that the private sector would emulate the government's employment practices including fair wages, equal opportunities, health and safety etc, partly through the strategy of contract compliance.

The government's good or model employer policies, however, came to an end in 1979 upon the assumption of power by the Conservative government. Since then the state has abandoned the model employer ideology in favour of a more contingent approach. The Conservative government has sought to apply the economic philosophy, or if you wish, ideology of Thatcherism, with its emphasis on the primacy of the free market to its own employment practices. Fredman and Morris comment that:

The traditional model of the state as employer conflicts directly with the Thatcherite ideology, which perceives the 'free market' as the most efficient organizational principle. At the most fundamental level, this ideology calls into question the very existence of public service employment. It is a central tenet of Thatcherism that the role of the state in furnishing services should be pared to the minimum. This has led to the extensive programmes of privatization and contracting-out of functions traditionally performed by the state (p. 27)

Some of the recent state initiatives in the U.K. which have had substantial influence on PM, especially in the public sector and in the NHS in particular, will be discussed. Such a discussion requires a brief overview of the emergence of Thatcherism.

A number of writers including Gamble (1980, 1989); Hall and Jacques (1987); Jacques (1979); Aaronovitch (1981); and Winchester (1981); have in various ways analysed the emergence and nature of Thatcherism and place its rise in the context of the deepening crisis of the British economy. This crisis dates back to the mid-1970s when the post-war economic boom came to an abrupt end as a result of the 1973-4 oil crisis. Nairne (p. 21) maintains that the rise in oil



prices in 1973-74 and again in 1979-80 had severe effects on the global economy, resulting in escalating inflation and rising wage costs.

Of importance here is the economic stagnation which manifested itself in falling output and rising unemployment in the U.K. in the early 1980s. Soskice (1984) argues that the economic crisis undermined, and finally destroyed, the 'moderate' consensus upon which British politics had been based since World War II. This, in his view, precipitated the radical rightist reform; consequently, the Conservative party's old notion of a humane and guided capitalism was replaced by a doctrine of economic liberalism, under which the free market mechanism is considered the ultimate arbiter of human destiny. Since its assumption of power, therefore, the Thatcher government has emphasized the doctrine of laissez-faire in economic life. It thus places unquestioning faith in the utility and existence of free market mechanisms (Brown, 1985).

Soskice (p. 306) points out that the Thatcher government's policy was aimed at: (1) weakening the power of the private sector unions by indirect means (that is, by relying on macro-economic policy instruments concerned with interest rates, the exchange rate and unemployment), (2) moving away from union cooperation at the national level and (3) reducing the size and influence of unions within the public services and sheltered public sector industries. This was intended to redress what it identified as an imbalance of power favouring trade unions. The implementation of these policies led to a rise in unemployment.

The Thatcher government's policy of deflating the economy to put pressure on employers to initiate changes in their IR and PM practices contributed to the recession in the early 1980s which further aggravated the problem of high unemployment. In line with these policies the government sought to erode the collective rights of employees. In the view of the Conservative government, collective organization is not an appropriate mechanism for protecting workers and industrial stability; rather trade unions are seen as interfering with the operations of the market, a hindrance to efficiency and incompatible with individual freedom.



In view of this, the government intervened in the labour market, and attempted to subordinate labour law and the trade unions to its economic philosophy. This marked a sharp break with the traditional British 'voluntarist' or 'absentionist' approach to IR. The government used its power in the legislative arena to pursue its economic and ideological goals. The 1980s therefore witnessed what many observers consider as anti-union legislation (Beaumont 1986:174) enacted by the Thatcher government. These include the Employment Acts of 1980, 1982 and 1988, and the Trade Union Act of 1984, passed to curb trade union power and also to shift the emphasis of the law from collective rights to individual rights.

In discussing the Thatcher government's IR legislation, Soskice, and Beaumont (1988) place the government's approach in a historical perspective and assert that the government's approach was influenced to a great extent by the earlier IR experience of the Edward Heath government. In spite of the sustained attack on trade unions, the rising unemployment in the early 1980s cowed union members who might otherwise have challenged the assault on collective rights. Overall it resulted in a decline in union militancy, and a period of acquiescence and demoralization. In Winchester's (1981:20) view, the trade unions had to deal with the most hostile economic and political environment in the last half century.

Beaumont (1988) points out that the decline in trade union membership was due in part to adverse labour market conditions and increased management opposition, which were encouraged by the policies of Thatcherism. Indeed, the government encouraged public sector employers to disregard the traditional values of consultation and consensus, and adopt a more abrasive and confrontational style of management (Winchester 1989:7).

The Conservative government's deflationary and tight monetary policies pushed up unemployment from 5% in 1979 to 10% in 1982 and 12% in 1985. The unemployment figures began to show a downward trend in 1986, and in 1988, it fell to 9.5% (Towers 1989:164). Annual rates of growth and labour productivity have both gone up by 3-4% and as Towers (p. 165) points out, the rising British GDP was accompanied by falling rates of inflation (from 12% in 1982 to 3.3% in early 1988)



and, after 1986, falling unemployment. However, the period since 1988 has witnessed a sharp rise in inflation and interest rates.

Nevertheless the increasingly strong economic pressures are having a major impact on occupational structure. The service sector is expanding rapidly and this has resulted in the growth of jobs traditionally performed by women. In spite of these developments, there is still a decline in trade union membership, relatively high levels of unemployment and major changes in the composition of the labour force. Towers (p. 164) thus sees these issues as deepening the crisis of trade unionism in the U.K.

The main essence of the above discussion therefore is to show that the government's assault on trade unionism continues in many ways. In the 1980s the government has made attempts to control the unions and management has taken advantage of that. However, trade unions are adopting strategies to counteract such policies and ultimately the decline of their membership. It is clear, however, that the recent economic and structural changes will most probably continue their adverse effects on unions and result in changes in IR and PM.

With the limited industrial action by nurses in 1987 and, more recently, the summer 1989 industrial action by public transport sector employees, ambulance staff and private sector employee (such as the dockers), there seems to be a renewal of trade union confidence. This resurgence of industrial militancy has occurred against a backdrop of a marked improvements in British economy since 1983. Thus, Winchester (1989:7) points out that the resurgence or revival of industrial militancy has been precipitated by the threat to real incomes generated by the rapid rise in inflation, and by the increasing assertiveness of some groups of workers encouraged by the recent labour market shortages in most parts of the country, but most especially in the south-east of England. It is within this broader context that the Conservative government's public sector policies -in particular the departure from the state's model employer role mentioned at the beginning of this section -should be examined.

The Thatcher government arrived in 1979 with the objective of reducing both the size of the public sector and the level of



expenditure. This policy was based on the belief that lower taxation and lower real interest rates were prerequisites of economic growth. Furthermore, lowering public expenditure would permit the lowering of taxation or a smaller public sector deficit and, hence, with a given growth rate of money supply, would lower borrowing and interest rates (Soskice, p. 315)

Having identified excess money as the principal cause of inflation, the government was determined to control the growth of the money supply by controlling the size of the Public Sector Borrowing Requirement (PSBR). As Sheaff (1986:55) shows, the government was determined that the growth in the money supply should be restricted to that which was possible to meet through increased output. In view of this, the reduction in the size of the PSBR through cuts in public expenditure was seen as a necessary precondition for achieving this wider objective.

In order to achieve these objectives the Thatcher government used various methods to pressure employers to initiate changes in their IR and PM practices. For the publicly owned corporations in the competitive sector, the government made it clear to executives that financial subsidy would be given only upon evidence of satisfactory performance in reducing losses. Corporations were therefore actively encouraged to cut costs by reducing overmanning and introducing labour-saving machinery.

In many organizations in the U.K., management unilaterally initiated changes which resulted in the reduction of job demarcation and thus work intensification for skilled workers, and many redundancies among semi-skilled and unskilled workers occurred. In order to carry out these strategies, in some areas, management threatened to dismiss workers who would oppose the changes, call for strike, or ultimately close the company if government subsidy was not forthcoming.

The government was also determined to sell some of the state owned industries in the competitive public sector to the private sector and also to promote greater freedom of choice in social services, especially health care and education, by promoting competitive tendering and contracting out (subcontracting) of



particular services where possible to non-union companies. These policies which come under the general heading of privatization are an important aspect of the Conservative government's strategy to revive the British economy, cut public expenditure and reduce state regulation of the economy (see for example, Chapman 1986, Leedham 1986, Whitfield 1983, and Walker and Moore 1983).

Beaumont and Leopold (1985:38) maintain that the government's privatization policy was based on the following goals (1) to reduce the PSBR, (2) to widen share ownership, (3) to increase consumer choice, and (4) to improve efficiency through the operation of market forces. The more implicit reason, in the view of Beaumont and Leopold, however, was the desire of the government to break the concentration of union membership and power in the public sector. This was aimed at exposing trade unions in the public sector to the greater discipline of the market forces in the private sector. Thus the Conservative government's privatization policy, which began in 1979, had the main objective of replacing public ownership, provision and finance by private provision.

Under privatization therefore, the role of the private sector in the economy is increased. Equally privatization opens the public sector to competition from the private sector. It also injects a sense of private sector commercial approach to the public sector.

As Bach (1989:2) shows, the argument in support of privatization stems from a belief that private sector provision is inherently more efficient and provides the consumer with greater choice than the monopolistic public sector organizations can provide. The opponents of privatization, however, argue that this is not always true. Bach's case study shows that contracting out of health care services to a private sector firm did not necessarily result in efficiency. In fact, it resulted in some deterioration in the provision of services. Such a finding, however, will not diminish any enthusiasm in competitive tendering of ancillary services because privatization is an essential element of Thatcherism.

The government is encouraging also the break up of national centralized bargaining arrangements, and emphasizing greater flexibility and greater responsiveness to market forces. It therefore



favours decentralized bargaining which takes into consideration local variations in wage levels. The government has considered the possibility of promoting differential payments on two levels: first, in terms of geography and skill, and secondly, in terms of individual performance (Fredman and Morris, p. 27). Accordingly performance related pay has been introduced for senior managers in the public sector.

In the public sector in the U.K., the Thatcher government's mechanisms to cut expenditure and control finances have undermined job security for workers. These government policies have also contributed to the reduction of trade union membership. In the public sector, employment has declined by between 11 and 15 per cent in 1981-1987 (a 5-8 per cent decline if the effects of privatization are discounted) (Beaumont 1988:6). In addition, some public sector employees have experienced significant relative wage loss in the 1980s.

In other developments, public sector organizations such as the Post Office and British Railways have been in the forefront in dismantling closed shop arrangements. The government also accused the Civil Service Department of being too friendly to unions and therefore abolished it and assigned its responsibilities to the Treasury.

The public sector has also seen a decline in the use of unilateral arbitration. With the introduction of performance related pay to the public sector, comments Beaumont (1988:8), the Thatcher government intend to make the public sector look 'more private sector-like'.

The assault on public sector employment and trade unions has prompted Beaumont and Leopold (1985) to argue that:

...there is no denying that the Thatcher Government has a reputation second to none for being 'anti-public sector' (p. 4).

To back this accusation they cite the public expenditure cuts, cash limits initiatives as a public sector incomes policy, the banning of union membership and the subsequent 'decertification' of the union at the General Communications Headquarters at Cheltenham, privatization and contracting out of services in the public sector, and a reduced commitment to consultation and discussion with unions in the public



sector.

The government's desire to control public expenditure has resulted in a funding crisis in some sectors of the public sector, particularly in the NHS. The 1973-74 oil crisis pushed the labour government in 1975 to adopt some restrictive macro-economic measures which resulted in drastic cuts in public expenditure.

One aspect of the Labour government's strategy to reduce public expenditure was the introduction of cash limits in 1976. Winchester (1983b: 171) explains that cash limits initially provided an administrative support for the existing incomes policy of the Labour government but the system was retained and rigidly enforced by the Conservative government in 1979. The Thatcher government abolished the Pay Comparability Commission it inherited from the Labour government which had recommended substantial pay increases for public sector employees to catch up with private sector employees and to keep pace with inflation. With the demise of the comparability system, the government introduced the 'ability to pay', or 'affordability', as the major criterion for public sector pay determination. Furthermore in 1981 the government set a pay 'norm' for the public sector as part of a policy of stipulating a pay element within cash limits. Winchester (1989) writes that:

Cash limits and other financial controls defined the 'ability to pay' of public sector employers. The macro-economic implications of cash limits were profound. The British government virtually abandoned the previous system of volume planning of public services; from 1981, cash planning implied that the volume of public services emerged as a residual after taking account of pay increases, labour force changes, and non-labour costs (p. 5).

Cash limits meant that public sector employees could exceed the pay assumptions within the cash limits, but only if the extra cost could be made up by cuts in employment, reductions in services or 'efficiency savings'. In other words, the Conservative government demanded additional expenditure on pay to be financed by staff cuts and administrative savings.

Many of the issues discussed here have been applied to the health services sector in the U.K. For instance, 1975 marked a departure



from the period of steady growth in the public sector in general and the NHS in particular. Prior to 1975 the NHS enjoyed an annual increase in funding of nearly 4 per cent in real terms. In the post-1975 period this increase was reduced to 2 per cent at most (Nairne p. 21). Equally the issue of resource constraints has affected the management of the NHS. New policies concerning efficiency savings, privatization and public expenditure constraints have influenced the adoption of managerial strategies in the management of human resources in the public sector. These government policies have been the dominant influence on the management of human resources in the NHS in the 1980s.

As Maily et al. (1989:130) point out it is the various initiatives designed to increase organizational and managerial efficiency that most clearly demonstrate the practical translation, in the NHS, of the Conservative government's attitudes towards the public sector. In pursuit of its policy of controlling public expenditure, the Conservative government changed health care finance from demand-led to finance-led, a policy often referred to as supply-side finance. The critical supply-side issues of the 1980s revolved around tightening public expenditure constraints, the demand for greater efficiency in the use of NHS resources, and the privatization programme. With supply-side finance came a shift of emphasis from planning public expenditure in volume terms to planning in cash terms. In previous years, if the actual rate of inflation exceeded the expected rate, so that cash expenditure exceeded its target, cash shortfalls in the NHS were made up in the following year. However, in the context of tight public expenditure controls in the 1980s this policy has been abolished (King's Fund 1988:7).

Robinson and Judge (n.d.) have shown the extent to which health care cost has been constrained by cash limits. From 1981/82 to 1986/87 expenditure on Hospital and Community Health Services (HCHS) on the average increased at a rate of less than 0.5 per cent per year in real terms. In 1986/87 there was considerable improvement: an increase of 4.1 per cent in real terms and 2.7 per cent in volume terms. Between 1980/81 and 1986/87 NHS expenditure grew by nearly 60 per cent in cash terms; however, the rate of growth in real terms was



just 12 per cent after taking inflation into consideration (Robinson and Judge). This figure fell behind the increases in resources as prices for medical products increased more rapidly than the general level of inflation. In addition, improvements in productivity, advances in medical technology and new service developments have also made it difficult to maintain standards despite the fact that more has been spent on these services than ever before.

Quite apart from these constraints on expenditure, some DHAs have fared poorly as a result of the redistribution of funds under the RAWP process of distributing funds. The health authorities in London have been particularly hard hit. The tight expenditure constraints have thus created the need to generate supplementary and alternative sources of funds. Some of the strategies adopted include: (1) income generation from non-clinical activities; (2) the sale of clinical support services to the private sector; (3) the joint finance of projects through partnership with the private sector; (4) increased use of NHS pay beds; (5) private insurance schemes; and (6) health vouchers schemes (King's Fund, 1988).

Income generation from non-clinical activities has become increasingly popular since the introduction of general management in 1984. This policy is in line with the government's policy of encouraging private sector practices in the public sector. In an attempt to generate extra revenue at the local level for the provision of health care, some general managers have adopted 'business-like' approaches. Such entrepreneurial general managers have incorporated some commercial activities, mainly in the concourse and waiting rooms in hospitals, to generate funds. Such commercial activities include newspaper stands and bookshops, hairdressers, photography concessions in maternity wards, florists, taxiphone lines, installation of video equipment systems in the wards, chemists and leasing of advertising space (King's Fund, p. 72)

In 1982, the government instructed the health authorities to initiate programmes for efficiency savings. This was essentially a supply-side initiative designed to meet service development in the NHS through savings generated from existing budgets. Efficiency savings were to generate 0.5 per cent of existing budgets for service



development, and the DHSS set targets for the health authorities. In 1981/82 and 1982/83 savings of 29 million pounds sterling and 25.5 million pounds sterling, respectively, were reported. It has been argued, however, that only 50-60 per cent of the savings reported were actually derived from efficient use of resources. According to Robinson and Judge (p. 5), transfers from capital accounts, deferred developments, savings from the previous year and revenue from the sale of land were all erroneously reported as savings. In view of this discrepancy the DHSS ceased to set targets for health authorities, but instead, in 1983/84, introduced Cost Improvement Programmes (CIPs) which are the backbone of the current pursuit of efficiency. Such programmes are measures to release cash or manpower used in providing a service by obtaining the same service output for a smaller input of resources, or to improve productivity by achieving a higher output for the same input or a less than proportionate increase in input (Robinson and Judge p. 5).

Since 1984/85 the DHSS has required every DHA to include CIPs within its short term plans, and success in the implementation of short-term programmes is an essential part of the annual review process which is taken into consideration in the renewal of the general manager's contract. CIPs so far have been successful in yielding savings. In 1984/85 they yielded 1.1% and 1985/86 1.4% of the total amount of current expenditure in the NHS. This was achieved despite the overall decline in the volume of expenditure by 0.1% in 1984/85 and the minimal rise of 0.4 % in 1985/86 (Robinson and Judge p. 6). It is, however, uncertain as to how long savings can be achieved, for the desire to achieve greater efficiency will eventually have to face the inevitability of diminishing returns.

The Conservative government has also pursued a policy of restructuring the system of pay determination in the public sector. As a response to the 1982 NHS pay dispute, and a series of work stoppages, the Secretary of State for Health announced in 1983 the formation of pay review bodies for nurses and midwives and professions allied to medicine. The formation of these two bodies in addition to the Doctors' and Dentists' review bodies means that the pay of more than half the NHS staff is decided outside the Whitley system. Since



the pay review bodies are not negotiating bodies it weakens managerial influence over the pay determination of those NHS staff. Although management, along with the staff side and government, can submit evidence to the pay review bodies, the members make the final decision on recommendation to the government. Once the recommendations have been made, whether the award is implemented in full, in part, or in stages is the sole responsibility of the government. As part of its public expenditure restraint policy the government has in recent years rarely funded the awards in full. The underfunding of pay awards generates further pressure on NHS managers to produce savings. Within the Whitley system of pay determination, the government has since 1983 attempted to increase the influence of NHS managers over pay strategy but as Mailly et al. (p.125) succinctly put it, it is difficult to envisage how NHS management can formulate pay strategy within the constraints of the cash limits policy.

Another issue facing general managers in the NHS is that of difficulties in recruitment and retention of staff. This problem is especially acute for nurses and ancillary staff because of the uncompetitive level of NHS salaries in relation to local labour markets. Dyson (1988), for instance, sees recruitment and retention as the central labour market issues facing the NHS. After examining NHS pay trends and their internal relativities and relationships with external pay comparators, he argues that if the trends in recruitment and retention are to be reversed, NHS pay should be competitive with that available in comparable organizations (Dyson p. 9)

Among nurses, for instance, uncompetitive salaries have led to low entry into nursing and a high turnover. Delamothe (1988a) captures the extent of this turnover with the following story:

Two Decembers ago one London hospital ward was unable to find its Christmas decorations. Not one nurse was still working there from the year before. An annual turnover of 100% may be disruptive, but at least it allows wards to remain open. That was back in 1986, when high rates of turnover could still be perceived as a problem. Since then the game of musical chairs that passes for nursing manpower planning has speeded up. When the music stopped in 1987 the shortfall between nurses and vacancies had never been greater. Some wards have always been difficult to staff: last year no where was spared. Even those most emotive areas - leukaemia units,



dialysis units, and paediatric intensive care - were closing beds and refusing admissions. For short periods some even closed completely because of shortages of nursing staff. This Christmas in many wards in many hospitals they were searching for more than just the decorations (p.25).

Of the one million people employed by the NHS, half are nurses, and their salaries account for 22 per cent of the total NHS expenditure (Delamothe 1988a:25 ). Nurses in the NHS complain about budget cuts, staff shortages, and consequently increased workload. A recent survey asking nurses why they are contemplating leaving the NHS identified low morale, low pay, and stress as some of the major reasons (Delamothe 1989b). Low morale in the NHS is by no means limited to nurses, since it also exists among other members of staff.

Barnard and Harrison (p. 7) note that the proportion of labour costs to total costs in the NHS is considerable. It is estimated that about 75 per cent of current expenditure of the NHS is spent on salaries and wages. This is hardly surprising, since health care is a labour intensive industry requiring personal care. With such a high expenditure on wages and salaries, reducing labour cost was one of the important means of achieving savings and cutting government expenditure.

The reduction of the size of the public sector was to be achieved also through competitive tendering and contracting out of ancillary services in hospitals and administrative units in the NHS. Prior to 1983 one of the factors which hampered private sector competition was the imposition of value added tax on work subcontracted, while in-house operations were not subjected to the tax. The Thatcher government changed the policy and made the value added tax charges refundable to health authorities (Chapman, p.12). According to the government, savings derived from provision of services are to be added to hospital budgets to improve overall health care provision. The contracting out of ancillary services in the NHS thus ties in closely with the Thatcher government's economic objectives. Since 1983 the government has required health authorities to subject their ancillary services such as cleaning, laundry, domestic and catering to competitive tendering. Competitive tendering



is being extended to portering and pathology services.

It is widely believed that the first round of contracting out of ancillary services in the NHS offered favourable conditions for savings because private sector firms competed side by side with in-house operations (Minogue and O'Grady 1985). The first round of contracts have currently run their term and are in the process of being renewed. As alluded to earlier the second round of tendering is expected to take place in an unfavourable environment which may reduce efficiency savings. Bach notes that:

In a period of financial stringency, NHS managers are keen to make further cost reductions. However, this process will be tempered by the private sector's realization that their bids were frequently too low in price to be viable, and an increasing awareness amongst NHS managers that standards have been allowed to fall too far. A rise in prices by private sector firms will help to continue the trend of services being retained in-house (p.18).

Savings derived from contracting out of domestic services in the NHS fell from 32 per cent of costs in 1984/85 to 18 per cent in September 1986 (National Audit Office, 1986).

Critics of CIPs argue that the savings achieved have come from cutbacks on maintenance programmes and service reductions rather than from more efficient use of resources. Others maintain that the efficiency savings do not necessarily correspond to any matching improvement in efficiency, since some health authorities set lower budgets and expect managers to operate within them (National Audit Office, 1987). Such practices invariably result in cuts or reductions in service to which the DHSS is strongly opposed. Given that one of the criteria for assessing managerial success is finance, then practices of cutting service in order to achieve efficiency savings are to be expected.

Barnard and Harrison (p. 1217) give other examples of 'efficiency' measures: (1) the detachment of senior officers to perform ad hoc scrutinies of expenditure; (2) the use of commercial firms rather than the DHSS as auditors to examine accounts; (3) the establishment of an inquiry team to identify surplus land and property for disposal; and (4) the development of indicators by which health



authority performance might be measured. These indicators are constructed from a wide range of financial data and other information. As Winchester (1989:11) comments, the overall objective is relatively uncontentious, but the problematic nature of measuring health care provision has encouraged a narrower pre-occupation with comparisons of the relative cost of discrete activities than wider issues of efficiency.

Other initiatives include the introduction of the annual review process, whereby the Secretary of State, through the NHS Supervisory Board, reviews the NHS Management Board. The NHS Management Board reviews the RHA, the RHA reviews the DHA, and the DHA reviews the Unit. The Ministry and the NHS Supervisory Board use the review process to assess progress in the implementation of national policies and priorities. This process also determines how well or how far a unit, district or region attained its plans and objectives. These activities by the DHSS to intervene in the NHS amounts to central government centralization of the NHS in spite of claims to decentralization. In a sense the government's policies amount to centralization of financial control and decentralization of accountability to make sure that its policies are followed in the NHS. Pettigrew et al. (p.6) and Hunter (1983) also see these processes, including Rayner Scrutines and Kroner Information Systems, as attempts by central government since 1982 to tighten its 'grip' on the NHS. These processes increase centralization, and some writers maintain that Griffiths restructuring makes the problem of centralization more acute (Nairne 1985; Hunter 1984; Patchey 1986; Cox 1986; Pettigrew et al. 1988). It may also encourage ministerial intervention and enhanced accountability of managers through the organization.

Nairne (p. 121) argues that the Griffiths restructuring brings to the fore the tensions between centralization and decentralization, since general managers would want to be left as free as possible to formulate and implement their own policies and to plan with the approval of their authorities. On the other hand, higher levels of authority, and in particular, the new NHS Management Board at the top, will be concerned with ensuring that local policies take as much account as possible of the national policies and priorities with which



the Health Service Supervisory Board will be concerned. Thus, the shift from organizational policy to management policy has resulted in the formulation of policies for the improvement and control of the service.

In this era of dwindling financial resources, general managers must cope with a myriad of health care issues, all of which deserve equal attention, but for financial reasons cannot be treated equally. General managers must therefore develop strategies for the delivery of health care in order to achieve their objectives and be able to show results in the least possible time. This is essential, because they are appointed on fixed contracts ranging from three to five years, and their performance is assessed annually by Individual Performance Reviews (IPRs).

One objective of the introduction of contracts and performance related pay for general managers is to ensure managerial efficiency and the effective and efficient delivery of health care. However, there is no performance measurement, or set of criteria for measuring managerial success, in the NHS. Consequently, there are no clear objective criteria for assessment in managers contracts. West (1988: 107) points to the introduction of IPRs, but argues that it is too early to assess whether these reviews will help to clarify the complex issue of management performance. In recent years, financial control has emerged as the only objective criteria for measuring managerial performance. In view of this, finance dominates discussions of performance. Over-spending the district's budget could be interpreted as a failure in terms of managerial performance, making it easier to weed out undesirable general managers.

The introduction of fixed term contracts for general managers simplifies the dismissal of general managers (i.e., the poor performers), since a contract can merely end, whereas prior to Griffiths the difficult task of incompetence was necessary before an administrator could be dismissed. There is, however, lack of clarity regarding what constitutes a good or bad performance. This lack of clear objectives for performance for general managers thus seriously undermines the entire accountability and reward system in the NHS. Therefore, in order to keep their jobs or achieve promotion, general



managers now have to make and implement unpopular decisions, for example, privatization of services and hospital closures, with much more vigour and enthusiasm than in the past. The role of general managers, then, writes Mailly et al. (1989):

Has been to translate (albeit not unthinkingly and on occasions relatively unwillingly) the Conservative government's policies at local level-often with little resistance from weakened trade union organizations (p. 147).

This affirms the view that general managers are under considerable stress to show positive results in managing their organizations in order to have their contracts renewed. General managers under pressure have adopted strategies; that is, consciously articulated plans to achieve their organizational objectives. They have turned to strategic management as a means of managing their organizations in a rapidly changing health care environment. This requires the formulation of effective organizational strategies and the development of appropriate organizational structures. It is argued that the adoption of strategies offer a good opportunity for general managers to navigate their way through the difficult and seemingly impossible managerial task.

### Conclusion

This chapter has addressed a number of issues. The most important, however, focused on the pressures on the general managers emanating from the government's public expenditure and centralization policies. State policies particularly in the areas of economics and legislation in the 1980s encouraged employers, particularly those in the public sector, to carry out changes in their IR and PM practices. These changes reflected some change in managerial values. Such values include emphasis on individualistic rather than collectivist perspectives in the management of human resources and consequently the placing of personnel and HRM issues high on the agenda of the boards of organizations.

The state initiatives also gave the impetus to management to



develop organizational strategies, to improve the efficiency and effectiveness of organizations, and to respond to the demand for improvement in the quality of services offered to consumers. These U.K. developments in both the private and public sectors are not very dissimilar from the developments in the U.S. described by Kochan et al. (1986), which allowed employers in the U.S. to adopt new managerial strategies in the management of human resources.

It is against this background that general managers have adopted certain strategies in the management of the NHS which have had profound effects on the management of human resources in the DHAs. General management encourages individual decision rather than consensus decisions. Consequently it has increased the power and status of management and conferred on it greater legitimacy, so as to weaken the professional ethos that is entrenched in the NHS (Bach p. 1). General managers are required to carry out the government's efficiency policies and by so doing, at least balance the health care budget if they are not able to cut it down.

The above discussion has many implications which will be explored in the empirical section of the thesis. Firstly, it has outlined the managerial structure of the NHS and shown how policies initiated at the top influence managerial strategies at the DHA level. National health policies initiated by the NHS Supervisory Board are pushed down to the NHS Management Board which in turn pushes it down to the RHAs. The RHAs issue guidelines for the DHA which formulate their strategic plans and implementation policies at the unit level. In view of the top-down nature of the national strategic policies, it raises some issue: firstly, to what extent managerial strategies in the DHAs follow the NHS Supervisory Board and for that matter the government's double-edged policy of centralization and decentralization; that is, the simultaneous pursuit of centralization and decentralization policies?

Secondly, the discussion indicates some of the ways in which the adoption of managerial strategies at the DHA level in the NHS is a response to changes in the NHS environment. As it was indicated in Chapter three, the adoption of managerial strategies to cope with environmental changes often involve changes in values and ideologies



which, in turn, influence the management of people in the organization. More often such changes involve some emphasis on HRM with an increasing role for line managers in personnel issues. Consequently personnel managers are relegated to the background, or their activities are limited to issues requiring specialist knowledge. The discussion here raises the issue of the extent to which such managerial strategies have influenced changes in the personnel management role. This will be explored in the empirical chapters, after the next chapter which explores the evolution and current changes in PM in the NHS.

Thirdly, the discussion of managerial strategy and strategic management will allow an analysis of the formulation and implementation of managerial strategy at the DHA level. It will provide a starting point for the analysis of the emergence and implementation of the managerial strategies of QA and QCs. It is the emphasis on individualism that influences management to adopt strategies which encourage employee involvement schemes, such as QCs. The discussion here is a prelude to the conceptual discussion of QA and QCs in the health care sector undertaken in chapter six.



## CHAPTER 5

PERSONNEL MANAGEMENT IN THE NHS

As chapter three reviewed the general development of PM in the U.K., and the specific issue of PM/HRM interface, this chapter deals specifically with PM in the NHS. It has two purposes. The first is to explore the various factors which contributed to the development of PM in the NHS. The second is to explore the influence of the Griffiths restructuring on PM. It is argued that the post-Griffiths period has witnessed the simultaneous pursuit of two policies: the first was aimed at increasing line management involvement in personnel issues and the second was meant to strengthen PM. This was because Griffiths emphasized broad line management involvement in all aspects of management in the health service, including personnel issues, and at the same time stressed the strengthening of the personnel function. In view of this some institutional attempts to boost the personnel function in the NHS are also discussed in this section.

This chapter underscores the influential role of the government, and the Griffiths restructuring in particular, in redefining the personnel function in the NHS. The main focus of the chapter therefore is to examine the main challenges which PM in the NHS had to contend with in the 1980s. This includes the effects of the Griffiths restructuring and the emergence of HRM models in the NHS. These issues are examined in terms of their effects on line and staff issues in personnel. The chapter thus provides the basis for the empirical illustration of the above issues, as well as the general issue of the relationship between PM and HRM, in the empirical chapters.

The Development of Personnel Management: 1960s to 1980.

The development of PM in the NHS has to some extent followed the general development of PM in industry. It was not until the outbreak of the second World War, and the years soon after the war, that



personnel emerged as a separate managerial function in industry in the U.K. This was partly due to the effort of the government to promote the growth of PM in industry. Despite this stimulus, it was not until the 1970s that PM came of age and was fully accepted in industry (private sector) in the U.K.

As indicated in chapter three the fortunes of personnel improved rapidly in the 1960s and 1970s. Guest (1982) and Thomason (1980) have offered various explanations for this growth. Prominent among these factors was the way in which the problems of industry were defined at both the national and organizational levels in the 1960s and 1970s. Guest (1982) in discussing these industrial problems maintains that:

throughout the period in question they were defined in IR and employment terms. The national debate centred around the 'problem' of strikes and the 'problem' of productivity and the 'problem' of legal regulation and participation. The solutions, from Donovan and the Industrial Training Act of 1964 to the Bullock Report and incomes policies of the later 1970s, all pointed to the importance of the need for more IR and PM at organizational level, reinforced by institutions and legislation at national level (p.37).

This reform was believed to be necessary in institutionalizing conflict and achieving efficiency objectives in IR and PM in organizations. There was also the need for the formalization of personnel function, particularly its IR component, and to separate it at least partially from line management.

Quiet apart from the passage of employment legislation, and the move towards the reform of IR recommended by the Donovan Commission and a variety of quangos (Batstone 1980:36) the general trend towards managerial specialization and professionalization, also contributed to the development of PM in organizations in the 1970s. This period witnessed a rapid growth in both the number of personnel and IR specialists, and in their status and influence. In due course these developments spilled over from the private sector to the public sector including the NHS.

These issues, in combination with other factors, gave a stimulus to the establishment of specialist PM roles and departments in the NHS. The most prominent of these other factors, however, was the crises



in the traditional system of IR in the NHS. On its inception in 1948, the Whitley Council system for determining pay and conditions were introduced in the NHS. As Maily et al. (1989:114) have pointed out the centralization of negotiations left little scope for the development of local bargaining. Although in 1950 the General Whitley Council allowed the formation of Joint Staff Consultative Committees (JSCCs) at hospital levels, the subject matter of agendas dealt with minor issues and consultation at the hospital level was thus generally regarded as a failure. In spite of this, a passive work force and a faith in the Whitley system ensured stability in NHS IR in the 1950s and 1960s. During this period there was virtually no industrial action over pay as most disputes were settled by arbitration. This state of affairs was attributed to the weakness of the trade union side as the NHS had low union membership in comparison with other public sector organizations (Clegg and Chester 1957:142). Moreover, a significant proportion of the NHS staff were members of professional associations such as the Royal College of Nursing (RCN), and the British Medical Association (BMA), which at the time did not consider themselves as unions.

In the early 1970s the relatively stable NHS IR system was challenged. During this period the NHS moved from a period of relative stability and growth, paternalistic management and obedient and well motivated staff to organizational crisis. The causal factors that challenged the NHS IR system, and consequently paved the way for change in the late 1960s and mid-1970s, have been well documented (see for instance, Dimmock and Farnham 1975; Manson 1977, Bosanquet 1979,1982; Carpenter 1982; Trainor 1982; Barnard and Harrison 1986). For this reason only a brief summary of the main factors will be provided here.

One aspect of the pressure for change revolved around the problems of the Whitley system. Governments' incomes policy, together with the operation of the Whitley system often adversely affected NHS staff pay which, in turn, resulted in frequent and intensified pay conflicts. Trainor explains the nature of this problem in the following way:



The fragmentation of bargaining, due in part to the diversity of occupations and self-interest, together with the slowness of Whitley to respond to pay adjustment, results in some occupational groups being caught in a pay trap. The added effect of incomes policy has therefore been particularly dramatic for traditional areas of low pay, such as ancillary workers and indeed it was basically the impact of incomes policy that led to the 1973 ancillary workers strike (p.34).

The centralization of pay bargaining through the Whitley system encouraged wage drift particularly prior to the 1970s. The Whitley system was particularly susceptible to government interference through such incomes policies as 'freeze', 'squeeze', 'pause', 'restraint' (Trainor p.34). It was this incomes policy which contributed to the institution of an alternative method for improving pay linked to productivity for ancillary workers.

The National Board for Prices and Incomes (NBPI) argued that the low pay of ancillary workers was due to their low level of productivity, poor structures of work and standards of management. As a solution to this low pay and low levels of productivity, the NBPI in 1967 recommended changes in the pay structure by the introduction of earnings incentive bonus schemes based on work study techniques. In addition an interim productivity scheme was also recommended. Under this scheme an agreed percentage savings in labour costs would merit an equivalent rise in basic rates of pay as a first step to fully work studied schemes. The introduction of bonus schemes for ancillary staff gave a great stimulus to unionization in the NHS. Furthermore it had direct consequences on the conduct of work relations and also set the NHS on a managerialist path. Trainor argues that the introduction of the bonus scheme:

stimulated managerialism, not only by the establishment of specialist management services division, but also by the need to introduce functional managers for ancillary groups to manage schemes. Furthermore, job consciousness was increased as duties were more tightly defined and work group awareness was enhanced. The need for representation in the development of schemes was first taken on by elected representatives from the workplace which was later turned into trade union workplace representation. Concern about jobs and fairness resulted in a dramatic increase in trade union membership as employees became conscious of the need to organize (p.35).



Although the development of this trade union consciousness had its roots in ancillary staff it soon spread to other groups of staff who were concerned that the scheme might be extended to them. As Mailly et al. (p.114) point out, with the introduction of the bonus schemes came the emphasis on the 'cash nexus'. This together with the use of work study assisted the development of trade union consciousness amongst health care workers. Similarly Vulliamy and Moore(1979:20) argue that the incentive bonus scheme made workers think more clearly about the work they performed and the payment they received for it. This newly developed consciousness about the effort-reward bargain encouraged them to meet fellow workers, elect representatives and laid the foundation for trade union membership and activity. The implementation of the bonus scheme, however, was patchy due to the heavy work load involved and the critical shortage of management expertise.

Winchester(1983b) argues the introduction of the scheme in many respects provided the first significant focus for workplace bargaining in the NHS. The introduction of the bonus scheme resulted in the decentralization of a significant amount of pay bargaining to the workplace level. This, then, was the beginning of work sensitive contracts in the NHS. It also resulted in potential pay anomalies, drift and conflict as management in many cases attempted to adjust slack schemes.

As the trade union continued to gain membership in the 1970s, the NHS workers began to adopt more confrontational and militant attitudes. The employees exhibited this sort of militancy in 1973. The separation of pay link with local government workers due to the introduction of a new incomes policy by the Heath government led to a national strike by the ancillary employees in 1973. Prior to this time militancy did not result in direct action through withdrawal of labour, and essentially the 'patient first' ethic prevailed. Seen against this background, the 1973 ancillary workers' dispute marked a watershed in NHS IR. With it, the record of almost twenty years of industrial peace was ended and in the years up to 1979, virtually every occupational group in the NHS threatened to take some form of industrial action. The 1973 ancillary workers dispute also had the



effect of increasing employee consciousness, increased trade union membership and strengthened the trade union organization. In 1974 nurses also threatened to go on strike. Trade union militancy in the NHS was again exhibited in the 1978/79 campaign during the 'winter of discontent'.

In the face of these disputes the NHS lacked consistent procedural arrangements for handling disputes, hence the NHS was seen to be strike prone and in crisis. This perception was perhaps due to the system of management prior to 1974. It was based on a combination of paternalism, autocracy, and a unitary perception of the exercise of managerial prerogative. Professional management supported by training was conspicuously absent in the NHS. Therefore when the passive nature of the workforce changed as a result of their involvement in trade unions, it posed a fundamental challenge to the basic values and assumptions of management. Workers demanded their involvement in decision making and refused to accept the traditional hierarchical authority. In view of this challenge it was hoped that the 1974 reorganization would ensure consensus decision making in an objective and informed manner. The 1974 reorganization, however, did not end the criticisms of the management of the NHS as it compounded the uncertainty of role within management and increased the potential for intra-organizational conflict. Trainor comments that,

the lack of a clear service objectives and leadership coupled with a failure to define managerial executive systems led to a confusion of managerial role and relationships and to claims that decision making was ineffective. These factors must have influenced the regulation of work relations and were likely only to be compounded by the growth of managerialism and the changed division of labour that occurred in the post 1974 reorganization period (29).

With the change in managerial structure in 1974 came a more managerialist ideology. Managers began to assert their control over their areas of responsibility, and in the process tended to view the problems of the NHS as mainly due to trade union activity. It was this perception of IR matters that may have resulted in the formation of barriers and treatment of IR as a 'special' area requiring special attention.



At another level a series of employment legislation passed by the government during the 1970s were particularly influential in the growth of PM in the NHS. The implications of the legislation for the formalization of workplace IR, as a means of strengthening collective bargaining, resulted in the development of workplace IR at local levels in the NHS. The legislation also encouraged many professional associations such as the BMA, the RCN, Royal College of Midwives (RCM), the Chartered Society of Physiotherapy and the Society of Radiographers to seek legal certification as trade unions. Their certification as trade unions was accompanied by the introduction of workplace representatives and more sophisticated workplace organizations (Trainor p.26). This was a radical departure from the pre-1968 situation where, with the exception of the craft unions, no workplace representation existed and a few branch officers at post performed mainly administrative duties. The National Union of Public Employees (NUPE) introduced workplace representatives in 1968, and they were followed by Association of Scientific, Technical and Managerial Staffs (ASTMS), RCN and Confederation of Health Service Employees (COHSE) in the early 1970s. The workplace representatives challenged traditional areas of managerial prerogatives as the representatives sought to influence organizational decision making. As Trainor puts it, workplace organization therefore fostered a new arena for IR activity challenging those issues which were previously subject to control only through national bargaining. With this came the awareness of the workforce about its ability to exercise some control over managerial decision making.

All these factors together necessitated expertise in dealing with personnel and IR issues. There was the need for specialist skills to deal with PM issues arising from the legislation; for instance, how the unfair dismissal legislation affected management practice. Personnel officers were also required to deal with the trade unions; negotiating some local agreements and implementing national collective agreements etc. Moreover, the 1974 reorganization required specialist staff that were able to deal with the employment and career consequences of the changes.

With the changes in the NHS environment, the lack of any



systematic policies in PM became a matter of concern. By the early 1970s, officials in the NHS began to point to the need to reorganize personnel policies and procedures into a specialist management function. The series of pressures mentioned above thus generated the need for personnel input and therefore in the 1970s the NHS began to discover personnel managers.

In summary, Trainor (p.109) argues that the encouragement by the government (DHSS) to promote the growth of PM in the NHS was a response to the need to fill the gaps in management expertise created by the changes in the social environment of organizations, the increasing complexity in people management and the emergence of more active trade unions in the NHS. Charles-Edwards (1980) adds that the threat of industrial action by various staff and professional groups was also influential in this respect from 1970. These changes encouraged managers to seek advice and support from specialists with knowledge of personnel and IR issues.

In view of these issues, the DHSS encouraged the establishment of the post of personnel officer within the hospital management committees. It recommended that each employing authority should appoint a personnel officer who would report to the administrator at the district, area and regional level and who would handle personnel issues, including discipline. The DHSS issued a circular stipulating the personnel and training structure to be set up and the appointment of personnel officers for late 1973 and early 1974. The circular was aimed at encouraging health authorities to appoint personnel officers, but its effect was quite limited, since only a handful of health authorities heeded the circular.

Following this, another circular on PM was issued in November 1973 [HRC (73) 37,] which reiterated the need to establish the specialist personnel function. This circular described in detail the general aims, objectives and responsibilities of the specialist personnel function. It emphasized the task of PM at the national, regional, area and district levels, specified the relationships among personnel officers, teams and line managers and stipulated the responsibilities for personnel managers at each level.

Chaplin (1982:369) summarizes the aims of the specialist



personnel function detailed in the circular as follows: review or preparation of plans and budgets, provision of specialist advice on personnel issues and practices, support of subordinate personnel officers, and undertaking of establishment work. Other functions included IR and manpower planning, the development of training activities and the provision of personnel services for all staff employed. In a sense, personnel officers were expected to recruit, retain and motivate staff and to develop effective communication and consultation systems. This circular, which had the objective of clarifying the task of the personnel function, however, did not clearly distinguish between the responsibilities of the specialist personnel manager vis-a-vis the line manager. It did, however, lay the foundation for the establishment of PM in the NHS.

A subsequent circular, HSC (IS) 57, issued by the DHSS further clarified the policy and organization for the training function. This included, among other things, detailing the role and scope of training, the tasks, the design and provision of training, and the various roles for the training officer at area, regional and national levels.

In spite of these developments, formal PM, as indicated earlier, was not fully established in the NHS until after the 1974 reorganization, at which time the health authorities were required to appoint personnel officers (Beaumont and Leopold, 1985a, McCarthy 1984). This period ushered in a new era which witnessed the appointments of personnel officers at the AHAs and RHAs levels. However, not all districts appointed personnel managers, and in those districts without personnel officers, personnel work was integrated into the general administration function, with more junior officers performing the more routine personnel work. This arrangement was similar to the years before the establishment of formal personnel departments. In the pre-1974 period issues such as recruitment, terms and conditions of service, training and application of pay rates were largely the duty of the administrator and the finance officers of the various hospitals (Chaplin p.369). These administrators and finance officers also involved the matron and other senior nurses in issues related to the nursing staff. However, nurses' pay and conditions of



service were usually handled by establishment officers or salaries and wages officers. Management committees often consulted hospital administrators on staffing and employment matters.

In the post-1974 period even in those districts with well established personnel departments (including training sections) some personnel tasks were performed by line managers and others were performed by the specialist personnel managers. Chaplin (p.371), thus, indicates that in the period of formalization of personnel and employment procedures personnel work was not uniformly organized and different patterns emerged in the NHS. The extent to which the personnel function was comprehensively integrated with the line management role varied from authority to authority, depending upon such factors as the geographical distribution of services within the authority, the resources available to the personnel function, the amount of personnel work that line managers themselves were expected to undertake, and the degree of interaction between the different management disciplines.

It is thus clear that there has never been a clear differentiation between the specialist personnel function and the line management responsibilities for personnel in the NHS. Somehow the two perspectives have co-existed without much overt conflict. Since the Griffiths reorganization, however, line managers have increased their involvement in personnel issues in the NHS. This, then, necessitates a discussion of PM in the NHS in the 1980s.

#### Personnel Management in the 1980s.

The Griffiths reorganization was aimed at achieving greater organizational and managerial efficiency in the NHS. To paraphrase Mailly et al. it was the practical application, in the NHS, of the Conservative government's ideology towards the public sector. In this respect many health authorities are seeking to achieve efficiency in order to meet public spending targets. In an attempt to achieve this objective many health authorities have instituted programmes in employee involvement in quality improvement. Such strategies call for the integration of human resources into the organizational strategy.



Managerial finance-driven strategic decisions regarding human resources have been adopted at the top level of the district health authority. Line managers and management consultants have been actively involved in the employee involvement, commitment, motivation, development and quality initiatives. Line managers have taken a more pro-active role in organizations because the changing organizational environment requires employee involvement in quality and productivity issues, better control of employee costs, recognition of good customer relations, value for money (that is, higher quality goods and services at the same price). In some organizations line managers and management consultants have participated in the development of QA and QCs initiatives to achieve these objectives. Some may be responding to the shift from collective to individualistic perspective in PM. However, the increasing involvement of line managers and management consultants in personnel issues could potentially make the personnel function more diffuse and perhaps increase the ambiguity in the personnel role in the NHS. This raises the issue whether these developments are part of what Tyson (1987) refers to as balkanization of the personnel function.

Perhaps it is the desire to guard against any such erosion or balkanization in the personnel role that Griffiths recommended the strengthening of the personnel function in the NHS. It is therefore against this background that the personnel role in the post-Griffiths NHS will be discussed.

In the post-Griffiths period there has been an emphasis on strengthening the personnel function. McCarthy (1984) argues that prior to this period the NHS, and indeed the DHSS, never understood the proper role and importance of 'personnel' in its widest sense. Griffiths recognized the importance of the personnel function and advocated the institution of centralized personnel policies. The Griffiths report recommended the appointment of a personnel director for the NHS who would among other things be responsible for developing training policies for all staff, including management and clinicians; reviewing and implementing effective personnel policies; and ensuring, with line management, the operation of a policy for performance appraisal and career development (McCarthy p. 4).



These are attempts to fill gaps which have been created in the organization of the personnel function in the NHS. McCarthy points out that unsuccessful attempts have been made in the past to bridge this gap. The failure of previous attempts results from the fact that the motivation for change in the personnel function in the NHS came mainly from personnel officers and people interested in personnel - mostly Regional Personnel Officers (RPOs). Often these people did not wield enough clout to carry out changes and have not been successful in getting their ideas through to the DHSS. However, with the establishment of the National Association of Health Service Personnel Officers (NAHSPO), personnel officers can now make collective decisions and to some extent indirectly influence the development of the personnel function. In its response to the 1982 reorganization of the NHS, NAHSPO advocated the establishment of an integrated personnel function with central personnel directives. It appears that Griffiths saw the wisdom in this proposal and therefore responded favourably to it.

The Griffiths restructuring succeeded in instituting changes in an area where the personnel officers have been unable to achieve any changes. As Dyson (1984:256) points out, the Griffiths restructuring was bound to usher the NHS into a period of greater change and greater conflict in IR and PM. This necessitated a strengthened personnel function, one that is dynamic and committed to management objectives. Dyson continues that the appointment of a national personnel director who shared these objectives and provided a national focus for professional leadership would do much to boost the morale and status of the personnel officers in the NHS. Dyson (p. 256) wrote:

The Secretary of State's decision to establish manpower controls, his directives on efficiency savings, and the requirements of competitive tendering, not to mention the reform and revitalized management side of Whitley Council's negotiating machinery, all create a challenge for the personnel function within the districts, and to couple this with the appointment of a national personnel director cannot but help the service achieve its objectives.

Since the Griffiths restructuring came into effect, the NHS Management Board has been at the forefront of attempts to boost the



role of personnel in the NHS. When Mr. Paige resigned as the first chief executive of the board, Mr. Peach, the board's director of personnel, was appointed and held the positions concurrently. He took various initiatives to improve the status of the personnel function in the service.

The current Director of Personnel has emphasized the board's objective of ensuring that the proper role of PM is accepted and established in the NHS (Wormald, 1987:11). He admits that a great deal more needs to be done for PM in the NHS, since it is clear that even those authorities with personnel departments still have not developed fully. Mr. Wormald urged the NAHSPO to balance its staff-oriented perspective with a commitment to the achievement of management goals. These include, among others, a coherent personnel and manpower strategy to bind together all the different elements in a mutually reinforcing way. Such strategies, he continues, should optimize the attractiveness of the NHS as an employer, enable management to manage effectively, and help to make the best possible use of available resources and skills.

In view of this, the NHS management board in 1987 initiated a training programme for personnel officers aimed at developing and strengthening the PM function in the NHS. This was the first attempt since 1974 to develop training to meet the needs of personnel practitioners in the service. Chumbley (1988:592) sees the need for such training because the introduction of general management, together with the increasingly complex pay and productivity systems, the care in the community initiatives and the competitive tendering programmes, has taken place in an environment where it is becoming increasingly difficult to recruit and retain qualified staff. The rapidly changing NHS environment demands creativity and imagination in redesigning jobs, scrutinizing skill mix and providing training or retraining to match the supply and demand data generated by the application of more sophisticated staff planning techniques. In addition to the training initiatives there is also the need to boost the morale of those personnel officers whose rates of pay suffer in relation to those of their colleagues in the private sector, but are nevertheless expected to advise managers on the best ways to motivate staff.



In view of the above, a national working party on career development and training of personnel managers in the NHS was formed in 1987 under the chairmanship of Mr. Philip Marsh, Manpower Director of North East Thames RHA. This working party was initiated by the chairman of the NHS board and regional directors, who decried the understaffing and undeveloped nature of the personnel function to match the challenges created by the introduction of general management. The objective of the working party was to examine quantity and quality issues, and make recommendations for the recruitment, retention and career development of specialist personnel and training staff within the NHS (ibid, p. 592)

The objective of the NHS board is to attempt to encourage a planned change which will allow future personnel managers to be increasingly involved in providing specialist skills and advice on HRM, expertise in organization development and change management, advisory service for line managers on HRM issues, meaningful contributions at senior levels to corporate and strategic management of the service, and specialist skills in staff information, planning, recruitment and retention.

This is necessary because the NHS is facing a potential crisis in recruiting and retaining qualified staff to maintain and develop services to meet the required standards. The supply of manpower to the NHS has been declining although the NHS is yet to be affected by the demographic changes, which will almost certainly result in a further shortfall in the supply of young people of the appropriate calibre and potential (Townsend, 1989:60).

The shortfalls in the supply of manpower in the NHS, particularly in nursing, physiotherapy, occupational therapy, professions allied to medicine, as well as the other caring non-medical professions, becomes more critical when viewed against the backdrop of the demands that will be made on the service. Between 1985 and 2001 there will be a 4% increase in the population. Over the same period there will be a sharp increase of 22% in the elderly (over 75) population. This shift in age structure of the population will most likely exert more pressure on service over and above the demand arising from actual growth (Baird n.d.:1). DHAs require personnel managers to develop



strategic responses to these challenges. It is, therefore, no wonder that the NHS board is encouraging a shift in the present and past focus of personnel on routine and administrative tasks to strategic and development objectives.

The NHS board is also urging regional personnel directors to strengthen the professionalism of PM and make PM a viable route to general management. Similarly, the NHS training authority has been urged to give more exposure to the personnel function in the general management training scheme. This is aimed at projecting the image of the personnel function as an appropriate and attractive career option for trainee general managers. There was also felt a need to begin work on the development of a graduate entry training scheme for personnel.

Before achieving this, however, there is a need to strengthen the personnel skills and core competences of the existing middle level personnel officers through training. It must be noted that at the inception of the personnel function in the NHS, most personnel officers were not trained for the job; they were generally low graded staff who were pushed into personnel, often with complete disregard of their experience, aptitude or interest in PM. During this period the personnel specialist emphasized the IR role, reflecting the increasing unionization in the NHS (Walker, 1979). In time, however, as the NHS environment changed and in the early 1980s, the IR role was de-emphasized and personnel officers shifted their attention to employment services, manpower planning, training and organization development (Gourley, 1981).

From the mid-1980s, personnel managers in the NHS have made attempts to respond to further changes. The improvements in British economy in the mid-1980s have resulted in shortages of skilled workers in many sectors of the economy. The government's policies such as cash limits and low pay in the NHS have made it difficult for the NHS to recruit qualified staff. In view of this personnel managers are adopting new strategies in recruitment. There is now more emphasis on training and equal opportunities at work has received increasing attention. In addition personnel managers play some role in the competitive tendering process and continue to play an active role in



negotiating with unions, handling conflict, developing procedures and dealing with the impact of the law. Seen in this respect it can be argued that the IR component of PM probably did not experience much decline under the Conservative government. This view is contrary to the more general development of PM in other sectors noted by Guest (1982) and Tyson (1987)

Guest (p.37) argues that the arrival of the Conservative government in 1979, and the recession and unemployment in the early 1980s, shifted the way in which personnel problems had been defined and solutions advocated at the national level. He comments that the Conservative government moved the emphasis away from the IR system, and the need to reach an understanding with the trade unions, towards an economic philosophy which emphasized the need to control money supply. As Guest maintains such a view relegates IR and personnel issues to a subsidiary role on the periphery of the economic system whereas previously it had been seen as a major influence on industrial performance. Tyson (1987) also argues that the recession and the ideological shift from collectivist to individualistic ideology initiated by the Thatcher government has resulted in some changes in PM. It is not clear whether these issues apply to the NHS.

### Conclusion

This chapter has shown the various factors which contributed to the development and growth of the personnel function in the NHS. It showed the phenomenal growth in PM in the NHS throughout the 1970s. The early 1980s, however, witnessed changes in government policies which slowed the growth of PM. Moreover the recession in the early 1980s, the subsequent high unemployment and the ideological shift sponsored by the Conservative government's philosophy of Thatcherism shifted the emphasis in PM towards employee relations although the policy in some respect, perhaps indirectly sustained the importance of IR in the NHS.

At the DHA level this change in emphasis was accompanied by a tendency on the part of top management to develop managerial strategies for the management of the organizations. These strategies



were designed to be integrated into the organizations' human resource strategies, including QA and QCs which attempt to introduce changes at the workplace level. The argument in chapter three, that the development of HRM often results in an increased role for line managers in personnel issues, can be set against the history of PM in the NHS. This chapter has shown that given the late and uneven manner in which PM was introduced and developed in the NHS, it has been very difficult for the function to be solely responsible for the management of people in the health service. Personnel managers have always had to work with line managers and to fight for the status and authority to develop policies. The introduction of general management, therefore, has in a sense merely reinforced this tendency in the NHS.

The Griffiths restructuring encouraged the strengthening of PM in order to be able to deal with specialist and strategic issues facing the NHS. These issues have emerged primarily as a result of the implementation of government policies, especially the cuts in public expenditure. Furthermore the improvement in the British economy since the mid-1980s has resulted in shortages of skilled manpower in critical areas of the economy. The health services sector has been hit by these developments. The NHS faces critical manpower supply problems over the next decade and personnel managers need to develop strategies to respond to these changes in the NHS environment. Even with the attempts to boost PM, personnel managers often need to cooperate with line managers in developing strategies to deal with the emergent PM issues.

It is clear from the discussion above that whilst the Griffiths restructuring emphasized an increased involvement of line managers in personnel issues, at the same time, it recognized the need to strengthen the specialist personnel role in the NHS. It did not, however, indicate a clear differentiation between line and staff functions in personnel. In view of this lack of clear differentiation the Griffiths restructuring has only served to accentuate the ambiguity in the personnel function. It is therefore no wonder that the post-Griffiths period has witnessed an increasing involvement of line managers in personnel issues in the NHS. In spite of this development it is not clear whether the Griffiths restructuring has



had any significant impact on PM in the NHS and, more importantly, whether the post-Griffiths line management involvement in personnel issues poses any threat to PM. The pace of change in the 1980s has been overwhelming and it is difficult to judge whether personnel has continued with its 1970s growth and whether it has played any significant role in redefining the priorities of the organization in the face of resource constraints. These issues will be explored in the empirical sections of the thesis.

In order to explore these issues, the discussion in the empirical chapters will be guided by the following questions: (1) what changes have occurred in the personnel function in the case-study DHAs since the Griffiths restructuring and, in particular, the implementation of the managerial strategies of QA and QCs?; (2) What kind of line management involvement in personnel issues can be seen in the case-study DHAs? and; (3) Is there any evidence of PM involvement in in the formulation and implementation of the managerial strategies of QA and QCs? The study uses QA and QCs to illustrate wider HRM issues. In order to be able to answer these questions effectively there is the need to discuss the concepts of QA and QCs. These concepts therefore are discussed in the following chapter.



## CHAPTER 6

QUALITY ASSURANCE AND QUALITY CIRCLES IN THE HEALTH SERVICES SECTOR.

This chapter traces the emergence of both QA and QCs in the health services sector. The first section deals with the role of the government in the promotion of quality awareness in the U.K. This is followed by a general survey of the definition of QA. A review of the increasing interest in quality issues, and the emergence of centralized QA programmes in the NHS are also discussed.

The second section explores the origins and main characteristics of QCs. It also discusses the different philosophies and managerial theories in Japan and the West under which QCs are carried out. It reviews the debate over the need to modify Western management practice and philosophy if they are to succeed in the West. This section also deals with the permanent nature of QCs as opposed to other ad hoc initiatives, such as project groups or task forces. The similarities between QCs and QWL initiatives are discussed. It also considers, among other things, the supposed advantages that accrue to management as a result of the institution of QCs; trade union and middle management scepticism about QCs; the need to introduce QCs for justifiable reasons rather than a quick fix for personnel and quality issues; and the prerequisites for the success of QC programmes. Particular attention is given to the need for top management to show real commitment to the programme and to win the support of both middle managers and trade unions.

The third section provides a brief discussion of the development of QCs in the health care sector beginning with developments in the U.S. which later spread to the U.K. Some of the earliest initiatives in QCs in the NHS are mentioned. This section also highlights the relationship between QA and QCs. The chapter concludes with a brief consideration of the links between QCs and developments in HRM.



### Quality Assurance in the U.K.

QA has become a topic of increasing interest in the U.K., in both manufacturing and service sectors. This interest is partly due to the efforts of the government. The British government, through the Department of Trade and Industry (DTI), has been at the forefront of the National Quality Campaign. In 1982, the government published a White Paper on Standards, Quality and International Competitiveness, which made the case for an independent accreditation system for companies. The rationale behind this proposition was that it would encourage companies to follow agreed standard for quality. The companies meeting these standards would have their names published in a Department of Trade and Industry register.

The Department set the tone for quality with the publication of two booklets, The Case For Quality and Getting To Grips With Quality. These booklets define quality, explain why it is important and discuss how it can be achieved. In the foreword to The Case For Quality, the then Secretary of the Department of Trade and Industry, Lord Young, wrote:

The Campaign [National Quality Campaign] was launched in 1983 to promote a 'company-wide' commitment to quality, involving everybody from top management to the newest recruit, with the aim of making everyone aware of the importance of their own particular role and where it fits into the drive to improve total quality (DTI, n. d.: 3).

Other initiatives to promote quality consciousness among company executives include the holding of seminars and the distribution of videos by the government.

The campaign encouraged companies to improve the quality of their products in order to be accorded the British government standards accreditation BS5750. As Chapman (British Journal of Occupational Therapy: 1987) indicates, the quality campaign succeeded in influencing many corporate executives in manufacturing and service industries in the U.K. to incorporate QA in their management structure and policies. Before discussing QA there is the need to explore the definition of quality in health care.



### Definition of Quality in Health Care.

What constitutes quality is a difficult question for health care providers. The problematic nature of the definition of quality has influenced many DHAs and individual hospitals to conduct surveys of patient opinion of quality in health care delivery. Plant (1985), and Coopers and Lybrand (1986) are strong advocates of surveys as a means of soliciting information from patients.

Thompson (1987:10) shows that asking patients what they think of the service they have received in hospitals is not a new practice as the King's Fund questionnaire, 'Patients and their hospitals' has been used widely in the NHS to this end. The Royal Commission on the NHS also recognized the importance of soliciting the views of hospital users (Gregory 1978). However, during the post-Griffiths period interest in this area has intensified. Ad hoc surveys have proliferated into many areas of hospital activity with the aim of improving patient satisfaction.

This has resulted in an on-going debate on the right of patients to criticize or comment on the care given by professionally trained staff. Some people criticize such involvement on the basis that the average patient does not possess the knowledge or sophistication needed to challenge medical and nursing practice. A number of arguments could be gathered to demonstrate the opposing views. Thompson (p.10), however, captures the essence of the debate by arguing that if soliciting patient views will improve quality, then it behoves the NHS management to do so. Similarly, Stacey (1975) remarks that the free release of the consumer viewpoint can only improve the efficiency and humanity of the service. In Matt's (1987:47) view, customer satisfaction surveys play an important role in the assessment of health service quality and enhance the rate by which customers attain satisfactory levels of health. The debate indicates the difficulty of identifying the essential components of quality, and highlights the problematic nature of its definition. Nevertheless some writers have attempted to provide a definition of quality.

From the perspective of the NHS Management Board (NHS Management Bulletin, 1986:2), quality is concerned with the appropriateness and



effectiveness of the clinical care delivered to patients, and the manner in which this care is delivered. Seen in this respect, efficient technical care delivered without compassion, courtesy or regard for the patient's wishes is unlikely to satisfy most people's criteria of quality. Matt argues further that Western societies have a culture that demands consumer satisfaction. Accepting that this culture is pervasive and all-embracing, it would be premature to suggest that technical care is all that is required in health care delivery. This being the case, it would be appropriate for both technical and customer/client involvement in health care to co-exist in a synergistic manner. In Matt's view customer/client involvement in health care delivery through responses on service surveys promotes the view that health care institutions have high regard for clients and that these institutions are following a culturally harmonious application of health care delivery.

Shaw (1986a) and Maxwell (1984:1470), on the other hand, see good quality in health care delivery in terms of the following: the individual's access to service (i.e. overcoming boundaries of geography, money, time, age, class, ethnicity, language etc.); relevance to the need of the individual as well as the community; effectiveness (i.e. optimizing the prognosis for the individual patient); and efficiency in cost (i.e. the lowest unit cost per unit of output).

Robinson and Strong (1987:11), building on Vuori's (1982) and Maxwell's (1984) views of quality, add the concept of humanity. Humanity here implies the provision and delivery of health care which is sensitive to the complexity of individual needs, including human dignity. These authors maintain further that almost all perceptions of quality involve a preoccupation with effectiveness, since that is logically prior to efficiency. Referring to Drucker (1977), they note that efficiency is doing things right; effectiveness, on the other hand, is doing the right things.

From these various interpretations, it is obvious that quality is very difficult to define. As Lorentzon (1987:23) points out, the acceptable level of quality probably falls somewhere between 'adequacy' -the minimum standard below which the health care must not



be allowed to fall under the threat of legal prosecution -and 'excellence' -the optimum standard for which all professional workers should aim. She points out that it is the duty of professionals to ensure excellence in professional practice while statutory regulatory bodies should ensure that standards do not fall below the minimum level of adequacy. In order to guard against the erosion of standards, health care institutions have adopted QA programmes. What, then, is meant by QA?

A survey of the literature on QA yields many definitions. Hunt (1987:29) adopts Nish's (1981) definition which states that QA is a process in which standards describing the level of quality desired and feasible are set, the level of achievement of those standards is measured, and the action is taken to correct identified differences. In a similar fashion, Van Wyck (1985:141) utilises Juran et al.'s (1974:2-3) industrial definition of QA, which also states that QA is the activity of providing, to all concerned, the evidence needed to establish confidence that the quality function is being performed.

Having made references to these definitions, Van Wyck counterbalances it with a definition from the Canadian Council on Hospital Accreditation (1985), which states that:

QA is the establishment of hospital-wide goals, the assessment of the procedures in place to see if they achieve these goals, and, if not, the proposals of solutions in order to attain these goals... QA should be internal, internally-administered, on going, specific to the institution, structured and coordinated throughout the facility (p.45).

MacDonald and McCoy (1987) suggests that QA is the method for assuring that a quality product is continuously delivered. This view of QA is similar to that of the World Health Organization (WHO) (1986) which contends that QA is the process of assessing the quality of health care with the aim of improving it if need be. MacDonald and McCoy bring all these various definitions together and define QA as;

the process of assuring the consumer a specific degree of excellence of a product or service through continuous measurement and evaluation, using established criteria and standards for the purpose of improving the product or service...In a health care context, it is accomplished



by developing and implementing both hospital and departmental standard of practice. (p. 24).

They go on to list eight major components of the QA process which organizations with QA programmes generally follow in order to ensure their effectiveness. These components are: (1) identification of problems, (2) determination of priorities for problem assessment and problem resolution, (3) establishment of criteria, (4) selection of assessment methods, (5) identification of corrective actions, (6) planning corrective actions, (7) monitoring corrective actions, and (8) evaluating corrective actions. Following these components an Inner London RHA (1988) strategy for quality prepared by Lorentzon and Bryant, sums up the purpose of QA as follows:

The purpose of QA is to identify correctable deficiencies in the provision of health care and to assure that the appropriate actions are taken to correct these deficiencies. (Inner London RHA, 1988: 3).

This definition has been the guideline for the QA strategy in one of the case-study authorities (Metropolis).

It is clear from these various definitions that QA implies the incorporation of QA structures into health care institutions to measure, monitor and evaluate the effects of functioning resources, be they human, technological or structural, on the quality of health care provided. Such a process brings to light existing or potential deficiencies and thus attempts to modify policies, procedures, and standards of care which can improve the use of resources. QA is thus a managerial function, for it requires a continuous process, it involves the development and implementation of solutions to identified problems and the evaluation of the effectiveness of corrective actions. Prescott (1985) points out that its success requires the total commitment to excellence by both top management and health care providers. It is for this reason that QA has been incorporated into the management structures of various organizations.



The Emergence of Quality Assurance Programmes in the NHS.

With the determination of the Conservative government to introduce private sector industrial practices to the public sector, it is no wonder that quality became a priority on the Griffiths agenda. QA began in the manufacturing industry, but has now spread to the service industry in both the public and private sectors, not least, health care. In the NHS there is now an increasing awareness of the need to provide good quality service to patients and clients. This awareness is perhaps a resurgence of the previously discredited phrase 'patient first'. In this sense, it is similar to the QA campaign in industry which is referred to as 'customer first' or 'customer care' (Thomas, 1987)

QA has been the theme of a number of conferences organized by the Institute of Health Services Managers and the National Association of Health Authorities. These conferences have often reminded health service managers of the need to develop coherent managerial policies on good quality care including customer care.

Although quality of care has assumed increasing importance in the NHS, Plant (p.1296) contends that it is not new. The NHS, in her view, has always been concerned with the quality of its service. This was achieved through the professional groups which were responsible for the maintenance of its standards within the normative values of its own profession and assisted by periodic reports from the relevant professional training authorities, colleges and institutions. Maxwell (1984) cites Florence Nightingale as an early pioneer in QA. Quality, therefore, has been a perpetual concern of health professionals in the U.K. What has been lacking in the pursuit of quality in the NHS is central or government leadership in setting standards or in measuring quality in health services.

Shaw (1987: 192) attributes this state of affairs to a number of causes: (1) the existence of a national DHSS which was assumed to fulfil the need (seen in many other countries) for a separate body to coordinate quality, and (2) the assurance of relative independence, both for doctors and for local health authorities, which was one of the original conditions under which a national health system was



deemed acceptable in 1947. These factors acted as a force opposing the development of a centralized or formal QA programmes that recent changes in the health care environment have encouraged.

The introduction of formal QA programmes in the NHS has, no doubt, been influenced by developments in North America. In the U.S. the Joint Commission on Accreditation of Hospitals (JCAH) required health care institutions to have instituted QA programmes by January 1980. Failure to comply with this directive meant loss of accreditation. In 1983, the Canadian Council on Health Accreditation (CCHA) issued a similar ultimatum to Canadian health care institutions (Van Wyck p.141-144). The Canadian health care institutions were required to have their QA programmes in place by January 1986 (Wilson 1986:22). In an effort to meet these accreditation requirements, health care institutions in both the U.S. and Canada began employing QA coordinators, and QA became conference themes (Wilson, 1987b). This, then, signalled the emergence of the 'systems approach' - a centrally coordinated, hospital-wide QA programme, replacing the previously fragmented ones. QA has developed in a more systematic way in North America than in Europe. However, the WHO's European Sub-regional Office has urged all member states to implement QA programmes in their health care systems by 1990 (WHO 1986:487). This, together with other factors detailed by Shaw (1987:192), explains the rediscovery of quality and the subsequent adoption of more formal QA programmes.

In recent years the consumer advocacy movement in the Western world has educated the public about their rights as consumers. Alongside this development, the health care sector has been one of the focuses of media attention, which has exposed medical malpractice. In the U.S., in particular, this has resulted in an increase in legal action in the form of medical malpractice suits. Van Wyck (p.144) points to the malpractice insurance crisis of the late 1970s, which forced health care institutions and providers to take more control over the monitoring of their service delivery with the aim of improving quality. QA then was part of the effort of reducing risk.

Whilst this is true of the U.S., and probably of Canada, risk management has not been a major factor in the development of QA



programmes in the U.K., although a few malpractice suits have been successfully brought against some hospitals (see Dearden 1987). In the U.K., the public is gradually, but steadily beginning to exercise its right to know that the taxpayers' money is being spent equitably and effectively, and that individual patients receive a high standard of care. As health care becomes increasingly sophisticated and costly, and financial resources to provide the delivery of care remain limited, the issue of value for money assumes increasing importance. These have resulted in the commercialization of certain aspects of health care (e.g. competitive tendering and contracting out) as private sector firms have been encouraged to compete with the NHS. Currently the competition has highlighted some elements of quality, such as waiting times, personal service and physical environment.

An important reason for the emergence of QA is, thus, purely economic. Pollitt (1987:75) has shown the importance of the economics of health care in the development of QA. She points to the attempts by the U.S. government to control health care costs as they rose steadily and more quickly than general inflation. Economic concerns drove consumers, insurers and the state to interfere in the medical arena, and it became clear that a crisis would soon arise in health care spending. Similarly, Maxwell (1981:101) has shown that, for nearly two decades, annual increases in health care expenditure throughout the developed world have consistently outstripped increases in national income.

In the U.K. this has generated a confrontation between the central government (as the paymaster) and the medical profession (as spender). Britain initially resorted to purely financial measures to lower cost. The high rate of input growth was terminated between 1979-85. This resulted in an inadequate provision of services, in view of both demographic and technological change (Robinson 1986; Maynard 1986).

As shown in Chapter four, public expenditure (including that of health care) in the U.K. has recently become a politically explosive issue as the government has attempted to bring it under control. Shaw (1986a) maintains that it was in this context that issues of quality were bound to arise. Thus there is increasing concern that the



restraint on health service spending in the U.K. will adversely affect the quality of care. However, when the government threw a challenge to the public and professions to prove the threat to quality as a result of cuts in budget, very little evidence could be provided because of the absence of quantifiable measures of quality. This, however, prompted the professionals involved in the quality debate to recognize their responsibility not only to maintain high standards, but also to prove them. In view of this, the Royal College of General Practitioners (RCGP) developed an explicit programme of voluntary QA in Britain.

Another impetus to the QA initiatives has been the contribution of researchers at training and research institutions. Notable among these are the King's Fund and John Yates' team at the University of Birmingham Health Services Management Centre. These groups tend to work very closely with both health authorities and professional institutions on quality issues.

The Griffiths report has helped prompt the revival of interest in QA and customer satisfaction. It also cited the need for account to be taken of the views of the service users. The Report (p.9) noted the need to ascertain how well the service is being delivered at the local level. It emphasized the need for managers, as well as employees, to be sensitive to consumer needs and to improve the NHS awareness of the experience and perceptions of patients and the community.

This philosophy has been adopted by the NHS Management Board, which regards quality as an integral part of its own function. The board thus provides support for managers and staff whose work is at the forefront of the long-term process of making quality a component of management and of operational practice (NHS Management Bulletin 1986:2). As Rowden (1986:8) rightly puts it, Griffiths has put customer satisfaction in the NHS firmly on the map. Coad and Hyde (1986:519) admit that Griffiths, if nothing else, puts customers where they should be -centre stage. Sir Roy Griffiths, the Deputy Chairman of the NHS Management Board, writes:



Since my inquiry into health service management in 1983 there has been a veritable explosion of interest in quality.  
(NHS Management Bulletin, August 1988:1)

Young (1986:38) shows that QA and consumer/customer satisfaction have become a major aspect of the post-Griffiths management structure. DHAs have included positions for QA officer or Consumer/Customer Relations Officers.

In addition to the Griffiths recommendation, health authorities have improved practices and emphasized quality in response to legislation, DHSS circulars, Health Advisory Service visits and pressures from voluntary organizations. Complaints and suggestions from patients and investigations by Health Service Commissioners, in-house reports and complaints about incidents involving patients and staff have also had an impact on improvement of quality.

Quite apart from the Griffiths report's role and influence in the transfusion of the commercialist philosophy to the NHS, there has been an increasing use of private sector consultants by health authorities in the 1980s. Pollitt argues that these consultants' advice reflects the contemporary preoccupation of British business that 'quality' and 'service' are areas of national weakness. Coopers and Lybrand (1986) for instance, point to quality as the basis for the success of Japanese business and, as indicated earlier, recommend surveys of patients' opinions to know what they want.

These reasons for the resurgence of interest in quality are in harmony with Kahl and Kranjnak's (1986) view that public accountability, cost pressures and concern by the government over rising health care costs have prompted managers to attempt to develop cost-effective high quality health care.

In the U.K., a number of agencies have been concerned with QA, although Shaw (1986b) contends that there is no agreement on a coordinated national strategy for QA in the NHS. These agencies include, among others, professional bodies (eg. RCN), local health authorities, academic and professional (medical) bodies, CHCs, and the King's Fund (Shaw, 1987, Maxwell et al. 1983.). In many respects, the King's Fund was an early pioneer in research on QA in the U.K. As Lorentzon (1987:23) shows, soon after publication of the Griffiths



Report in 1983, the King's Fund set up a project group to consider current activity in QA. In early 1984, it produced a report entitled, Towards the Assessment of Quality in Care, which recommended that a steering group undertake an initiative in quality assessment (see Harvey, 1986). The coordinator of the project, Shaw (1986a), later published the results of a survey of QA activities undertaken by medical, nursing and paramedical professional bodies.

The King's Fund approach aims at stimulating interest in QA and at promoting best practice. This involves finding out what other institutions are doing in QA and providing the necessary assistance in the form of published and unpublished literature. It also maintains QA Information Service, which is essentially an inquiry service, and publishes a regular bulletin. The inquiry service provides details of published information relating to specific aspects of QA. In conjunction with the DHSS library, the King's Fund publishes a bimonthly QA abstract which gives summaries of documents on QA (Lorentzon (1987:23). The King's Fund has established a computer based literature retrieval service on QA (mostly in Europe) and an index of current activities in the U.K.

Another main source of information is the data collected through interviews in key organizations and with individuals. These groups include professional bodies, statutory authorities, consumer organizations such as community health councils, academic institutions and editors of health related journals. It is believed that the process of asking questions itself stimulates awareness and even action in some of the areas. The Kings's Fund intends to supplement the work of the WHO in promoting the teaching and practice of QA.

#### Quality Assurance Initiatives in DHAs.

The responsibility for QA in Britain rests directly with the DHAs, which have a statutory responsibility for providing services to the community. The DHAs are ultimately responsible to the DHSS for providing preventative, primary, secondary and tertiary care to defined populations. Since the DHA is a lay body which cannot make judgements in clinical and specialist areas, it must delegate much of



this to those who are and must require evidence that it is being done.

The DHA is required to plan, organize, control and evaluate the entire range of services from preventative health to tertiary hospital care. This, in Shaw's (1987:194) view, introduces legitimate aspects of quality other than the professional or consumer viewpoint. In particular, it considers those who do not receive service as well as those who do, whether one service is as effective as another, whether limited resources are being equitably allocated and whether prevention is really better than cure.

The development and implementation of QA programmes requires the commitment of the DHA to QA, to provide the necessary resources and to support the management efforts. In some DHAs the establishment of QA departments has encouraged the drawing up of some agreed standards of quality which will be used to provide QA. This requires the development of medical audits -the measuring of medical care against objectively predetermined, explicit criteria. This involves explicit statements about the nature and extent of individual services, and has to be done within the context of financial and manpower constraints.

In the pursuit of QA, there is an effort on the part of NHS organizations to exchange ideas and information with private sector organizations in the U.K. and with health care institutions overseas. For instance, British Airways has been involved in training Trent RHA staff on QA. In a joint conference of the Institute of Health Service Management and the Association of Health Service Treasurers, management consultants and British Airways managers were invited to share their views on QA with health service professionals (Coad and Hyde 1986). The participants from the private sector pointed out to the public sector participants that management can improve the quality of its operations by deciding on objectives, focussing on better management of resources and backing this up with an employee involvement or communication strategy.

In another development, the Director of QA in Brighton Health Authority, and other officials under an exchange scheme, made a number of visits to George Washington University Medical Centre in Washington D.C. This U.S. hospital has 470 beds and 16 QA specialists. The visit culminated in the development of QA policy and strategy in Brighton



DHA (Bowden et al. 1986). Subsequently, Brighton Health Authority set up customer relations and QA departments. It is expected that QA in Brighton Health Authority will become an active part of all departments, both clinical and support services.

Shaw (1986b) has shown that the strategies for implementation of QA include the development of policy statements, mission statements and values. A number of RHAs and DHAs have already done this. Several RHAs, including Trent, Mersey, Wessex and South Western, have undertaken initiatives in QA in such diverse areas as patient care, catering, ambulance services, out-patient departments and patient reception arrangements. Likewise, many DHAs have undertaken QA initiatives. Trent RHA says in its policy document, 'Providing a Personal Service,' that the provision of a personal service to those who are ill or handicapped... must be the aim of every member of staff (NHS Management Bulletin, 1986). The Trent's programme of action, has been adopted by its member districts.

Similarly, Birch (1986:21), Director of Patient Services at North Lincolnshire Health Authority, discusses the mission statements and values of his DHA as follows:

North Lincolnshire Health Authority seeks to provide personal and comprehensive health care services of the highest quality in a co-ordinated integrated and cost-effective manner... To achieve this purpose, the authority intends to position itself as a locally and nationally respected, influential organization and will encourage leadership in the development of necessary management, human and financial resources to support locally governed health care organizations (Birch, 1986:21).

On values, Birch (p.21) states that the authority believes in (1) respecting the dignity of all people who need health services, (2) helping individuals develop and maintain the highest achievable levels of personal health, (3) seeking the opinion of patients, the public and related organizations, (4) providing the broadest range and highest quality possible of health care services to people living in North Lincolnshire, (5) having local devolved control of its services with support from the authority, (6) managing its services in both an open and sensitive way, (7) working closely with medical and other



professional staff, and (8) developing a commitment to excellence among all staff by nurturing personal motivation, provision of meaningful work responsibilities, expectation of superior performance, and encouragement of personal initiative, innovation and creativity.

The advocates of centralized QA argue that in planning for a high quality service at the district level, the DGM should appoint someone at the district director level with proven managerial ability and considerable knowledge of health services. This individual should report directly to the DGM. Departmental targets and responsibilities must be agreed upon and reporting lines identified. Since the Griffiths reorganization of management in the NHS, many districts now have the post of 'Director of QA' who acts as the resource person regarding QA. These DHAs see QA as a management information system; therefore, management must assume full responsibility for its design, implementation and ongoing operations (Davies, 1986:110).

Plant argues that the success of a centralized QA programme depends on the commitment and support of top management. It is the duty of the director of QA, therefore, to increase the commitment of the district and unit general managers and their teams to a continuing awareness of the quality of service and of the need for education and communication of the required standards of quality. The commitment of a district to quality may be identified in policy statements supported by the health authority and the general managers, indicating a commitment to quality in the delivery of care. Similarly the attitude and style of management can also signal commitment to quality (Plant p. 1297).

The development of QA raises the question of who is the most qualified person for the QA job. Rowden (p.8) encourages the appointment of an officer with a nursing background to head the QA department, since nurses are suitably qualified to head and develop QA programmes. Rowden maintains that:

The nurse is unique in her perception of health care for two reasons: the nurse is the one professional who is situated in close and continuous contact with those who use the service. The contact exists 24 hours a day, 365 days a year. The nurse is also unique in that she has direct contact with all other service departments



and witnesses firsthand the effects the other departments have on patients. If laundry, catering, works, records etc. are failing to deliver, nurses know. This broad background is invaluable in making quality assurance meaningful (p.8).

This view implies that QA can cover both clinical and non-clinical services.

Very often the formulation and implementation of a QA programme requires another strategy which will translate the resulting quality consciousness into practical terms. Often this is done through QCs which are discussed in the following section.

#### The Origins of Quality Circles.

Although QCs are known for their popularity in Japan, they originated in the US. The movement was born out of the notion of improved worker motivation through employee participation in the decision-making process. Whilst the Americans largely ignored these ideas, the Japanese paid attention to them, particularly to the U.S. research on motivation and satisfaction as a result of employee participation in decision making. The Japanese also heeded Juran's (1967, 1976) call for the quality control function to be decentralized throughout the organization rather than remaining as a specialized function.

Bradley and Hill (1983:291) contend that during the 1950s, the Japanese gave a detailed attention to Deming's (1970) notion that statistical analysis of production data would reveal causes and solutions to problems, and that quality could be built into work design, rather than controlled through inspection. As Littler and Salaman (1984) point out, these concepts and views were transplanted to Japan in the 1950s, where they were adopted and reworked by several management theorists, particularly Kaoru Ishikawa.

After these ideas had become popular in Japan in the 1960s and 1970s, they were exported to the West, buttressed by an aura of Japanese productivity and economic success. Academics and management consultants alike have urged Western organizations to adapt the



Japanese model of management to halt any further decline in employee morale and productivity, and improve their labour-management relations. Ouchi (1981), Pascale and Athos (1981), among others, have analyzed managerial practices in Japan and have indicated that Western managers can learn from them. Such a recommendation perhaps underestimates the fundamental differences between Western and Japanese managerial philosophies.

It must be noted that QCs emerged in Japan under a managerial philosophy which is substantially different from that which prevails in the West. Prominent among the scholars who have studied managerial philosophies in Japan and in the West are Bradley and Hill (1983), Hill (1981), Hayes (1981) Dore, (1973) and Cole (1979a). They argue that favourable conditions influenced the development of QCs in Japan; including organizational structures and policies with strong emphasis on individual effort and reward, and life-time employment for permanent employees which results in employee dependency and commitment to the organization and an incentive to improve efficiency. These policies protect employees from lay-offs and dismissals arising from an increase in productivity. Therefore, employees have no hesitation in participating in QC to increase productivity.

Yet another favourable condition is what Dore refers to as 'welfare corporatism', a policy which promotes high trust relations and cooperation between managers and labour. (Cole, 1979a; Allen, 1981; Littler, 1982). Yet another condition is the Japanese system of job-rotation and skill development within an internal labour market, which allows the employees to acquire a wide range of skills, knowledge and resources. The Japanese thus have a unique management and employment system in which all permanent employees of the Japanese organization work with a high degree of consensus to help the firm to succeed.

As Bradley and Hill (1983:293) put it, the employment relationship is viewed as more than a simple wage transaction; employees are seen as full members of a community, a membership which carries with it full rights and obligations. The organization is seen as comprising all of its permanent employees. The firm is identified neither with its management nor with the owners of its shareholders -



the latter constituting but one of several outside interests that need to be satisfied if the firm is to succeed. These conditions have given birth to weak enterprise unions which often seek to harmonize their objectives with those of the firm.

While many cultural and social factors encourage the reportedly extensive and intense participation of Japanese workers in QCs, one important and mostly hidden factor has been the desire of the workers to secure their future by helping to make their companies successful (Klein, 1981).

Seen from this perspective, the Japanese employment system is quite different from that which prevails in the West, where the private sector firm essentially belongs to the shareholders, whose interest management is obliged to serve. Under this philosophy labour is only a factor of production with contractual obligations and rights. This philosophy does not encourage a shared consensus, common interest or trust between labour and management. On the contrary, manual workers in the West typically exhibit low trust in the management of the workplace. Consequently, management attempts to reduce employee autonomy, discretion, and influence by separating job planning from execution, removing decision-making from the workers and thus, resting the control function and the responsibility for productive-efficiency in management. This philosophy equally inhibits employee commitment to the organization. As Bradley and Hill (1983) put it,

Indeed, they have played a significant part in the development of systems of IR based on the cash nexus, which has also promoted an adversarial competition of interest between managers and other employees (p.293).

It is this same philosophy which has allocated the role of overseeing quality and efficiency mainly to managerial specialists rather than to rank-and-file employees. This division reflects the view that non-managerial employees cannot be trusted to work for the achievement of organizational goals and should be denied the chance to frustrate it.

In recent years, however, with the increasing pressure on managers in the West to reduce operating cost, improve worker



productivity and increase revenue, and with the fear of dismissal hanging over their heads if they do not perform to the satisfaction of the board and ultimately the shareholders, managers have adopted some strategies which attempt to minimize cost whilst at the same time maximizing productivity. These strategies pose a fundamental challenge to the conventional Western managerial philosophy. QCs have become part of this challenge and have resulted in some modifications in the philosophy. Beneath this emerging philosophy is the view that workers will take more pride and interest in their work if they are given the opportunity to develop new skills and influence their work related decisions (McKinney, 1984). QCs have thus become part of the managerial strategy for the achievement of their HRM objectives. Bradley and Hill (1983) comment that:

QCs express a different perspective: that management and labour share common interests, managers recognize quality problems as technical rather than motivational, companies are willing to restore to employees some responsibility for planning and problem-solving as well as execution, and employees are trusted enough to be allowed to participate in the decision-making process as it directly affects the tasks they are employed to carry out (p.293).

Littler and Salaman (p. 87) argue that the introduction of QCs in organizations in the Western world is meant to bridge the mental-manual dichotomy inherent in the existing managerial human resource control strategies. Seen from this perspective, QCs are meant to foster a high commitment to the organization to the extent that the workers will devote time and effort even outside working hours to analyse and solve work-related problems. QCs, after management vetting; provide the means to institute new work practices in order to solve problems of productivity and quality.

It is believed that QCs can counter worker indifference and low productivity. Moreover, it is expected that QCs will encourage employee commitment to the organization whilst at the same time modifying the cash nexus and improving, if not eliminating, the low trust style in the management of the workforce. As a QC programme allows employees participation in organizational decision-making, its advocates maintain that it encourages the development of trust between



workers and management.

Since one of the important rewards for participating in QCs, according to circle proponents, is the feeling of involvement, QCs can tap the worker's need for involvement and create within the individual a sense of participation and contribution to the success of the organization (Boyce, 1985:73). The rationale behind QCs thus relates directly to many of the behavioural science theories of motivation in the popular tradition of human relations. In particular, it is consistent with the theories of Maslow (1943), Herzberg (1966, 1978) and McGregor (1960) in that it potentially allows the employees an opportunity to participate in decisions affecting their work. QCs recognize the individual employee as a human being with the ability and desire to participate. It is believed that participation in work-related decisions often makes individuals recognize their value to the firm, and the value of their ideas. Since QCs involve participation they presumably satisfy many of the higher order needs of ego, self-esteem and self-actualization, ideas popularized by Maslow and Herzberg. According to this line of thinking self-actualization is also achieved because the problem-solving nature of QCs encourages personal growth and creativity. QCs are thus seen as an attempt to move away from minute division of labour, low discretion and their attendant boredom (Hutchins, 1981).

Wine and Baird, (1983) argue that the benefits of participative ventures include increases in productivity, recruitment, communication, interpersonal relations, reduced labour turnover and absenteeism, improved QWL of employee, and enhanced organizational success as workers' knowledge and experience are tapped. Others cite cost containment and improvements in union-management and employer-employee cooperation. QCs are believed to generate support among employees for managerial prerogatives and improving work force (including work team) human relations (Cline and Palau 1982). Furthermore Cole (1979b), Dore (1981), Mazique (1981), Yager (1981) and Quible (1981) list improvements in employee motivation and morale, reduction of conflict, reduction of resistance to change, promotion of



job involvement, improvements in quality awareness and, generally increased efficiency and profitability.

Since the 1970s, QCs have become more widespread throughout the world as organizations seek higher productivity, industrial harmony and improvements in employee morale and satisfaction. In both North America and Europe, the concept has become very popular. In the U.S. the aerospace industry was the first to embrace QCs. Lockheed instituted a QC programme in 1974 and its success motivated other U.S. companies to adopt similar practices. Since then, enthusiasm over QCs has grown rapidly.

In the U.K. more than 100 companies, mostly in the private sector, had adopted QCs by 1980 (Lorenz, 1981). Rolls-Royce was the first company in the U.K. to embrace the concept in its plant at Derby in 1978. Dale and Barlow (1984:22) give a partial list of well-known companies with QCs, such as Dunlop, Eaton, IBM, ICI, ICL, Jaguar, Leyland Trucks, Rank Xerox, Wedgwood, etc. A National Society of Quality Circles (NSQC), which promotes their development was formed in 1982 under the auspices of the Industrial Participation Association. The NSQC also provides information, and holds workshops and conferences on QCs (Dale and Duncalf, 1984). Recently, however, public sector organizations, not least those in the health care sector, have also embraced QCs.

The 1980s, therefore, has seen an increasing interest in QCs in the West. It is therefore necessary to examine some of their characteristics.

#### Characteristics of Quality Circles.

A QC is a small group of seven to ten employees who normally work together and volunteer to meet regularly to identify and analyse the causes of work-related problems, and recommend solutions for management's consideration. If the recommendations are approved by management the employees take action to resolve the problem. That is, where possible the employees implement the recommended solutions (see for instance, Bradley and Hill; Boyce 1985; Campbell and Hatfield 1982). QCs, unlike project groups or task forces, are designed to have



some degree of permanency; they are not ad hoc creations to solve specific problems. Usually meetings take place during company time, but the frequency varies; some are weekly while others are monthly. The workers take the initiative in decision making rather than merely reacting to management's proposals. In view of this Jenkins and Shimada (1981), Hegland (1981), and Gryna (1981), argue that QCs differ from other forms of participative management in which workers only offer ideas during the planning process or review plans already developed by management. Similarly, Littler and Salaman (p. 87) contend that QCs are intended to stimulate motivation and involvement at the shop-floor level and, by so doing, improve quality, reduce production costs, and increase productivity.

QCs try to reinforce the idea that quality is everyone's business, not just that of managers or technical experts, and that quality is an integral part of the entire production process. Thus QCs aim at reducing supervision or inspection of products or service. The emphasis is on self-supervision of 'quality', making sure that quality is in-built in the production process. QC training provides the tools for such self-supervision and quality control. The self-supervision view of QCs is meant to ensure QA.

The above discussion indicates that there are some conflicts or variation in the motives for setting up QCs. One school of thought argues that QCs are set up to motivate employees, increase employees involvement and commitment, improve the QWL of the employees whilst at the same time controlling quality and cutting cost. The other school of thought argues that QCs are set up primarily to control cost and to ensure effectiveness and has little, if any thing at all, to do with improving employee QWL. These two views are referred to as the 'soft' and 'hard' versions of QCs respectively.

The advocates of the 'soft' version of QCs maintain that QCs form an integral part of QWL innovations because of their shared structural characteristics. (Bradley and Hill 1987; Russell 1983; The Ontario QWL Centre, 1980; Kochan et al. 1986; Sherwood et al. 1985). Here, QCs are treated as part of a long-term strategy for change. They are seen as part of a broad agenda for organizational change including work reorganization or the reorganization of the production system



(Tynan, 1980). The rationale behind such reorganization is to arrange work procedures and jobs for the maximum deployment of individual talents and skills in order to create more challenging and satisfying work and so improve organizational effectiveness, communications, participation and involvement. Thus Bradley and Hill (1987) write that:

QCs , like QWL programmes, generally rest on employee participation in decision-making... They share the basic characteristics of QWL initiatives: organizational practices and structures have to be changed to accommodate QCs; participation fosters self-actualization and improves workplace relations (at least according to circle advocates) and, finally, QCs are innovative and part of the change process (p. 69).

In its broadest sense, however, QWL initiatives aim at improving the relationship between the employee and his/her work environment by finding alternative means of organizing work roles and the employee's relationship to them, by changing the nature of the task. This is based on the assumption that if employees are allowed to determine the nature of their task it can result in both higher productivity and improved QWL (Taddeo and Lefebvre 1979: 116). QCs, in a limited sense, allow some employee participation but more significant QWL initiatives require changes to the organizational structure which involve modification of systems of communication, decision making, authority distribution and motivation. This may be done if the motivation for the institution of QCs included a desire to encourage participation, to stimulate employee satisfaction and to foster high trust relations. Both Sherwood et al. and Dale and Ball (1983), arguing in support of the 'soft' version of QCs, suggest that whatever the reasons for instituting QCs, it is evident that the objective for improving product quality is at least as important as employee concerns.

In spite of the desire of some employers to use QCs to improve the well-being of their employees, the advocates of the 'hard version' of QCs, such as Lawler and Mohrman (1985), raise serious opposition to the classification of QCs as part of QWL initiatives. They argue that the managerial motivation for the introduction of QCs may be economic, -that is, to improve product quality and thus cut wastage and reduce



cost- whilst that for QWL may not be. According to this view management introduces QCs as a means of dealing with recalcitrant personnel and quality problems and only pay lip-service to employee QWL issues. Bradley and Hill (1987), on the other hand, criticize Lawler and Mohrman for ignoring the economic motive behind the introduction of any form of QWL initiatives, particularly the desire to benefit from the more efficient use of resources. They further point to the development of QCs by the Japanese as a dual-purpose programme that enhances both economic and work life benefits. According to this view QCs are a means of streamlining operations, reducing costs and boosting production, increasing job satisfaction and worker fulfilment, improving quality and safety, and increasing productivity (Klein, p. 11).

This view is consistent with that of McKinney (1984:74) that organizations adopt QCs for economic as well as employee benefits. Kochan et al. (1986:147), agree with this view. They maintain that the QWL initiatives in the manufacturing sector in the U.S. have two basic objectives: (1) to increase the participation and involvement of individuals and informal groups so as to overcome adversarial relations and increase employee motivation, commitment and problem-solving potential, and (2) to alter the organization of work so as to simplify work rules, lower costs, and increase flexibility in the management of human resources.

QCs often have a simple organizational structure. Each has a leader who arranges meetings and sometimes trains members on QCs problem solving skills such as 'brain storming', 'cause and effect analysis' etc. The leader often seeks the advice of the facilitator in the performance of his duties. The individual QCs are under the supervision of a steering group which is responsible for their strategic direction. The steering group reports to a management executive board.

The literature on QCs indicates that senior management commitment to the programme is crucial to its success. According to this view the introduction of QCs requires a genuine commitment on the part of management to develop a system of work reorganization which gives maximum scope for employee participation, involvement and



commitment. As Robson (1984:32) argues, QCs should first provide a genuine opportunity for staff to become more involved in decision making, to give people throughout the organization the opportunity for developing their skills and to make their own contribution to the improvement of work practices and the solution of work related problems. It is argued that QCs are likely to succeed only in such an environment (Metz 1981).

The prescriptive literature thus cautions that where management has no interest in long-term participative management, nor in employee ideas, QCs should not be introduced. It warns that failure to establish the proper foundations for the programme may lead to misunderstanding, mistrust and eventual collapse of the programme. Where management only pays 'lip-service' to the programme, but do not want employee input or participation, QC recommendations are likely to be rejected by management. The resentment aroused by the failure of QCs creates a destructive rather than positive force in the organization. Therefore, only companies which are ready to modify their management philosophies and structures (that is, innovative and change oriented) can successfully implement QC programmes. Senior managers must be convinced that employees are an asset and a crucial factor in the organization's overall success, and that, their commitment, involvement, and participation are therefore necessary for the success of the organization (Thompson 1982; Bartlett 1983; McKinney, 1984).

The proponents maintain that for QCs programmes to succeed, there must be a desire among employees to participate, and they must have or be guaranteed a reasonable degree of job security. When employees feel that they are not getting adequate compensation for their efforts or are concerned about probable lay offs and terminations they are unlikely to voluntarily participate in the QCs programme to contribute their ideas to management (Wine and Baird P. 10). Similarly Dutkewych and Buback (1982) suggest that where there is lack of enthusiasm from both management and employees to participate in QCs programmes, then the organizational culture must be changed to one which encourages participation.

This is all the more necessary where there is opposition from



middle managers, who may perceive QCs as a threat to their authority and leadership. If this happens it is likely to reduce the potential benefits that QCs may accrue to the organization and for this reason, senior managers must try to win the cooperation of middle managers. That is, middle managers should be assured that QCs will not pose any threat to their authority and thus they should be persuaded to modify their managerial style to incorporate QCs. Levitan and Johnson (1983) warn that the failure of middle managers to change their styles of managing to accommodate the participative nature of QCs can have negative effects on the QC programme.

At another level senior management needs to overcome union leaders scepticism and resistance to the introduction of QCs. Although some union leaders view QCs with suspicion, they have not made any overt attempt to discourage their members from participating, only warning their members to be careful of management's intentions (Cummings and Molley, 1977). They fear that QCs could undermine the role of the local union and the sanctity of the collective bargaining contract or could threaten union power and influence. Union leaders are also particularly concerned about the effects of QCs on job security. These fears are fuelled by the fact that most of the earliest applications of QCs in the US were in non-union settings and were designed, in part, as a union-avoidance strategy. Consequently, many union leaders see the QC movement as a hostile force, devoid of any sensitivity to trade unionism and unwilling to accept the view that unions are independent and legitimate representatives of worker interests.

Other scholars dismiss the supposed negative effects of QCs on unions. Bradley and Hill (1983), for instance, point out that rather than weakening the union, QCs may in practice strengthen shop-floor unionism because QCs can potentially increase information available to members, who in turn pass on the information to the work force at large. The employees thus become better informed about management's role. This can improve communication in the organization as well as commitment to it. It is also possible that these processes may increase employee understanding of the organization and subsequently lead to more harmonious relations between management and employees.



Moreover, if communications between circles and union officials are open, the latter receive information regarding workers' participation in cost-saving exercises.

It is this realization which has motivated some union leaders to soften their resistance to QCs even if they do not, co-operate with management in the implementation of QCs. There appears to be some variation in union response to the introduction of QCs depending on the context in which they are introduced. Whilst a major TUC statement in 1981, and a later Transport and General Workers' Union (TGWU) pamphlet, express some scepticism and general suspicion of QCs, other views have been more enthusiastic (Income Data Services[IDS] 1985:9). For example, Eric Hammond, the General Secretary of (EETPU), in his foreword to a Department of Trade and Industry Quality Campaign booklet on QCs, writes:

I have no hesitation in advocating trade unionists to explore with their management and with their fellow workers how forming such QCs can bring benefits to them as individuals as well as to their organization. Such involvement would improve personal satisfaction and pride in their jobs as well as boosting our national performance at the level where the real remedy to our problem lies - in the plant and in the company (IDS 1985:9)

To avoid adverse effects from QCs the prescriptive literature recommends that QCs should not be established without agreement with the union.

Having discussed the general characteristics of QCs and the conditions necessary for their success, it is necessary to discuss the implementation of QCs in the health care sector.

#### Quality Circles in the Health Care Sector

Since the early 1980s, QCs have become popular in the health care sector in the West, especially in the U.S. Davies (1986), referring to the work of Lees and Dale (1985), explains the basis for this trend. In all countries where there are QCs, they are initially introduced in the manufacturing sector, then as the benefits are publicized and expertise is built up, different types of service



organizations begin to consider their introduction. The situation in both the U.S. and the U.K. has followed this pattern.

Robson (1984a), among others, have justified the introduction of QCs in the health care sector. Robson (1984b) for instance, argues that:

Health care organizations can learn a valuable lesson from industry if they realize that to meet future challenges they must rely on their staff to help resolve the issues which threaten their existence. Quality consciousness need not refer exclusively to the production line, indeed, patient care requires quality analysis and solutions as much as any manufacturing or service agency. After all, the provision of patient care is the hospital's end product just as the building of cars or machines is the end product in manufacturing (p. 32).

In recent years a number of health care organizations throughout the U.S. and the U.K. have been exploring the use of QCs (see Moore et al. 1981; Lee 1983; Harris 1983; Waszak 1982 and; Orlikoff and Snow 1984). McKinney (p. 75) reports that in 1984 the American Hospital Association estimated that 200 of its members had QC programmes; this number represented about 3 per cent of the association's membership. The figure, although minimal, nevertheless indicates a beginning in employee involvement in decision making.

Wine and Baird point to a variety of initiatives, such as task forces, new committee structures, and management-employee 'rap' sessions, which have been instituted in an effort to deal with the challenges in the health care environment. Of all the strategies, the most promising, they argue, is QCs. Below are a few examples of QCs programmes in U.S. hospitals.

In 1980 the Henry Ford hospital in Detroit was the first to transplant the QC idea from industry to the health care setting. The hospital's human resource development staff investigated the applicability of QCs to the labour intensive health care environment. According to Robson (p. 32), the research demonstrated that issues faced by industry -that is, improved quality of service, reduction of operating costs, and improvements in employees' QWL -were similar to those of health care institutions. Quantitative surveys carried out by Henry Ford Hospital on its QC programme showed improvements in



communication in the wards, quality of service, job satisfaction and morale. There was also a significant reduction in cost. (Robson p. 32)

Robson (p. 32) and Cornell (1984:90) also report improvement in communication at St. Joseph's Hospital in Fort Wayne, Indiana, as a result of a QC programme in the early 1980s. At Lakeshore Mental Health Institute of Knoxville, Tennessee, Cornell reports that in 1982, a QC recommendation led to the building of a fibreglass house for some patients who had developed some side effects of skin sensitivity from their medication -tranquilizers. According to Cornell (p. 90) this project resolved the problem and consequently improved the morale of both patients and staff.

Campbell and Hatfield report that in a few instances QCs have been instituted in health care institutions in the U.S. as part of a strategy aimed at recruitment, staffing and retention of health care employees. The authors maintain that the QCs had a significant effect upon the retention rate in those health care institutions. Similarly Wine and Baird argue that QCs have proved to be an effective mechanism for improving the quality of health care, increasing employee job satisfaction, reducing health care costs, and maximizing employee productivity. They argue that because of their ability to involve health care employees in decision-making they facilitate communication.

It is significant to note that most of these so-called benefits or promise of QCs are not supported by hard, objective evidence. Rather such claims often tend to be speculative. The difficulty of gathering data to support such claims, itself attests to the herculean task of developing measures to evaluate health care provision.

In spite of these shortcomings, the supposed achievements of QCs in the US have influenced the development of QCs in the U.K. As Lorentzon and Osborne (1985) explain, they provided the inspiration for the current QC initiative in the U.K. The King's Fund Centre also played a significant role by sponsoring a fact-finding trip to the U.S. by a project officer -Christine Davies -to prepare an information package for health care employees interested in QCs. The trip culminated in a paper on QCs (Davies, 1984).

The King's Fund became a good source of reference, and it also



organized a few workshops on how to establish QCs. The health care institutions in the U.K. interested in establishing QCs also turned to the NSQC for information on private sector companies using QCs. In the U.K., as in the U.S., private sector firms picked up the idea of QCs much earlier than public sector organizations. In fact public sector organizations, particularly the DHAs, take their cues from the private firms engaged in QCs.

QCs were introduced first in the NHS around 1982, but they became more popular only in the late 1980s. Although not confined to nursing, most QCs projects have concentrated on nursing issues. The reorganization of nursing thus appears to have paved the way for the development of QCs in the NHS. As Lorentzon and Osborne (p.24) point out, the shift from task allocation to individualized nursing care generated tremendous emphasis on the importance of the person and the need to treat patients as individuals rather than cases to be 'processed'. They point out further that alongside this a greater interest in the carer as people in direct patient care developed. According to Hyde (1984:49) the nursing reorganization together with the 1982 NHS restructuring and its concomitant changes in accountability and delegated responsibility required senior nurse managers to review both their philosophy and style of management.

With these changes emerged the problem-solving approach which encourages personal initiative and acknowledges the ability of every member of the team to contribute to health care delivery. The Griffiths report gave a boost to these issues by stressing the importance of quality in health care delivery. It is therefore not surprising that QCs in the NHS developed initially in nursing. The belief that QCs allow everybody involved in patient care to participate in decision-making via a problem-solving approach explains why QCs have become popular in the NHS.

Other analysis indicates that QCs have been introduced in the NHS as part of the larger agenda to improve the efficiency and effectiveness of the organization. As cash limits and other public sector constraint policies began to bite, NHS managers have attempted to use QCs projects to harness employees talents to the full and to improve or at least maintain the quality of the service (Hyde p.49).



In this respect the origins of QCs in the NHS can be traced to some of the reasons given earlier for the development of QA in the NHS. According to this view, QCs are part of the response to the public expenditure constraint policies and other government policies which affect the NHS. Economic difficulties have made it necessary for the health care organizations to minimize cost and maximize productivity whilst at the same time safeguarding quality. Moreover, the health authorities face recruitment and retention problems. The achievement of organizational objectives, therefore, encourages the adoption of a meaningful employee participation programmes such as QCs.

Resource constraints and other problems in the health care environment have prompted some to advocate that management should consider involving employees in work-related decisions, in order to build trust between the employees and management. In other words, the economic realities call for participative management. Underlying this view is the philosophy that people will take more pride and interest in their work if they are given the opportunity to develop new skills, and participate in decisions within their work areas. It is believed that the QCs will help to motivate the employees in the face of the problems in the health care environment. It is perhaps for this reason that many of the QC programmes were developed in DHAs which have in recent years fared badly under the RAWP system. Most of these DHAs are in the South-Eastern part of England -particularly in the London area. Examples of DHAs with QC programmes include Enfield, Barking, Havering and Brentwood, Mid-Essex, Basildon and Thurrock, Tower Hamlets, City and Hackney and Newham.

The interest in QCs in the NHS also result in part from the potential benefits that advocates of QCs claim can accrue to organizations that have instituted them. In answering the question, 'Can circles add to the quality of care in the health service?' Davies (1986) not only responds in the affirmative, but gives an expansive view of the benefits of QCs in health care:

A 'plus' for QCs in the health service is that as QCs are about people involvement, and people resource in the health service is a reality,...the NHS has one of the fundamental requirements for QC programme. The groundswell of creative energy which could be released and



channelled through QCs would provide an energizing source of a rare fuel for the health service. Not only could quality of care be a beneficiary, but the QWL for the individuals would also benefit (p.4).

Employee participation in decision-making in the NHS is not new as JSCCs have been in the NHS for quite a long time. However, JSCCs do not encourage individual employees to participate in decisions relating to the delivery of care at the workplace. It is believed that QCs allow this to happen. It is thus argued that those health authorities which have introduced QCs are trying to break the traditional non-involvement of health care employees in decisions relating to their work and introduce a more effective employee involvement and communication programmes.

QCs are, thus, part of the plan to develop an open participative and democratic style of management, which allows management to delegate decision-making as much as possible to the wards in order to improve health care delivery. As Hyde points out:

QCs are not an entity in themselves; they are a part of management's philosophy of a bottom-up approach which encourages staff involved in patient care to participate in deciding how to improve it (p.50).

The dual-existence of QCs and the JSCCs, however, raises the issue of whether the QCs are meant to undermine or support the existing consultative arrangements.

The QCs are also part of the larger post-Griffiths organizational development effort. They are part of the patient-centred organizational development, and part of the effort by senior management to change employees attitude to patient care and the delivery of health care in general. QCs may be seen as an attempt by managers to monitor and control quality. It appears from the literature that QCs are primarily about improvements in quality, a paramount objective of the DHAs. In this respect QCs and QA initiatives have similar objectives. The recent interest in QA has provided a fresh impetus for senior managers in the NHS to develop an interest in QCs. In spite of the growing interest in QCs in the NHS, some middle managers, fearing that the QCs will undermine their



authority have resisted their introduction.

Interest in open management systems in the health care sector in the U.K. is not new. An example of such management system dates back to 1968, when the Dingleton Hospital in Melrose emphasized this approach to management (Christie and O'Reilly 1984). However, the Griffiths reforms in 1984 certainly gave a boost to the interest in this sort of management practice in the NHS. Since 1984 there has been a movement towards QCs in the NHS. Robson reports of QCs at Farmile Psychiatric hospital, Wallingford in the West Berkshire Health Authority, which were set up in 1984 in response to the Griffiths restructuring. Although other QCs in the NHS predate Griffiths they certainly came into prominence in the post-Griffiths period. This include among others the QC in Central Middlesex hospital in London - in Brent Health Authority (now Parkside Health Authority).

QCs came to Brent in 1983. A senior nurse at Brent, was asked by the then District Nursing Officer, to introduce QCs. The District Nursing Officer had become enthused with QCs after attending a seminar at which a U.S. nurse discussed the implementation of QCs. In order to set up the Brent programme the senior nurse tapped the King's Fund expertise on the development of QCs. The Brent programme also benefited from the literature provided by the NSQC. The Staff at Brent visited some private sector companies to observe QC in practice. One of the companies, Rank Xerox, U.K., later offered to train the Brent staff on their employee involvement training scheme (Jones and Sado, 1985).

Jones and Sado (1985), Lorentzon and Osborne (1985), and Osborne (1987a, 1987b) have shown how the first QC project in Brent DHA was set up in Central Middlesex hospital in London. More important they document the achievements of this QC programme. The Brent QC programme had the objective of exploring the need for quality control in nursing/midwifery and how to achieve it. Initially there was a lot of interest in Brent, but with the merger and the creation of Parkside, interest has significantly declined.

The novelty of the introduction of QCs in the NHS and the variety of motives, forms and experiences that seem to have developed provide the basis for the fieldwork/case studies reported later.



## Conclusion

Quality in the service sector has long been recognized as an important aspect of an organization's output. In the NHS, however, it is only in the post-Griffiths period that such recognition has become formalized and integrated into the general management role.

Out of the Griffiths report, and indeed the general change in the health care environment, has emerged the realization that leaving quality to professional practitioners is not sufficient to guarantee acceptable standards. This realization has given birth two distinct views: on the one hand, there are those who advocate a need for a radical new approach to quality management in health care; and on the other hand, there are those who want to continue with the traditional means of quality management. Here, these two views are referred to as the radical (managerialist) and traditional (professional) views respectively.

The traditional perspective sees quality as the responsibility of health care professionals (Plant 1985). Here, quality is defined mainly in terms of technical and professional competence. Technical competence comes about as a result of the professional training of health care providers and their adherence to their code of practice. In this respect any attempt to centrally co-ordinate quality (that is, the new QA perspective) is viewed as an attack on the professional autonomy of the professional health care providers. The traditional perspective thus reflects the health care professionals' resistance to any increase in control over their work. Thus the long neglect of formal QA is attributed to those who subscribe to the traditional perspective.

In explaining the long neglect of formal QA programmes, Wilson (1987b: 12) argues that the values of excellence, professionalism and high quality in the provision of health care imparted to doctors in their training make them sceptical of any attempts to introduce any formal system of QA to measure quality of care in terms of process or outcomes. Doctors feel threatened by QA as they believe that QA is an intrusion and a denial of their professionalism. In view of this, both governments and health institutions considered QA as being the



responsibility of professionals. This view resulted in fragmented QA activity by professionals without the commitment of resources and managerial organization to coordinate it.

The radical perspective on the other hand, maintains that quality is not simply the experts' domain but that real improvements can come about with the full involvement of all people in the organization, culminating in total quality management (Thompson 1987:4). The basic assumption of the radical perspective therefore, is that the technical care provided by health care professionals is not sufficient, and that employees and consumers views should be taken into consideration in the determination and assessment of quality (Matt 1987; Shaw 1986a 1986b; Lorentzon and Bryant 1988 and; Maxwell 1984). In addition the radical perspective argues that the recent changes in the health care environment require health care institutions to implement formal QA programmes. This is due to the realization that a comprehensive, fully integrated QA programme may ensure that the quality of care is under constant review. This can, in turn, result in improvements in the general quality of care. This view is derived from the systems approach to quality management

The radical perspective is perhaps part of the broader agenda by the government to limit the clinical freedom granted to doctors and other professionals by the Minister of Health, Aneurin Bevan, at the inception of the NHS. The Thatcher government has sought to curb clinical freedom in order to instill cost-consciousness in all aspects of health care.

A review of the various definitions of QA indicates that they epitomize the radical perspective to quality control. If QA is a 'system approach' to ensure quality in health care delivery, then it is a radical departure from professional autonomy. It is the simultaneous co-existence of technical and customer/client involvement in health care. Whilst the proponents of the traditional approach argue that there is nothing particularly new about QA except for its rise to prominence in recent years (Maxwell 1984), the advocates of QA herald it as a new and radical change from the previous practice of quality management. The newness of the QA perspective, its advocates maintain, arises from its emphasis on explicit policies on quality,



the inclusion of customers/clients in the assessment of health care quality, developing standards of practice, establishing criteria for the measurement and evaluation of standards for the purpose of improving services for clients.

The introduction of QA in the health care sector raises a number of issues. For instance, it carries an ideological message that quality can be taken care of if planned consciously by managers. At least, in the views of its advocates, QA introduces a greater sense of quality consciousness in the organization. It was argued earlier that QA is thus a managerial strategy in that it reflects a managerial response to environmental changes. There seems to be some similarity between QA and the 'hard version' of QCs in that they are both concerned primarily with quality control. In general, however, both QA and QCs are responses to the threat to adequate health care delivery arising from the Conservative government's public sector expenditure constraint policies. In other words they are both strategies for managing under constraints. They are both management control strategies designed to ensure effectiveness, efficiency and value-for-money in the delivery of health care.

The proponents of QA see it as a management directed programme which requires careful planning and implementation. Rowden (1986) captures the importance of planning and the implementation of QA in the quotation below:

Tinkering can achieve some change, but the lessons from commerce at home and abroad are clear. The most successful programmes are well thought through, planned, provided with investment, and led from the top. The cynics may be tempted to believe that quality assurance in the NHS are merely the latest buzz words. The cynics risk missing the most important aspect of the Griffiths report (p.9).

Both QA and QCs are often seen as managerial strategies. However, to uncover the nature of QA in the NHS, this study tries to determine why DHAs introduce QA, whether it is a consciously articulated strategy developed by senior managers, whether management structures have been redesigned to reflect this strategy, and how this strategy, if it can be called such, manifest itself in the lower levels of the



organizations.

Secondly, it will consider whether QA is a significant innovation or merely a new awareness of health professionals concerned with quality in an era of intense resource constraints. Is it merely a new way of dealing with perennial and evolving problems, (eg. demoralization of staff and external pressures) or is it a small step forward to measure performance better? Put simply, is it a potential attack on professional autonomy - a means of evaluating the performance of professional health care providers?

At yet another level QA has important links with QCs. Both project the view that quality is everybody's business; that is, quality is not a professional prerogative. If QA is everybody's business, it must be incorporated into the work process and this may be achieved through QCs. Plant (1985) advocates, that in a labour intensive organization such as the NHS, QA programmes must incorporate employee participation, communication, involvement, and problem-solving groups and that if the management style of the organization is supportive, the implementation of QCs will be more successful.

QA may be seen as an organizational strategy and a QC programme as the human resource strategy which is often integrated into the overall organizational strategy. It is an operational means of pursuing the organizational strategy. In other words, one means of implementing a QA strategy is the development and hence implementation of participative, involvement and communication programmes, such as a QC. A QC programme supposedly allows management to communicate their QA strategy to employees at the lower levels of the organization. QCs could potentially provide an opportunity for all grades of staff, particularly those at the lower levels of the organizations, to participate and discuss improvements in health care delivery (Kingston 1987: 12)

The importance of participation is reiterated by Kahl and Kranjnak (1986), who maintain that some employees take pride in the quality of their work, and therefore participative programmes on quality could motivate them. The advocates of QCs believe that the stress, fatigue, and poor job satisfaction resulting from health care underfinancing, cuts and understaffing could be mitigated by the



adoption of QC programmes. As QA and QCs cover many dimensions and categories it raises the issue of whether it is possible to use QA and QCs to control cost and increase employees QWL simultaneously. Put bluntly, is quality control or improvements in employees QWL the primary purpose of QA and QCs in the NHS?

The implementation of QA and QC programmes in organizations or in health care settings is an innovation that often encounters some degree of resistance. Plant (1985), therefore, warns that QCs should be approached with caution, since the consequences of a participative management style must be fully understood and accepted by middle and senior managers if it is to succeed. Accordingly, it is extremely important that careful thought be given to the strategy to be used to facilitate the development of such activities. These should reflect the organization's environment, history, politics and resources (Van Wyck 1985).

As it has been shown throughout the chapter, the advocates of QCs maintain that they are most likely to succeed in organizations with a participative climate (i.e. organizations that genuinely encourages employee participation and involvement). Moreover QCs are most successful in health care organizations where they are part of a larger organizational development effort, and when management is committed to the participative system and is willing to invest time and resources in employee education. The implementation of QCs according to this line of thinking requires a new philosophy based on mutual trust between management and employees, a philosophy which allows employees to exhibit their talents and potential. This raises the issue whether such a participative climate exists in the NHS.

Whilst the potential benefits of QCs cannot be formally and systematically evaluated in this research, other equally important issues can be explored. For instance, the relationship between QCs and HRM can be explored as they involve an attempt to maximize individual talents, employees participation, consultation and involvement. The advocates of both HRM and QCs maintain that they emerged from the increasing interest in corporate culture and the resurgence of interest in excellence which, in the health care sector, is equated with quality.



QCs, QA and HRM are managerial responses to environmental changes to improve organizational performance. They are responses to the revival of interest in customer satisfaction, innovation, etc. In recent years the interest in the individual, as opposed to collective employee relations has influenced the development of direct forms of employee involvement and communication at the workplace level. This interest has encouraged both QCs and HRM. The advocates of HRM, such as Armstrong (1987), maintain that human resource policies and activities are often linked closely with organizational strategy and must fit its culture. QA and QCs initiatives attempt to do the same. Similarly, QCs when introduced as part of a HRM initiative, often result in increased role for line managers in the management of human resources. In the health care sector the QA and QCs programmes seem to be an attempt to integrate a human resource strategy (QCs) into a managerial organizational strategy (QA).

The above discussion raises the question of the strategic importance of QCs in the health care sector. For instance, it raises the issue of whether QCs in practice can be seen as part of the HRM strategies or whether they are ad hoc, piece-meal, short-term operational issues of little significance. In other words, are the QCs temporary fads which management pays lip-service to or are they something significant enough to be considered strategic?

Just as in the case of QA, this study will attempt to examine the factors that account for the emergence of QCs. Furthermore it will explore the role of general managers in the formulation and implementation of the QCs programme, the relationship between QCs and QA programmes, the nature of the organizational arrangements, the role of unions and the role of both personnel and line managers in the QC programme. More specifically it raises the question: has the emergence of QCs in any way affected the way the personnel departments conduct their work?. These issues are the focus of the empirical sections of the study that follow.



## CHAPTER 7

QUALITY ASSURANCE AND QUALITY CIRCLES IN  
METROPOLIS HEALTH AUTHORITY

This chapter traces the development of QA and QCs in the first of two case studies - Metropolis Health Authority. It explores the origins of the QA and QC programmes and locates them within the Authority's broader aim of 'total quality management'.

The chapter is divided into six sections. The first provides a brief description of the socio-economic characteristics of Metropolis Health Authority. The second section discusses the managerial structure and decision making process in Metropolis. The third section traces the evolution of the QA strategy in Metropolis, emphasizing the influence of both national and regional strategic priorities on the local strategy.

The origin of the QCs programme in Metropolis is the subject of discussion in section four. This section explores the influential role of the DGM, the director and assistant director of QA, the line managers and the QC management consultants in the development and implementation of the programme. It also examines the relationship between the QA and QC programmes, and discusses the formation of particular QCs. The fifth section discusses relations between management and the unions regarding the implementation of QCs. It emphasizes the staff side's reluctance to endorse the programme officially and the management's desire to get everybody involved. Both union officials and management views on QCs, gathered from fieldwork interviews, are reviewed.

The concluding section provides some brief comments on the Metropolis QC programme. Some of the reasons for the failure of QCs in Metropolis and the absence of a systematic review programme are discussed. It is argued that the QC programme is essentially an attempt by management to change the culture of the organization, to make employees more quality conscious. This reflects Metropolis



strategic plan's emphasis on maintaining a high standard of quality in the delivery of health care. The QC programme can be viewed as part of the management strategy on QA, and thus a response to the Griffiths recommendations on improving the quality of service and customer/consumer satisfaction.

### Metropolis Health Authority

Metropolis Health Authority is a product of the 1982 NHS reorganization. It is located in London and it is an integral part of one of the Thames Regional Health Authorities. It currently serves a population of 197,000 (Metropolis 1987a:7).

The district has two principal units. One handles most of the acute services and the other deals mainly with general services. These main units are supported by a comprehensive network of community services in over a dozen health centres and clinics spread across the district. These clinics provide district nursing, health visiting, chiropody, dental services, ante-and post-natal clinics as well as more specialized community services. There are also specialist services which support district nursing and health visits, including mastectomy advice, stoma care, sickle cell and thalassaemia counselling, care of the terminally ill, and a care-at-home scheme for orthopaedic patients (Metropolis 1987b:8). The growth in these clinics contrasts sharply with hospital closures which have occurred in the district since the early 1980s.

Under pressure to improve operational efficiency and to rationalize the number of hospital beds in the district, Metropolis has closed at least 3 major hospitals. In the view of the management the closure of the hospitals was necessary in order to transfer funds away from acute facilities into priority services such as mental illness and mental handicap. Metropolis is moving away from the idea of caring for the mentally ill and mentally handicapped patients in mental hospitals and to reintroduce these patients to care within the community, backed up by a network of doctors, nurses, social workers, carers and most importantly, highly responsive emergency facilities. This requires the building of new rehabilitation centres, through



which patients will pass as a preliminary to their eventual settlement in the community. In addition, modern day care centres and residential places will have to be developed.

Metropolis is also improving facilities for the care of the elderly. There is a substantial growth in the number of people aged over 75 in the catchment area. Since the early 1980s the authority has been under pressure to provide beds in the hospitals for 'psychogeriatrics'. In 1983, the DHA recognized the fact that it did not have nearly enough geriatric beds and therefore a major programme of expansion was required. In view of this Metropolis has made some improvements in community care. It now provides chiropody and audiology services for elderly patients and an incontinence adviser was appointed in 1986. The DHA has been forced by the changes in the demographic trend to hire more health visitors trained in geriatric care.

Metropolis has a substantial amount of old property in its estate. Some of its buildings are of nineteenth century origin. These buildings were not well maintained in the past, and backlog maintenance problems of some £12 million has accumulated. Since 1985/86, management put £1 million every year directly into clearing the backlog (Metropolis 1987b:11). These issues have prompted the Chairman of Metropolis Health Authority to comment that the disadvantages of Metropolis include:

antiquated building in poor repair, ... little or no provision for the elderly, the mentally ill and handicapped people. (Metropolis, 1987b: 3)

He points out that the DHA faces a formidable task in trying to correct these deficiencies.

This becomes even more critical when viewed against a local community background of considerable poverty, with substantial social deprivation. 14 percent of the houses in the catchment area of the health authority are owned by their occupants, compared to a national average of 56 percent (Metropolis 1987/1988-1989/1990: 4). Metropolis is among the most socially deprived areas in south eastern England, with a high number of single parent families, overcrowding, lack of



amenities, and high mobility. Its social deprivation reflects its inner city location, and in common with some other parts of London, Metropolis has an ethnically mixed population, with a considerable number of blacks and other ethnic minorities. Overall, about 45 per cent of Metropolis's catchment population were born in countries outside the U.K. (Metropolis *ibid*, p.6). This includes Afro-Caribbeans, (i.e., people of African and Caribbean descent). Asians (i.e., people of Asian descent mainly from India, Pakistan, Bangladesh, and East Africa), and Mediterraneans (i.e., mostly from Cyprus).

Metropolis has recognized the need to respond to the needs of the resident population so as to develop a health-care system which responds positively to the multi-cultural diversity of the local community. However, the Conservative government's public expenditure constraint policies, together with the changes in the RAWP, have adversely affected the district. Since 1975 the government has gradually been switching health care resources to the under-provided regions mainly the north of England. The effects of these policies is that Metropolis operates within tight staffing and financial constraints. It has responded to a recent review of the RAWP system to assert that the factors of social deprivation and ethnic composition should be taken into account in the allocation of the funding to the health authorities. Metropolis has attempted to develop a QA programme that can monitor and ensure quality in health care delivery to its residents largely as a result of these financial constraints.

#### Management Structure and Decision Making

The discussion below is a general analysis of the managerial structure and decision making in Metropolis Health Authority. Figure 7.1 outlines the management structure of Metropolis Health Authority. It shows a brief description of the responsibilities of some of the directors. The discussion excludes the structure and evolution of personnel management which are dealt with in chapter ten.







Since the introduction of the Griffiths-inspired general management, the management of DHAs has been modelled on similar lines to commercial enterprises, with a management group and a board of directors. In this structure the board is composed of the DHA members, and the management, in the case of Metropolis, is the District Management Advisory Board (DMAB).

The highest decision-making (policy making) body is the DHA, which is made up of approximately 17 people. The chairman is appointed by the Secretary of State. Some members are appointed by the RHAs, and others are representatives of the local authority, the faculty of medicine of the local university if there is one (Metropolis has no medical school), trade unions, nurses, general practitioners and consultants. The members meet formally on a monthly basis. They have full-time jobs elsewhere and therefore serve on a part-time basis. There are also sub-committees for major policy issues and financial matters. These sub-committees discuss major issues and make recommendations or proposals for adoption by the DHA.

Below the DHA is the DGM, the head of the DMAB, whose other members include directors of the following areas: personnel, quality assurance/nurse advisory, estate, finance and planning. The DMAB also includes the district medical officer, a general practitioner, a consultant and the UGMs. The UGMs are responsible for the management of the units and therefore have a number of subordinate officers who report to them. The Unit Management Boards (UMBs) are headed by the UGMs. In the Acute unit the other members of the UMB are the administrative services manager, resource (finance) manager, two directors for district nursing services-(one for general services the other for women and children services), clinical services manager and the unit personnel manager. Below the administrative services manager are domestic manager, general services manager, the administrative officer, catering manager, and patient services manager. The private patient manager, the information officer and management accounts officer report to the unit resource manager. Among the subordinates of the clinical services manager and the two directors of district nursing services are various service managers, district heads of service and departmental heads. The clinical directors in medical,



surgical, obstetrics and gynaecology, pediatrics, pathology and diagnostic imaging are ultimately accountable to the UGM.

The other members of the UMB in the district services unit are the personnel manager, the service general managers in mental health, mental handicap, community services and care of the elderly. It also includes the operational (administrative) services manager and the finance (resource) manager who perform the same roles as their counterparts in the acute unit and their responsibilities are similar. Here too the professional directors of the four service areas listed above are ultimately accountable to the UGM.

The DHA sets objectives for the DGM, who in turn sets objectives for the units and the functional managers. The units are responsible for the implementation of policy decisions. This means that most of the day-to-day operational decisions are made at the unit level.

On decision making (internal policy issues), the policy is initiated by the department concerned, which prepares a draft proposal. This proposal is then presented to the DMAB for approval. If the policy has a direct bearing on personnel, such as changes to the grievance procedures, then after it has been approved by the DMAB it goes to the district JSCC for approval before it is finally submitted to the DHA for approval. If approved by the DHA, it becomes the official district policy.

Wider policy issues, such as hospital closures, follow a different procedure. The process begins with a recommendation by the DMAB to the DHA that a closure is necessary or justified on certain grounds. A proposal is then submitted to the DHA and, if it affirms the decision, a consultation document is prepared. This gives the reasons for the closure, the disposal or alternative use of the site, the relationship between the closure and other developments in the area, and the implications for both staff and patients (Hardy, n. d. : 8).

The consultation paper is commented upon by the DHA, and if adopted the paper is distributed to the unions, the CHC, local authorities, staff organizations and advisory committees. The local Members of Parliament (MP), the RHA, the NHS Supervisory Board and for that matter, the DHSS are also informed, and a press statement is



issued. Most of these groups are expected to comment on the proposal and thus to have an input in the planning and decision-making process. The DHA has to take into account these comments when making its final decision.

Here the view of the CHC is particularly significant. If the decision is not challenged by the community associations, particularly the CHC, then the DHA can go ahead with its plans to close the hospital. However, if the CHC opposes the proposed closure and submits an alternative plan or view, it must be considered. If, in spite of the CHC's objection, the DHA still wishes to go ahead with the closure it must refer the decision to its RHA. If, after a review of the CHC's proposal by the RHA, an acceptable decision is not reached, then the decision is subjected to further review by the Secretary of State who then makes the final decision either to confirm or deny the closure.

On planning issues, the DHA takes planning initiatives from the RHA, reflecting national and regional strategic issues. Planning guidelines are issued by the RHA to the districts. In 1983, the RHAs issued strategic planning guidelines which the districts were required to follow in drawing up their strategic plans for the 1983-1993 period. Metropolis accordingly used these guidelines to prepare its 1983-1993 strategic plans, which detail the various strategies for the delivery of health care, for instance, strategies for general and acute services, prevention, primary care and community service, QA strategies, etc. The RHA also issues Regional Operational Planning Guidelines to the districts every three years. The districts follow these guidelines in drawing up their operational plans which addresses a variety of issues, including (1) short-term programmes, (2) waiting lists of the authority, (3) financial resources, (4) performance of the authority, (5) efficiency performance, and (6) manpower resources and planning.

Planning at the district level is the overall responsibility of the DGM who delegates it to the Director of Planning. In the acute side this is done with the help of professionals involved. In district (community) services planning, there is an interface between the health authority on the one hand and the local authority, FPC and



voluntary organizations on the other. Joint planning with the local authority permits joint care planning of complementary health and local authority social services.

In Metropolis the service general managers in the areas of mental health, mental handicap, community services and care of the elderly take their own initiative in planning their services. Since service planning is to some extent influenced by available finance, the finance and planning departments are responsible for harmonizing the diverse needs of the various departments and bringing them together in a coherent fashion. Therefore, the preparation of both the district strategic plan and the operational plan is done in the finance and planning department.

The 1983-1993 strategic plan of the RHA emphasizes the importance of quality health care delivery, maintaining that quality of service is the paramount objective, and that it underlies all targets and plans. Equally, the need to provide high quality health care to its residents is the main strategic objective of Metropolis. The district, following the region, has initiated QA strategies in an attempt to achieve its objective of total quality management. The next section therefore deals with the origins of QA in Metropolis.

#### The Evolution of the Quality Assurance Strategy

Total quality management has been the prime objective in health care delivery in Metropolis since the Griffiths restructuring was undertaken in early 1986. However, the interest in the quality of health care in Metropolis certainly predates Griffiths. As far back as 1982 the DHA recognized the need to deliver quality health care services to all of its residents; that is, health care should reflect the needs of ethnic minorities in its delivery. In this regard, the pursuit of quality at Metropolis was broadened to include those who do not receive the service as well as those who do.

This concern led to the institution of the Ethnic Minorities Development Worker Project - to review the appropriateness of service provision and its accessibility to Metropolis's black and ethnic minority communities. The funding body for this project insisted on



the development of equal opportunities policies (EOP) in both health care provision and employment policies. Metropolis was, therefore one of the earliest DHAs to develop EOP. This project initiated the development of service for blacks and other ethnic minorities in Metropolis. Service provision for blacks and ethnic minorities invariably raises questions of quality, and the QA strategy attempts to monitor such issues. It is therefore not surprising that in the post-Griffiths period attempts have been made to centralize the coordination and evaluation of quality in health care delivery. The management structure which emerged out of the Griffiths restructuring emphasized quality, and the importance of quality is reflected in the creation of a QA/Nurse Advisory department to coordinate quality initiatives in the district. This structure was consciously created to facilitate the implementation of the organization's strategy. It can also be argued that the Griffiths Report's overwhelming emphasis on quality tremendously influenced the development of the structure. Seen in this way structure influences strategy and strategy influences structure.

The Director of QA/Nurse Adviser traced the evolution of QA in Metropolis to the Griffiths restructuring, and its clear emphasis on quality and the extension of commercial management practices to the NHS. He also argued that the current interest in centrally coordinated quality initiatives is to a great extent influenced by the changes in health care finance. Thus the imposition of cash limits and the emphasis on value for money initiatives have been important. The strategy was also influenced by consumer demands for quality, the RHA's strategic initiatives on quality, and the importance of quality as a national priority in the NHS which is reflected in the annual review process. These issues are elaborated below.

According to the director for QA, the Griffiths restructuring was accompanied by finance-led service provision; i. e., services should be planned with available money, rather than the previous arrangement of patient-led services. The emphasis was now on cost-saving, to reduce beds and increase patient throughput. The issue of competitive tendering for ancillary services was also a factor which was taken into consideration in the development of the QA strategy.



It was felt that competitive tendering could potentially adversely affect quality. In view of this, quality must be coordinated and monitored from the top down to prevent any deterioration in service -be it clinical or non-clinical, such as catering and hostel facilities. Moreover, the DHA's quality strategy is derived from that of the RHA which, in turn, reflects national strategic objectives. The RHAs require DHAs to demonstrate commitment to improving quality by taking account of the function within the new management structure (Inner London RHA 1988:5).

The RHA covering Metropolis has been a source of encouragement in the development of QA initiatives. Its planning guidelines for the DHAs require the latter to demonstrate action and plans for improving service quality, and this forms an essential part of the annual review process -ie., the regional and district chairman's reviews of the district. These sorts of reviews have required the districts to toe the government's line. The RHA encourages the districts to develop and refine the methods to maintain quality in their delivery of health care. Also, the districts are encouraged to solicit and consider the views of their consumers on the services they provide, and to ensure that the consumers are involved in the planning and monitoring of services. The RHA also provides QA information to the districts through the organization of seminars, a forum on QA, and QA interest group meetings. The districts are also encouraged by the region to make effective use of journals, newsletters and scholarly publications on QA. In view of these initiatives by the region, and pressures from the NHS Management Board, it is understandable that the districts have developed QA programmes.

Formalized QA came to Metropolis in February 1986 as part of the Griffiths restructuring. The present Director of QA established the department alone and guided it through its early years. He was appointed in February 1985 as the District Nursing Officer and was in charge of professional nursing duties in the district. A year later, in February 1986, the Griffiths recommendation on general management came into effect in Metropolis. The new managerial structure was implemented at the same time and he was appointed the Director of QA and Chief Nursing Adviser, a professional role. As Director of QA, he



is responsible for planning QA in both clinical and non-clinical areas in the district. This implies that QA is by no means limited to nursing and other clinical areas. His responsibilities include (a) giving advice on QA issues to the DMAB and other managers, (b) providing help to individuals and provider groups on the setting of quality targets, (c) monitoring and receiving progress towards agreed targets, (d) ensuring that quality issues are featured within planning mechanisms (Metropolis Consultation Paper 1986:2).

In order to formulate and implement the DHA's strategy on quality, the director of QA prepared a strategy paper for the DMAB. This paper was meant to be the starting-point for the introduction and sensitization of quality issues in the district. The strategy paper describes the objective of a QA programme as follows:

The primary goal of a QA programme should be to make health care more effective in bettering the health status and satisfaction of a population, within the resources which the Authority and individual managers have chosen to spend for the care (Metropolis Strategy Paper 1986:1).

The strategy paper argues that QA programmes in Metropolis are catalysts; designed to enable the objective and systematic monitoring of service delivery, particularly its quality, effectiveness, acceptability, appropriateness and efficiency, and to provide opportunities to improve services and to remedy deficiencies. It thus identified five different, but interrelated, activities to be pursued: (1) information and development of communication networks, (2) the development of a consultation document, (3) policy formulation, (4) educational and skill acquisition, and (5) monitoring.

In view of the objectives, the director of QA developed an information and two-way communication process aimed at making management and all other staff familiar with the concept of QA and the work of the QA department. The QA department also set in motion the process of setting standards in quality of health care. The strategy also recognized the need for educational and effective training of employees as an investment in service quality. This realization follows the conventional wisdom that quality implies both the quality of employees and the quality of the product/service. For instance,



Wilson (1987b) maintains that quality care includes the quality of performance of staff, and therefore quality of performance is promoted by investment activities, such as training. According to this view, performance standards have to be taught and staff must acquire the necessary skills if quality is to be achieved and maintained. Training and development opportunities should be built into the plan - to make investments in the skills of employees.

Following this perspective the Metropolis strategy emphasized both in-house and external training as part of a continuous process to achieve quality in health care. The importance of developing monitoring programmes which include audits, consumer views, service reviews, etc., was also reiterated. In Metropolis QA is seen as a continuous process for improving quality in health care provision through the management structure; it is everybody's concern, from the lowest member of staff to the top executive.

Upon completion of the strategy paper in February 1986, the director of QA prepared the consultation paper which was completed in April. It had four objectives: (a) to define QA, (b) to gain the commitment of the authority and its officers to QA, (c) to state the values and objectives of the authority and to establish how these can be achieved, and (d) to request positive suggestions and comments as an essential element in the formulation of a QA policy for the authority. In addition to these, it emphasized the need to gain the commitment of all members of staff in order to ensure the success of the QA strategy. Moreover, it expressed in clear, succinct terms the values of the DHA and the expectations the DHA has of its staff. It included the following value statement:

The population of Metropolis is a collection of individual people, all with very different needs, who are entitled to the highest individual courtesy and dignity, and within the resources available, the highest level of individual care and attention (Metropolis Consultation Paper 1986:3).

The management believed that the adoption of these values would encourage staff members to accept the values in the performance of their duties and responsibilities. The links between QA and customer care/satisfaction were made in the consultation paper by suggesting



that QA projects should involve some public relations aspects; that is a 'front of the house' service with which most patients normally come in contact.

The consultation paper was subsequently circulated to heads of departments for their comments and then to the DHA, from where it went to consultation - that is, to employees, unions, community organizations, CHC and the general public. The responses were incorporated into a revised document, and eventually the DHA adopted its QA strategy.

Since the adoption of the QA strategy, all issues regarding QA have been placed under the QA Committee - a sub-committee of the DHA for quality issues. For instance it is the responsibility of the QA committee to ensure that the quality of care is sustained at all levels in all situations. This committee meets once a month to discuss issues pertaining to quality. The membership of this committee includes DHA members, - one of whom is the chairperson; the Director and Assistant Director of QA; a CHC representative; the Administrative Services Manager - acute unit; a service manager from the District Services Unit; the UGMs; and a medical representative.

As required by the QA strategy, the units prepare an annual programme of their QA projects and plans. They are assisted in the preparation of these plans by the director of QA and his assistant. The QA committee prioritizes the plan and monitors it. It also monitors accident rates and complaints, and visits hospitals to monitor quality, and it has the overall responsibility of overseeing quality in the districts, including the work of QCs.

After the formulation of the QA strategy the Director of QA's immediate task was to popularize the 'total quality management' objective in the DHA. This effort to raise the consciousness on quality was necessary because a large proportion of the staff at the time considered quality as an important but not a priority, issue. The Director of QA therefore took some initiatives to improve the quality of care. For instance, he audited the quality of nursing care and professional standards using 'monitoring' - an index of the quality of nursing care; he set nursing standards and published a standards booklet; he became involved in drawing up nursing specification; he



sought liaison with professions which were drafting QA policies (eg., pharmacy) and he developed links with QA resource centres in Europe and the U.K.

Having developed the QA strategy it was necessary to sustain quality consciousness at the workplace level. In other words, the quality consciousness in the district should be reflected in the work of employees at the workplace so that quality becomes an integral part of service provision.

After some discussion between the DGM and the Director of QA it was decided that the development of QCs would help carry the quality campaign in the DHA forward. It was believed that QCs would help the DHA to achieve the objectives of the authority's QA strategy and by so doing fulfil some of the Griffiths recommendations. The rationale was that QCs would help the employees to identify customer needs and make attempts to meet these needs. There would be service improvements and eventually improvements in customer relations.

Moreover in an era of financial restraint with its attendant problems such as shortages of staff and demoralization, it was believed that QCs would help to bring about genuine involvement and participation of staff in decisions affecting their work. Such a participation and involvement it was believed would not only improve the quality of service, but also the morale of employees. The management also believed that the QC training could potentially improve the quality of the staff. QCs were thus seen as potential tools for both crisis management and the improvement of employees QWL.

#### Quality Circles in Metropolis

Senior management in Metropolis indicated that their QCs are derived from the organizational strategy of QA. The DMAB apparently made a commitment to support QCs, but the introduction of QCs in Metropolis has been mainly the initiative of the present DGM, directors and assistant director of QA. Before assuming her present position, the DGM was the Chief Nursing Officer for another London DHA, where she was appointed a member of a committee at King's Fund to review accidents. However, the committee's role gradually expanded



into quality issues. She became very interested in the project and in turn encouraged two middle managers from her DHA to go to the King's Fund Centre to work on quality. These middle managers also became interested in quality and experimented with their ideas at a local hospital. One of them eventually became the QA manager at that DHA.

After the Griffiths Report, the present Metropolis general manager took up her appointment. Faced with dwindling financial resources, pressure from consumers and the NHS Supervisory Board to improve quality and at the same time cut costs, the management of Metropolis decided to develop quality-consciousness among the workforce. Having developed the QA strategy, QCs were identified as one of the key vehicles for changing employees' attitudes to quality and to service provision in general. It was believed that QCs could make high quality standards an integral part of the health authority's culture. The management therefore felt that the QCs were potential means of encouraging employee participation and involvement in the organization and to allow them to develop their roles and improve their quality of working-life. Moreover, it was hoped that QCs would eventually involve all employees in the quality improvement process.

With these objectives in mind the QCs programme was initiated in late 1986 with senior management support. At the outset the DGM invited the QA officer from her former DHA to set up QCs in Metropolis. This officer - who acted as a consultant/facilitator - worked in cooperation with the QA manager in Metropolis in the initial stages of the development of QCs.

The formation of QCs began with management information sessions. It outlined the reasons for the introduction of QCs in Metropolis, what the benefits were thought to be, and the general philosophy behind them. Most of the employees who first became involved in the QCs did so mainly at the instigation of management, although a few volunteered. Once a number of employees acquired some knowledge of and interest in QCs, the management sponsored those who were interested in becoming members to attend a QC course at the King's Fund Institute in London. The feedback from the course was poor - it was not what they wanted, for it did not adequately give the participants the skills required to solve problems in QCs. All these employees were therefore



later retrained by a management consultant. The management consultant also helped to develop the QC training courses. These courses covered the basic skills essential to lead QCs and promote team work. It also covered a number of specialist analytical and problem-solving techniques employed in QC activity.

Soon after the initial training, QCs were set up in the Accidents and Emergency (A&E) department and Operating Theatres in the acute unit. Some of the staff thus trained became leaders. In the A&E circles, an auxiliary nurse became the leader and the QA Officer from the other DHA was the facilitator. These two QCs, and indeed all subsequent ones, were set up without any pilot projects.

Later, as the director of QA became more and more involved in the work of the department, he had too much to do and could not help very much in the development of QCs. A decision was therefore made to appoint an assistant QA manager who would be primarily concerned with the implementation of the QC programme.

In December 1986, the Assistant Director of QA, was appointed and made responsible for the formation and implementation of QCs in Metropolis. Although a nurse by profession, she was fairly new to the idea of centralized QA, as well as the concept of QCs, but was very willing to learn and committed to the idea. She was immediately despatched to a course on QCs organized by a private sector company - Rank Xerox - which is involved in QCs. Rank Xerox trained her free of charge for the DHA.

After her training the Assistant Director of QA became the facilitator and was required by senior management to start five circles and then to pull out for the units to continue. At this time there was no steering committee so the facilitator's role was to provide back-up support for QC's leaders, to promote the growth of QCs in Metropolis, publicize the results and benefits of the QC activity, take responsibility for the administration of the programme and to make sure that QCs investigate 'worthwhile' problems. The A&E circle was going well, but the theatres circle was quite difficult to sustain because of the awkward meeting hours, for instance, 6:00 am, which was difficult for the facilitator to attend.

In spite of these difficulties, the two circles struggled along.



However a real breakthrough came in 1987, when the assistant director for QA attended a conference organized by the NSQC at Brunel University in West London. She talked about the Metropolis QCs and the problems they were facing. At the conference a management consultant came forward to offer the much needed help to Metropolis.

This management consultant decided to offer two training courses for Metropolis free of charge. If after the initial two training courses the district was satisfied and wanted him to conduct more courses, then he would charge a fee. The courses turned out to be quite good and consequently the consultant was asked by management to run all Metropolis's QC training course three times a year in April, July and October, for members, leaders and facilitators. The consultant trained the employees, including those who had been trained earlier by the King's Fund.

As a means of paying the consultant, Metropolis, organizes QC training courses for Metropolis staff at which private sector organizations and some public sector ones, sponsor their staff to attend. The fees that these outside organizations pay go to the management consultant. So, in effect, Metropolis is able to train its staff free of charge. The QA department had to adopt this innovative way to finance the QC programme because the department has no budget for QCs. The essence of the QC programme is to improve, or at least maintain, standards in a declining resource environment, and for this reason the department cannot afford to shoulder any significant costs. The training courses are organized at the DHA's training facility, but the training department plays no role in it.

During the course of the fieldwork, some of the training sessions were observed. They provided additional access to unit general managers, other managers, QC leaders, members, facilitators, members of the steering committees, etc. To show their commitment to the QA and QCs some members of the DMAB attended these training sessions. A number of QC projects have been undertaken in Metropolis and in the section below some of these projects are explored.

The QC in the A&E department was the first formed in Metropolis. Following a training course for five members of the A&E department, the first meeting of the QC was held in July 1986. The group meets



for at least one hour each fortnight. This QC is made up of nine members, including one leader and one facilitator. The leader -an auxiliary nurse -is responsible for arranging QC meetings. In the initial stages of the formation of the circle, the members used brainstorming as a technique for identifying the problems within the work area which were adversely affecting efficiency. This list was generated by asking the question, 'How can we improve our department?' In an attempt to answer this question, the QC used the brainstorming technique to generate 199 problems at the work place level. The list is rather too long to be reproduced here.

At subsequent meetings the initial brainstorming list was shortened by retaining only problems that the circle could handle using the following guidelines. Is it in our own house? Can we solve it reasonably quickly? Can we collect data about it? Will it assist our duties? Do we want to tackle it? Using these guidelines the members identified the following as problems which the QC could resolve: increased waiting times; cleansing room used as a dump instead of its intended purpose; wrong placing of washing-out trolley in the bay area, i.e. the A&E department general reception waiting area for patients awaiting treatment; and unused space in A&E whilst there was a shortage in the work area. By using a system of rank voting the main problem was identified as inappropriate positioning of the stomach wash-out trolley in the bay area. It was this problem which caused the increase in waiting times and over-crowding because the bay is taken up for washouts and this slows the treatment of other patients.

The QC therefore set itself the task of reorganizing the bay area and finding a better means of utilising the delousing (i.e., cleansing) room. This room was intended to be used for the washing of people infected with lice (body and head), radiation decontamination etc. but its use had been discontinued for some time. Using cause and effect, another QC technique for solving problems, the above problems were broken down to make the problem more amenable to solution. The QC perceived that if the cleansing room which was then used as a dump was cleaned and used for its intended purpose it would free the use of the bay areas as a cleansing place. The free



space created in the bay could then be utilised for the treatment of patients in a busy cramped department. It was considered that a remodelling of the cleansing room would allow stomach wash-out to be done in the room in addition to delousing. The QC reckoned that the benefits to be derived from the remodelling would include: a reduction in waiting time by increasing bed space in the bay without additional staff increase; more privacy for patients as delousing will take place in a private room rather than in the bay area where other patients will be watching; the room would be better suited to cleansing because it will have the necessary facilities; the room could also be used as a resuscitation room; less distress to visitors and other patients because they will not see the delousing of naked patients; and centralization of equipment in one room.

In view of these perceived benefits it was proposed that the cleaning room be cleaned, remodelled and used as a dual purpose cleansing room/stomach washout area. In the event of a patient being admitted for decontamination, the room could still be used for that purpose. An estimate of the work required was carried out and a request was made to the works department to programme the work needed to remodel the cleansing room to make it possible to use as a stomach washout room as well. The remodelling required that the A&E department also get a new model trolley.

The QC's problem-solving activity culminated in a presentation to management. The UGM and other senior managers attended the presentation to give moral support. Each member of the circle participated in the presentation. The QC described the nature of the problem; outlined the investigation carried out; showed the major causes of the problem, outlined the solutions considered and recommended the remodelling of the cleansing room for implementation. The presentation lasted for about an hour. The recommendations of the QC were approved by management, which gave the go-ahead for converting the delousing room for the dual purpose. The major repair work, such as retiling and fitting of the new sink, and installation of new shelves and shower curtains, was done by the works department and the League of Friends gave £1,000 for the purchase of the trolley. The room is reportedly now used with much more privacy and, in the view of



the staff, with much more dignity for patients.

Since completion of this project, the QC has undertaken other projects. In one of their meetings attended during the fieldwork research, the QC initiated a project aimed at reducing the waiting time at the A&E department (sometimes as long as four hours) by investigating inappropriate referrals by GPs. The effort was primarily aimed at GPs not doing their job by sending their patients to the A&E. That is, it was determined that GPs could provide some of the services in their own consulting rooms, but neglected their duties and sent the patients off to the A&E department. Those GPs identified through investigation by the QC would be informed through the FPC to refrain from making inappropriate referrals. The project was also aimed at educating patients who self-referred to services provided by GPs which would not require them to be in the A&E. Both QC projects have been essentially aimed at improving organizational effectiveness.

Another project most recently carried out by the QC at the Obstetrics and Gynaecology (O&G) department at the acute unit was aimed at improving both organizational efficiency and the QWL of the staff. In discussing how the QC was formed in the department the leader of the circle mentioned that she received a letter from her manager -Director of Midwifery and Gynaecology -which suggested she could take an opportunity to go to a QC course. She recalled that she could neither volunteer to go on a QC course or become a member, because she knew nothing about QCs at the time. After attending the course, however, she became interested in QCs and was motivated to form one. The other staff at the ward who also went to the training shared her enthusiasm equally. They were helped by the Assistant Director of QA in forming the circle. Initially the Assistant Director of QA chose a nurse as the leader and a nursing officer was chosen as the facilitator. The interviewees mentioned that initially the facilitator felt uneasy about the facilitator role and was somewhat reluctant to facilitate; however, the members were determined



to forge ahead.

The circle was formed not only because management was keen to have a QC at the ward, but also those who went on the training course realized that there were some members of staff who needed to be motivated and to build up esteem. For instance, enrolled nurses - almost at the bottom of the NHS hierarchy - had been in the wards for a long time, but there was very little recognition of their tremendous contributions. In the formation of the QC, therefore, the duty roster was prepared in such a way that the enrolled nurses could attend the QC meetings. Accordingly some of the enrolled nurses became members. The participants reported that as a result of their participation in QCs, those nurses who had formally sat and done nothing were suddenly bright and alive with ideas.

One of the projects recently completed by the O&G circle aimed at improving organizations efficiency and relationships with patients. It involved proposals to change shift hours. The problem which precipitated this project was inadequate change-overtime; the night shift, in particular, had some problems with the change-overtime. Prior to the initiation of the project, the shift hours were as follows:

7:45 a.m.	-	4:15 p.m.	early shift
12:30 p.m.	-	9:00 p.m.	late shift
8:45 p.m.	-	8:00 a.m.	night shift

It was discovered that when the night shift resumes duty at 8.45 p.m., the late shift had only 15 minutes to give them a full report including daily surgery cases, and check the drugs on 26 surgical patients, some terminally ill. In view of the amount of work involved they usually went off duty at 9:30 or 9:45 p.m. instead of 9:00 p.m. This created some problems for both staff and their spouses. Moreover, by the time this ward's staff went off-duty, all the other off-duty nurses from other wards were gone. It was therefore a bit lonely and dangerous for the O&G ward's staff to walk to their cars or walk around the hospital individually as the hospital was dark. Consequently almost everybody at the ward was fed up with the late shift change.



The QC then developed a questionnaire to ask all the nurses if they wanted to change the hours. This produced a unanimous affirmative response, but the circle could not recommend a change in the hours itself because that would be an infringement of the collective agreement and would get the nurses into trouble with the trade unions. They had to work 37 hours a week under the terms of the agreement. The QC therefore decided to reorganize working-time within the 37 hours. The following schedule was proposed:

7:30 a.m.	-	4:30 p.m.	early shift
12:30 p.m.	-	9:00 p.m.	late shift
8:30 p.m.	-	7:45 a.m.	night shift

This schedule gave half an hour instead of a quarter of an hour for the night shift-change, but still remained within the 37 hour week. It was decided to try this schedule at the ward for a two-month period. During this period records were kept on punctuality of staff and the frequency of the late shift being late going of duty. During the trial period, the late shift was late in changing shifts only once and that was because the elevator had broken down and they had to take the stairs to the ward on the 6th floor; it had absolutely nothing to do with the running of the ward. After the two month trial period, another questionnaire was used to gather information on whether to continue with the new schedule. Again, the response was unanimously in favour.

The QC therefore decided to present its proposal to management. The QC invited everyone associated with the hospital to attend. There was a good turnout. The UGM, the administrative service manager, catering manager, and almost all Sisters, turned up. They presented their project with the help of an overhead projector, flip-chart, etc. Management was very interested in the presentation. Soon afterwards, the QC received a letter from management which gave the new schedule as the official working hours. The participants indicated that the staff were enthused with the project; everyone had participated. The night staff liked the new schedule because there is less traffic at 7:45 a.m. when they get off duty, so they can get home and see their children off to school. All staff liked it because it allowed them to



say hello to colleagues on other shifts instead of rushing off. The late shift now goes off-duty on time thus improving the staff members' relations with their spouses. Overall the participants reported that it has improved communications, inter-personal relations, and social life, and it is safer going off duty. Moreover patients also benefit, since the staff now have enough time to learn more about each case during the shift-change-over.

As the QC made significant progress in its project the facilitator's attitude changed from reluctance to active involvement. She realized that the QC was not meant to undermine her authority, and eventually she was chosen to join the steering committee.

Other projects undertaken by the QC include one on patient health education. The QC has prepared health information leaflets addressing possible questions that patients have, but are embarrassed to ask. For instance, one leaflet provides information about the ward: meal times, doctors rounds, library rounds, medicine rounds, TV room, what time the patients can have a cup of tea, etc.

There is also health education for the public, i.e., people who come to the ward for services. According to the QC members, some people are referred to the hospital (ward) for biopsy; however, 'when they come in they tell the nurse that they have come for an autopsy'. In a similar case, a woman came to the hospital for a termination of pregnancy once and was put on the pill by the doctors to guard against an unwanted pregnancy. She, however, got pregnant again and was referred to the hospital again for a second termination. When asked why she got pregnant again in spite of the pill, she replied: 'I was so ill one day and I could not take the pill but I let my boyfriend take it.' From such experiences the QC members realised that it would be beneficial to provide health education to patients. A health education QC project was therefore planned and presented to management which approved it. It was therefore implemented in the ward.

The health education leaflets provide information for patients to read and discuss with the nurses. The members claimed to derive a great deal of satisfaction from such activities.

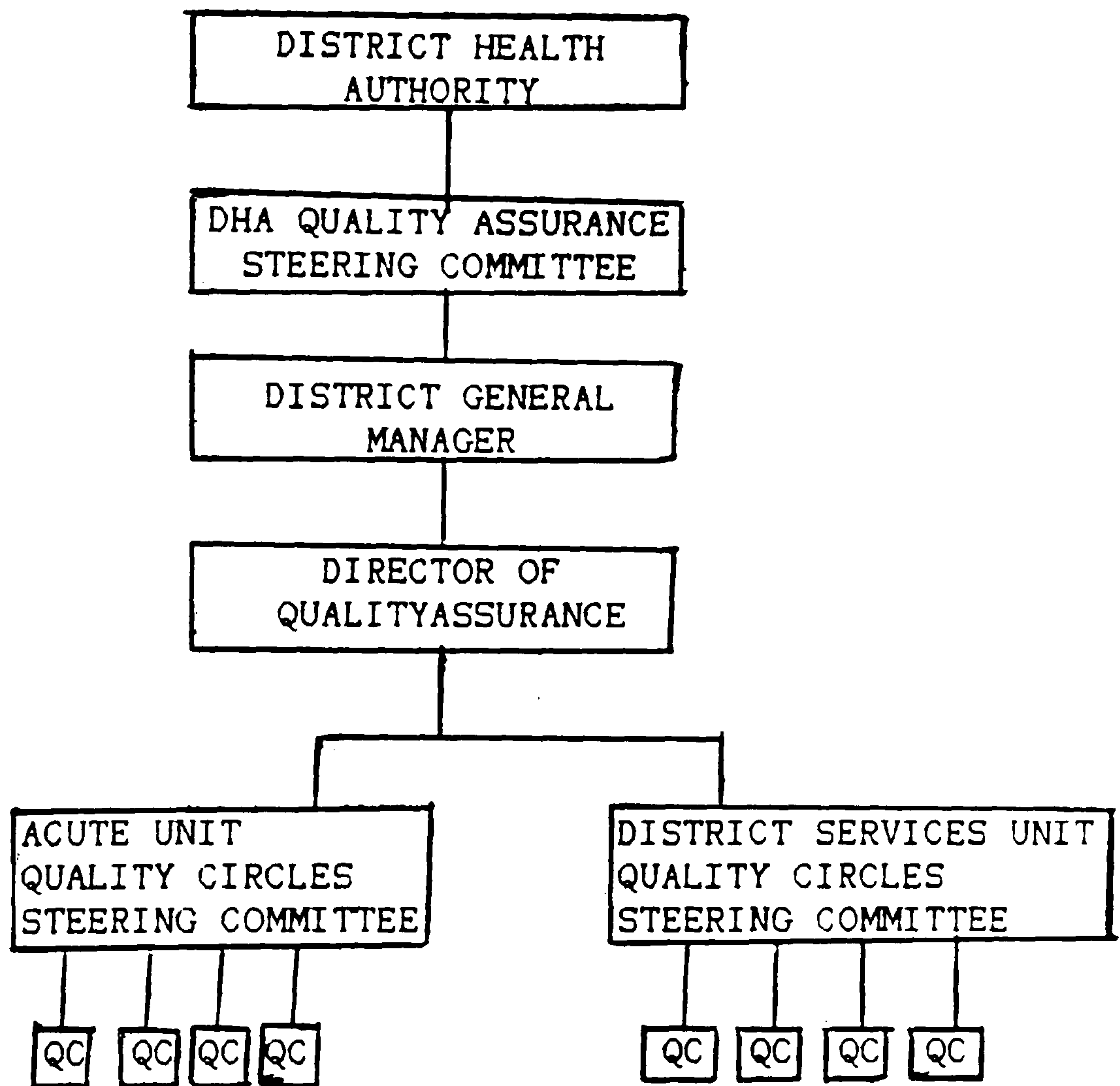


The Quality Circle Steering Committee

Metropolis has two QC steering groups, one in each unit. Figure 7.2 shows the QA and QC structure in Metropolis.

Figure 7.2

Metropolis Quality Assurance And Quality Circle Structure.



At the top of this structure is the DHA. Directly below the DHA is the QA steering committee, a sub-committee of the DHA. One step below this committee is the DGM. Below the DGM is the Director of QA, who reports to the DGM but has the overall responsibility for quality issues in the delivery of care in the district. Below the Director of QA are the steering committees in the two units. These steering committees are responsible for the overall guidance of the individual QCs in the units. While the UGM at the district services unit has been fully involved in the steering group, the UGM at the acute unit



delegated QC issues to his deputy and this did not please the staff. It implied, in their view, a lack of top management commitment. Therefore, the steering committee was a little slower in taking shape in the acute unit than in the district services unit. One manager in the acute unit reported that the beginning of the steering group was her lowest point with the QCs. She said people were involved with patients and could not attend. They have, however, overcome that problem now.

The acute unit set up a QCs steering committee in October 1988. This unit, at the time of the research in late 1989, had four active QCs in A&E, O&G, X-ray and Theatres. The steering committee is made up of a cross-section of the unit, and includes managers in nursing, domestic services, and catering. Others are the district dietician, administrative services manager and director of nursing services. Their role includes publicity for QCs, guiding and reviewing their activities in the unit, and helping in the formation of new circles.

In the district services unit, there were four active circles; two were in a health care centre, one in a day hospital, and the remaining one at a clinic. The unit operational services manager was influential in the formation of the steering committee. A previous sceptic on QC, his attendance of a QCs advanced facilitators course changed his attitude. He became enthused about QCs and talked to the UGM about a structure to develop a systematic approach to QA. Subsequently they formed a steering committee to give practical help and advice to staff who have identified ways of improving quality within the unit. A member of the QC steering committee explained that one of its objectives is to help establish more QCs by explaining to staff what they are, how they are set up and how they work. The steering committee intends to promote quality consciousness in the unit by initiating quality improvement programmes aimed at sensitizing staff to the values of quality.

The steering committee also intends to promote active employee participation and customer satisfaction groups. As one manager and member of a QC steering committee puts it:

We are looking for a win-win situation. Where the customers get a good service, the staff find their work enjoyable,



where both staff and customers are assured of safety and where there is improvement in costs.

The membership of the district services QC steering committee includes a UGM, a service manager for the care of the elderly, a unit operational services manager, a QC facilitator, a QC leader and the Deputy Director of QA.

Both steering committees in Metropolis are responsible for the strategic development of QCs. The committees meet once every month to receive oral reports from each circle and the projects they are involved in. Three QCs, however, existed only in name. The members had not met for at least three months, and when some of the members were interviewed they mentioned that they were resting - a polite way of saying the QCs were moribund (i.e., they formally existed, but no longer met regularly). Another QC had failed.

The Metropolis QCs do not offer any financial incentives for participation; rather, management maintains that the satisfaction members derive from participation is enough. It supposedly makes them feel part of the organization; helps to give job satisfaction and gives value to their contribution; provides recognition that they have talents and that they have solutions to workplace problems. Recently, however, the DGM suggested an achievement award scheme whereby individuals, departments or groups can submit ideas for improving efficiency on a competitive basis. The winner would be awarded £500. It is expected that QCs could submit ideas and compete, presumably, with other groups.

#### Union-Management Relations

Relations between management and the staff side have not been particularly cordial to say the least; they have been somewhat uneasy since the pre-Griffiths period. While the unions are not particularly militant, they are by no means subservient to management, and the union activists are sometimes vociferous in their demands.

The union representatives maintain that in the JSCC it is always difficult to get management to move on any issues affecting employees



which involves any expenditure by the health authority. According to the union officials this also applies to issues which are intended to 'improve' working conditions for the employees. The personnel manager, on the other hand, complained that the union representatives are unreasonable in their demands, and moreover raise unnecessary grievances as well as disciplinary appeals. Most of these appeals according to management are complete waste of time and resources.

Management-union relations in the late 1980s must be seen in terms of developments which occurred in the district in recent years. As indicated earlier, the district's rationalization of acute and community services resulted in many hospital closures. These closures led to some cases of redundancy and relocation of staff. Administrative and clerical, and ancillary staff were most affected. A reduction in the manpower levels obviously was a matter of concern for the unions. Since hospital closures often led to job losses and a decline in union membership, the unions quite naturally often sided with the CHC to oppose hospital closures and have suggested alternative solutions.

Where such opposition has failed the union representatives have been tough in negotiating the extent of such job losses and its consequences on the staff. For instance, relocation of staff often implies that staff may find that the extra travelling distance to the new work site may be inconvenient or unacceptable. The union officials try to mitigate the effects of relocation but they maintain that management very often takes an uncompromising stand.

Management's stand on such issues is based on the belief that it is its duty to carry out the rationalization to reflect the regional and national perspectives on service provision. Management argues that the authority's existing and projected increase in costs associated with providing services at the existing level, make it imperative to undertake such rationalization. In view of this, management argues that it cannot give in to the union representatives' demands.

In the light of these developments, the union officials maintain that the JSCC is not effective. It is more a case of management's imposition of its views than a consultation process. Such a



divergence of views often result in clashes that have soared the state of management-union relations in Metropolis. The union officials attitude to the QCs reported below is an example of the degenerating climate of union-management relations.

The introduction of the QC programme in Metropolis has not in any significant way improved management relations with the unions. Although the unions have not prevented or discouraged their members from participating in QCs they have not given their official blessing to the programme either. The official staff side position on the QCs is that it will not officially participate, but if individual members want to participate, that is up to them. Relations between the unions and management on the QCs came to a head when management decided to form steering committees. It was decided that each unit should have its own steering committee, made up of a cross-section of staff within the unit, which should include trade unions and management representatives.

The staff side did not want to participate in the steering committee and turned down the formal invitation. The staff side explained that it refused to nominate a representative to the steering committee because it was nearly 18 months after the initiation of the QCs programme that staff side representation was sought. This made union representatives sceptical of management's motives. The argument was that if management was keen on union participation it should have encouraged it from the outset; the question was 'why ask us now and not at the beginning?' According to management, the union leaders do not want to recognize the QCs because they think they are a management ploy to get staff to do work outside their job description. They are suspicious of the whole process and did not want to be involved in or associated with it. The union officials, however, pointed out that if the QCs eventually turn out to be beneficial to employees, they would certainly change their stand on them.

The union officials dismissed management's perception of unions resistance. The truth, they claimed, was that management neither fully informed or consulted the unions about QCs; they were imposed unilaterally by management. Management denies these charges and maintains that in the consultation stage for QA, the union



representatives did not voice any opposition, and even supported the idea. (Of course, QCs were not mentioned at the consultation stage since the discussion concentrated on QA). The management was therefore surprised that the unions at a meeting in 1988 suggested that all circles should be terminated.

The union representatives maintain that the JSCC could handle all the problems that QCs are supposed to solve, and therefore there is no need for them. The union officials view QCs as a management ploy for dealing directly with employees and by so doing, sidestepping or competing with unions. Moreover, the union activists maintain that since QCs have failed in a number of places, they are more likely to fail in Metropolis as well. This argument is not necessarily true. As management pointed out, the fact that QCs have failed elsewhere is not sufficient reason to prevent their introduction in Metropolis, where management believes that they have a good chance of success.

Management maintains that since QCs deal only with quality and QWL issues, and do not venture into areas of joint agreement between management and unions, there was no need to discuss the formation of QCs with the unions. Moreover, management points out that the QCs have a strict 'No-Go' policy concerning the areas covered by the contract of employment. Management disputes the view that the JSCC can solve quality issues, because union representation does not adequately allow many employees to participate in the day-to-day decisions affecting their jobs, whilst QCs allow this to happen.

Although the union officials, as well as the shop stewards, agree with the Griffiths recommendation that quality should be high on the agenda of the health authority, they believe that there are plenty of other avenues for looking at quality issues besides QCs. They argue that if management is able to motivate staff adequately, then quality will follow and there will be no need for QCs. The union officials point out that a lot of QCs have projects in areas that are neglected by management; therefore, employees should not take that responsibility.

Union representatives and shop stewards argued that it was improper to uproot QC from industry and implant it in the health service. Furthermore they pointed out that middle managers' hostility



was due to the fact that top management ordered them to establish QCs and to keep them going rather than to develop them over a period of time. The shop stewards, in particular attributed the lack of progress, stagnation or moribund nature of some QCs to these reasons.

According to the union officials, when employees were enthusiastic about QCs, and were participating, management never bothered to seek their support or representation, but with employees feeling the effect of the recent intensification of work arising from NHS policies, such as rationalization, competitive tendering, and clinical grading, some employees have lost interest, and QCs now face an uphill battle. The staff side view is that management is now seeking its support to legitimize the programme and win more converts. It adds that when employees are always told there is no money to buy new equipment and to improve their own working conditions, the employees are now sceptical as to whether QCs can help to achieve improvements in morale.

One union representative maintains that on QC issues there seems to be an 'us and them' attitude. On QCs all the unions share a common view. There was no significant differences in the views of RCN representatives and the ancillaries' union representatives.

This is probably because the unions in the NHS have some common issues to fight over. For instance, cash limits are biting hard, competitive tendering for ancillary services has affected employees badly, and health service employees are the poorest in terms of pay, particularly the ancillaries. The other sources of dissatisfaction are issues related to the environment: dilapidated buildings, poor amenities, heavy workload set up against an era of financial constraints, as well as critical shortage of staff. QCs are thus seen as the last straw in mitigating problems associated with these. As one union activist summed up:

QCs have been a popular buzz word since Griffiths. However, its method of introduction is suspect. It is a fad which with time will evaporate.

Management, however, does not share this pessimistic view. So far, management is not concerned about the staff side view, since the



trade union movement as a whole is not opposed to QCs in principle. As some of the rank-and-file members have disassociated themselves from the union officials' position, management intends to hold more information sessions to union members to minimize, if not eradicate, their fears.

### Conclusion

This section has provided a brief discussion of the QA and QC programmes in Metropolis. The main assessment of the programme will be undertaken thematically in chapter nine. In spite of the survival of most QCs in Metropolis it is important to explore the reasons for the failure and moribund nature of others. There was some indication from participants that lack of interest or a decline in interest resulted in the failure of some QCs, and the moribund nature of others. Some participants commented that after the initial enthusiasm wears off it becomes increasingly difficult to keep the QCs going. Labour turnover also caused some circles to be disbanded. Since only a small minority (about 25%) of the workforce are involved in QCs it becomes difficult to get staff to volunteer to participate and to replace those who resign or for other reasons leave the health authority.

Another reason for failure or moribund nature of QCs was that circle leaders lacked the time to organize meetings and the circle members lacked time to carry out activities. Other reasons cited included lack of proper training in QC techniques for solving problems, and lack of cooperation from middle management. Some middle managers felt threatened by the QCs; they were afraid that the QCs might erode their power and authority in decision making. Middle managers also found it difficult to accept the idea that lower ranking employees, as QC members, can identify and solve problems which are management prerogative. Senior management, however, assured the middle managers that the QCs are not meant to undermine their authority and they were persuaded to join. Most of those who joined have apparently changed their attitudes, but others are still reluctant to join.



A QC failed in a psychogeriatric ward because the senior staff, mostly nurse managers at the ward, were vehemently opposed to the QC concept. They feared that the QCs would undermine their authority. The failure of the senior management to alleviate these fears resulted in the middle managers effectively discouraging the staff at the ward from participating. In this particular case, management attributed the failure of the QC to the depressive atmosphere in a psychogeriatric ward which dampens enthusiasm for involvement programmes. Although management did not admit its failure to persuade the middle managers as the cause of the QC failure, it did acknowledge that if those middle managers left the ward the QC would probably flourish.

It must be noted that there has so far been no overt resistance from doctors, and in some cases, such as the A&E circle, doctors have participated. This is probably due to the fact that in a declining resource environment doctors are more concerned about quality and will therefore encourage any initiative which encourages quality if it does not interfere, hinder or threaten their own work. This reflects the new thinking whereby quality issues are removed from the domain of particular groups of professionals; quality becomes everyone's business.

Quite apart from the issues mentioned at the beginning of the chapter as being responsible for the introduction of QCs, there were other concerns about the quality of the delivery of services. The DGM thought that health care delivery needed improvement, and the decision was made to involve people in the service delivery to examine what they are doing, and if possible to change their environment, if that would make staff happier and improve patient services. QCs in Metropolis were aimed at achieving customer satisfaction, cost-effective schemes and improved QWL of employees. For instance, the A&E circle is an interesting case which shows staff input to work reorganization; while the O&G case focuses on working-time. Both claim service improvements as well as improvements in employee morale.

In spite of these and other objectives for the introduction of QCs in Metropolis there has not been any systematic attempt to evaluate the programme. The cost-effectiveness of the programme is yet to be evaluated. The cost of implementing or the savings



resulting from individual projects are not even monitored properly, although such costs can be determined fairly easily. It is, however, more difficult to determine the precise contribution of QCs to better provision of health care, or the effects of the programme on improved morale, improvements in employee motivation, or changes in employees attitude to work.

Nevertheless almost all the QCs members interviewed reported improvements in morale and satisfaction as a result of participation in QCs. They also mentioned that the QCs show how lower ranking employees can participate in decisions affecting their work roles and thus in a limited way change things.

Without much hard data to support their claims, management maintains that QCs have achieved benefits in areas such as better standards of care and practice; staff are more involved and better motivated, and have expressed increased job satisfaction. QC members have parties and meetings to socialize with members from other circles, which tends to improve interpersonal relations. The issue as to whether one should disregard these claims of advocates or take them seriously will be discussed in the next chapter.

It is evident, however, that the QA and the QC programmes at Metropolis are strongly supported by senior management. The formulation and implementation of the QA and QC programmes have been the work of senior managers and line managers, but with no input from the personnel department. QCs are seen as an essential aspect of the QA programme and both programmes attempt to achieve a strategic change in service delivery in the organization. As one manager puts it:

We are trying to make QCs part of the culture of the organization. QCs have to be part of the way the organization operates.

Along the same lines, another manager on a steering committee commented:

QCs are a total cultural change. A different way of doing things. It must permeate the whole organization. In order to achieve improvements in quality we need to change the culture of the organization.



The achievement of these objectives has not always been easy, especially in view of the middle management resistance. The steering groups are determined to persuade as many people in the organization as possible to join the QCs. They do not want to leave any group out. The management is planning to hold a conference in the near future for middle managers to discuss quality initiatives and how they affect them and their role in the organization. One manager argued that:

In the QCs we could have started from the top and down and bypass the middle managers but we did not do that. We intended to include everybody. Middle managers are included because we want them to feel part of the group even though they may not be participating. Nobody should be left out.

Another manager also maintained that the QC steering committee would educate the people who harbour doubts about QCs and alleviate their fears. She argues that this is necessary because such people often rebuff initiatives on the part of workers. Moreover, refusal to harness talents in an organization is terrible. She went on to say that resistance to new ideas is not new in the NHS:

NHS culture tends to say no to anything new. It fiercely resists change, it likes traditional hierarchy. This culture is a kingdom for a lot of people, and to attempt to change it, is like attempting to remove the divine right of Kings and replace with a constitution. It is a difficult process which requires commitment.

She stated that the challenge facing the steering committee is to change these attitudes and culture:

To change, educate, persuade, show examples and careful selling of ideas are the tasks of the QCs and their steering committees.

This cultural change is difficult because of the resource constraints, and the trade unions and middle managers resistance to the QC programme.



## CHAPTER 8

QUALITY ASSURANCE AND QUALITY CIRCLES IN COUNTRYSIDE  
HEALTH AUTHORITY

This chapter traces the development of QA and QCs in the second case study authority, Countryside. In contrast to Metropolis, QCs were developed first and the QA strategy came after in Countryside. It was, however, easier to formulate and implement the QA strategy because the QCs had already sensitized the staff to quality issues. As in Metropolis, both QA and QCs can be seen as managerial strategies developed as a response to environmental factors.

This chapter is divided into six sections. In the first, the background characteristics of Countryside are explored. The second section focuses on the evolution of the QC programme and the subsequent development of QA strategy. Having discussed the influence of national and regional strategic priorities on the Metropolis QA strategy, only a brief reference to those issues will be made in this chapter. It is argued that the primary objective of the QCs in Countryside is to improve the quality of patient care by tapping the grassroots for ideas. This section also discusses the Countryside's QA strategy and the shift in emphasis from staff participation to QA initiatives.

The third section addresses the formation and implementation of the QCs in Countryside and explores some of its QC projects. In section four the discussion focuses on the QA structure in Countryside. This is followed by an overview of the relationship between the unions and management on the QC programme. Management's deliberate attempt to by-pass the unions, and the unions' acquiescence in the programme is explored.



### Countryside Health Authority

Countryside Health Authority was created by the 1982 NHS restructuring within a Midlands RHA. It encompasses three Borough Councils, and its catchment area is mostly rural with a few industrial centres. There are four major towns but it also has many unspoilt outlying country villages. Countryside currently serves a population of 173,000 (Countryside, 1988a:2).

The profile of Countryside is a sharp contrast to that of Metropolis. It is located in the heart of England, surrounded by beautiful, rolling countryside -hence the pseudonym. Its location makes it both a pleasant and convenient place to live and work, as it has major transportation links with the rest of the U.K.

Housing, in the form of either modern estates or country cottages, is both plentiful and relatively inexpensive. There are excellent sports and leisure facilities, including a water park for sailing, fishing and swimming; two golf courses; various canals developed for recreational use; and a country park. The major towns also have excellent traffic-free shopping centres. Above all, the area boasts of high educational standards (Ibid, p. 3).

In relative terms Countryside has considerably less social deprivation and poverty than Metropolis; it serves mainly a racially homogeneously (white) population. Although the Conservative government's public expenditure constraint policies have adversely affected Countryside, it gained from the changes in the RAWP system, and it is therefore in much better shape financially than Metropolis. Fewer clinics have been closed in Countryside.

Countryside has its headquarters in one of the major towns and the DHA is divided into two management units: Acute and Community and Mental Health. Community and Mental Health services are based in two hospitals in the South-West of the district, and caters mainly for the adults and children from some neighbouring urban centres. It also has two health centres, nearly a dozen purpose-built clinics, including a child development centre, general practitioners accommodation and other rented premises. These provide a comprehensive community service, including active community nursing services.



In order to make best use of the skills and resources available Countryside has made plans for further development giving special emphasis to community nursing, the elderly, mentally ill and mentally handicapped, and providing a district-based health promotion service. Just as in Metropolis, Countryside has responded to the national priority of caring for the mentally ill and mentally handicapped within the community by establishing two community mental handicapped teams within the unit. Countryside has also responded to the needs of its elderly residents by building a new geriatric ward block, and an associated day hospital.

The acute unit is made up of a district general hospital, a maternity hospital and a children's hospital. These hospitals provide an integrated midwifery service, trauma and orthopaedic, and plastic surgery, in addition to accident and emergency services to the residents of the catchment area. Another hospital in this unit provides in-patient services for child mental illness and mental impairment. Unlike Metropolis, Countryside has relatively new buildings. For instance, the district headquarters is housed in a new building with modern facilities whilst quite a few buildings are under construction. These include a new Pharmacy and X-ray departments as well as a Pathology laboratory. Countryside was chosen as the second case study to contrast with different catchment area of Metropolis and also because of its well-developed QC structure.

Figure 8.1 below outlines the management structure of Countryside Health Authority. As in Metropolis, there is a management group and a board of directors. The board is made up of the DHA members, and the management is the Corporate Management Group (CMG). Just as in Metropolis, the highest decision-making (policy-making) body is the DHA, and its composition and function are similar.

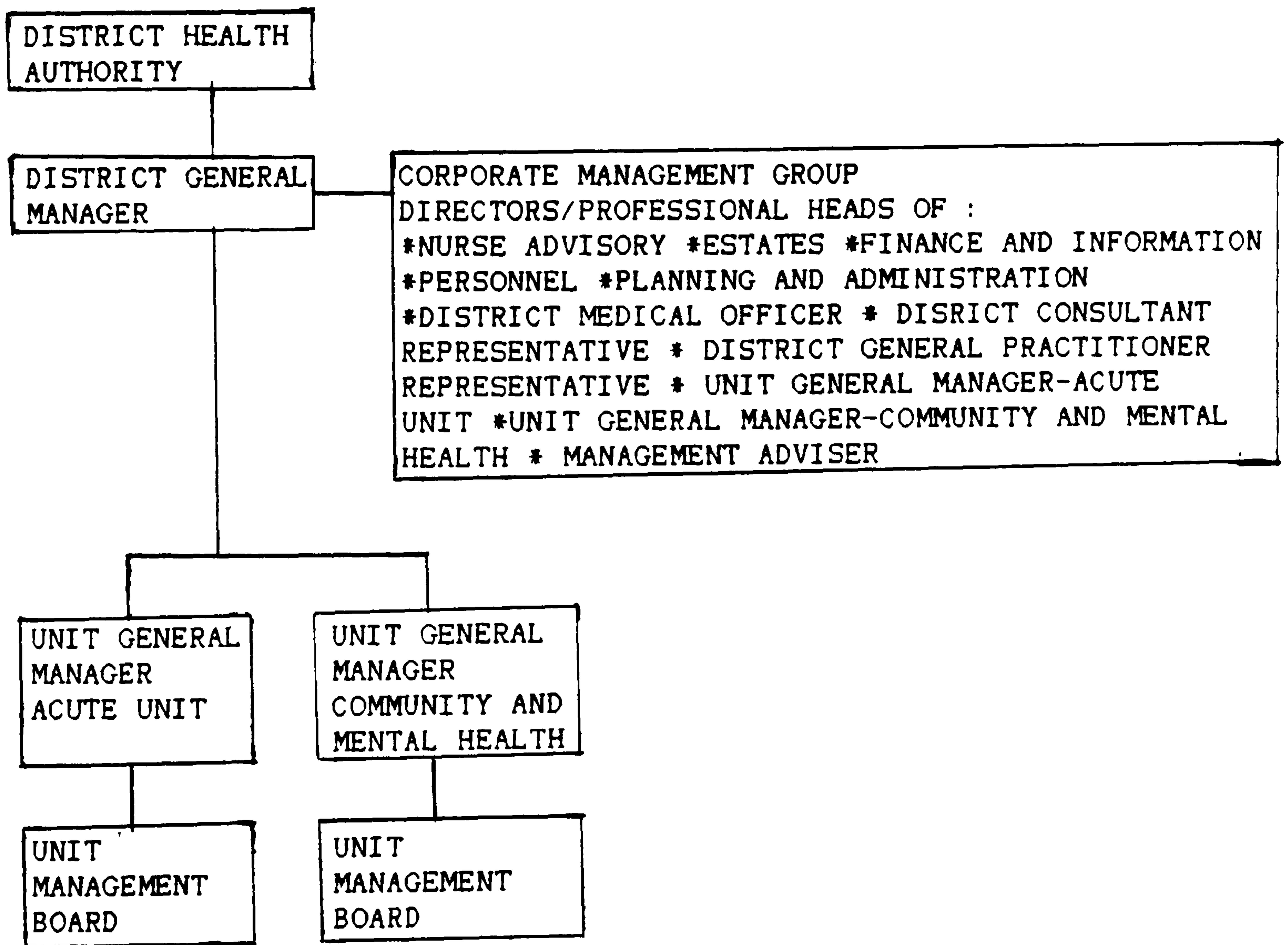
Immediately below the DHA is the DGM, the head of CMG, whose other members include directors of the following areas: finance and information, nurse advisory, planning and administration, estates and personnel. The CMG also includes the district medical officer, the district general practitioners' representative, the district consultants' representative, the general managers of the two units and a management adviser. Each of the two units has a Unit Management



Board headed by the UGM. The composition of the Unit Management Boards are similar to that of Metropolis. There appears to be no major difference in the composition of the boards in the acute units in both DHAs. The district services unit in Metropolis, however, has a personnel department and therefore the unit personnel manager is a member of the unit board, but there is no personnel department in the Community and Mental health unit in Countryside so there is no personnel representation on the unit board.

Figure 8.1

Organizational Structure of Countryside Health Authority.



Decision-making and planning processes are also similar to those of Metropolis. Having thoroughly discussed the decision-making process in the DHAs in both chapters four and seven, it may be prudent to



avoid repetition here. For this reason the discussion will move on to the evolution of the QC strategy in Countryside.

### The Development of Quality Circles.

Countryside is one of the pioneers and leaders in the field of QCs in the health sector in the U.K. The current Chief Nursing Adviser (CNA) played an important role in the development of QCs in the district; indeed he still plays a leading role in the programme.

QCs were introduced in Countryside in the summer of 1983. At the time, the present CNA was employed in the health authority as senior nurse in research and development. He traces the origin of QCs to the 1982 NHS restructuring which was aimed at greater staff involvement and participation in decision-making with regard to work roles. This restructuring resulted in many changes, including more central control, more accountability and more delegated responsibility. These changes compounded those which the earlier reorganization of nursing had brought about.

In view of these changes, senior nurse management wanted to develop new policies, philosophies and management styles. QCs were seen as a means of meeting these challenges and also achieving the objectives of the 1982 restructuring. While the concept of QC was new in the health service at the time, employee participation was not a novel concept. Consultative committees have existed in the NHS since 1948. However, as Hyde (1984; 49) argued, their main function has been that of passing on information about management decisions to employees' representative. Consequently, consultative committee meetings were often seen as post-boxes for management, lacking real value and allowing very little staff participation.

The research officer decided to investigate staff participation in decision-making in Countryside. He started his study with an examination of agenda items on JSCC meetings to find out how many were inspired by staff and how many by management. He discovered with little wonder that the items were 100 per cent inspired by management. He did not consider such overwhelmingly management-led meetings as participation, and therefore sought a better way to encourage active



participation.

At just about the same time, the research officer heard about a QC programme at a neighbouring car factory. He went there on a fact-finding mission to learn more about how QCs operate in industry. He was convinced of the potential benefits of QCs, such as improving the morale of employees, communications, and cooperation between staff and management. He decided to import the idea of QCs from industry, with some modification, to the health services sector.

In the pursuit of this objective, his most difficult task was to convince management that QCs were a good idea, worthy of emulation. In Countryside, the concept was discussed at a senior nurse management meeting. At this initial briefing, some nurse managers were sceptical about the value of QCs, but they were enthusiastic about supporting circles as a means of improving the quality of patient care. The 'doubting Thomases' therefore adopted a 'wait and see' attitude. For those managers who expressed some scepticism about this type of participative plan, their concerns were rooted in a possible loss of power and control. Some nurse managers pointed out at the briefing meetings that the nursing officers' meetings already in existence allowed participation, since everybody involved in any change was informed and allowed an opportunity to make an input. They argued, therefore, that there was no need for QCs in the DHA. As the CNA points out, in reality these meetings rarely encouraged a participative role because they hardly involved the lower ranking employees in decision making. Where lower level employees are involved, the main purpose of these meetings was the passing of information down the hierarchy to the wards.

The research officer's task of selling QCs to management was, however, indirectly made easier by the Griffiths Inquiry's brief on improvements in health care delivery. During this period there was much talk about improvements of quality of care, value for money, QA and so forth. With the wind of change blowing in the NHS, the management could hardly turn down a suggestion to improve the quality of care whilst concurrently improving employee morale and satisfaction.

Moreover, as the effects of the government's fiscal constraint



policies, particularly cash limits, were being felt severely in the NHS, the management was all too happy to embrace any innovative means of tapping employee potential knowledge and talents to cut cost while simultaneously preserving or improving the quality of health care delivery. According to its advocates, QCs have the potential for achieving this objective. Moreover management felt that QCs could encourage involvement and participation of employees in decisions affecting their work roles and consequently improve their morale, satisfaction and QWL. In view of these potential benefits, senior management made a commitment to set up QCs in the summer of 1983.

This commitment was part of the senior nurse management's new philosophy of maximum delegation; that is, giving employees greater responsibility in decisions affecting patients. This was the emergent management strategy on participative management in the organisation. The strategy manifested itself in a bottom-up approach to problem-solving, involving all levels of management so as to achieve the organizational objectives. The QC programme was initially derived from this strategy.

Although the initial decision to implement QCs in Countryside was made in the pre-Griffiths period, the growth and development of circles have occurred most forcefully under Griffiths' proposal for general management. The post-Griffiths period has seen real managerial commitment and support for circles. Whereas the initial decision limited circles to the nursing department, general management has made QCs an organization-wide policy and extended it beyond the wards.

The Griffiths report was published soon after the first QC pilot project was introduced in Countryside; when the Griffiths' restructuring came to Countryside therefore QCs were already in place, at least in pilot form. After reviewing these pilot projects, the new general management decided to continue the QCs policy.

General management showed greater determination and commitment to the QCs; they actually encouraged the further development of the programme. They saw it as essentially a managerial strategy to achieve some QA initiatives and to improve the quality of care in the health authority. In view of these developments, it is appropriate



to conclude that although QCs in Countryside began in the pre-Griffiths era, they have essentially become a post-Griffiths development. Just as is the case in Metropolis, the new managerial (organizational) structure which emerged in Countryside included the role of CNA, who is also the co-ordinator for QA and QCs. These follow the general pattern of the development of the post-Griffiths CNA position. Robinson and Strong (1987:10) show that almost one third of Chief Nurse Advisers in the post-Griffiths NHS now carry the responsibility for some aspect of QA including customer relations.

While no one department in Countryside is responsible for QC developments, QCs are generally nursing-led, and managed by the nursing advising department, which has a definite line of authority to implement and monitor change. The rationale for housing the QCs in the nursing department was that nurses have greater access to information and direct contact with patients. It is interesting to note that these are the same reasons given by those who advocate that QA departments should be placed in the hands of nurses. Although QCs in Countryside were initially concentrated in the area of nursing activities, and therefore involved mostly nurses, now other groups, including consultants, junior doctors, psychologists, and secretaries participate in QCs. With the involvement of other groups besides nurses the circles have gained a multi-professional perspective. Since QCs deal with essentially lower level quality issues, management realized that it was necessary to develop a QA strategy which will determine the overall direction of quality issues in the DHA. The next section pursues this issue.

#### Quality Assurance In Countryside

With Griffiths general management has come some formalized initiatives in QA. These are responses to the pressures emanating from the region to develop specific policy and organizational structure on QA and to integrate this structure into the operational management of the service. The 1983-1993 strategic plan of the Midlands RHA emphasizes the importance of improving the quality of health care delivery. The DHAs are required to develop specific work



on quality issues such as customer/consumer relations with its specific training and education programme; implement specific quality standards; indicate quality implications in short-term development and cost-improvement policies; and build quality into the review process in the district, including unit reviews and IPRs (Midlands RHA, 1987).

In order to meet the region's requirements on quality, the DGM at Countryside developed a strategy paper on QA in 1987. This paper set out the strategic objectives and the values of the district on quality. This stipulates that the DHA is accountable to the public for the quality of service it provides, and is committed to providing a high degree of quality of care which is co-ordinated, integrated and cost-effective. The needs, wishes and dignity of patients/consumers are paramount. Countryside's QA strategy went through the same process of policy formulation described in the preceding chapter regarding Metropolis's QA strategy. The process started with the development of a strategy paper, and this was subsequently developed into a policy paper which has since been accepted by the DHA. The DHA, therefore, has adopted a strategy to monitor, implement and review quality issues.

The strategy paper utilizes Maxwell's (1984) definition of quality. It also highlights measures to ensure that high quality is achieved, and sets and defines standards to measure performance. Following the agreed strategy on quality, a multi-disciplinary group with a member from each unit, led by the chief nursing advisor, has been formed to develop QA in Countryside; in other words, to put QA high on the agenda. Other objectives of the group included stimulating, co-ordinating and monitoring the development of QA programmes in the units, and highlighting areas of improvement.

The group was also to act as a catalyst in raising the level of appreciation in individuals of their contribution to quality of care and services. Moreover, it was given the task of defining quality measures or other ways of setting standards and monitoring effectiveness that can be used in day-to-day issues in the units (Countryside, 1987a:2). Having formulated a strategy on QA it was necessary to provide a structure that allows the DHA to improve overall quality and the attitude of all groups of staff; to develop a



QA process which covers the whole district; and to develop quality standards and measures for use by the health authority (Countryside 1987-90: 1).

The QA service strategy and objectives aim at the best use of available resources to ensure the delivery of an appropriate quantity of care at an acceptable quality. This includes the development of clinical involvement in management of quality so as to improve services to meet patient needs. To achieve these objectives the DHA will try to ensure that it has a well-trained, well motivated and committed workforce. This is essential because all employees are valued for their present and potential contribution to the organization. Countryside thus intends to work towards the development of appropriate staff welfare and development policies, training, management development, and organizational development strategies as a means of managing change within the organization (Countryside, 1988b: 2).

Countryside's corporate objectives, then, essentially spell out the organization's values in terms of QA. The underlying philosophy is that quality should be seen as every employee's business, and for this reason, there is no delegated QA officer. Although the chief nursing advisor performs the co-ordinating role on quality, the DGM has the overall responsibility for policy review and enhancement.

Having developed an overall strategy on QA, senior management felt that there was the need to implement the strategy at the workplace level. In other words, senior management was looking for an effective means for the employees to be involved in quality issues at the workplace. Senior management realized that one of the prime means of achieving this participation is by the use of QCs. Put another way, QCs became one of the operational means through which the organization attempted to achieve its QA strategy.

The link between QA and QC is succinctly described in the Countryside QA strategy as follows:

service quality begins with customer satisfaction which includes internal and external services to patients and staff alike... The Authority therefore has a commitment to QA and was one of the first, if not the first, to implement the concept of QCs (Countryside, 1989: 33).



The QA strategy goes on to mention that:

QCs are one of the methods of improving staff participation and therefore providing a better service for both patients and staff (Ibid. p. 33).

The post-Griffiths period has witnessed an emphasis on QCs as an important aspect of QA. The organization is moving towards a strategy of total quality management through the development of QA, and QCs are seen as a means of achieving this objective.

The relationship between QA and QCs is shown clearly in the structure of QA in Countryside which is reproduced below. The membership and role of the various levels of the structure are explored in the discussion of the steering committee.

Since QCs were already established before the Griffiths restructuring, Countryside had already sensitized its employees to quality issues and therefore the formulation and implementation of the QA strategy went smoothly.

#### The Formation Of Quality Circles.

Senior management instigated the formation of QCs in Countryside. At the inception of the circle programme, senior management prepared a paper explaining the purpose of QCs and gave it to the members. This paper generally suggested that all circles should carefully indicate the nature of the problem that they are to resolve and how the problem is to be resolved and prevented from recurring in the future. The paper also indicated that notes of QC meetings, with suggestions for action, were to be forwarded to senior management to inform them of problems identified so that they could offer help. Management also required that circles demonstrate to them why they had arrived at their chosen solution from possible alternatives.

At the beginning of the programme, management supposedly 'encouraged' staff to volunteer. The research, however, revealed that the request to volunteer was more or less an ultimatum - volunteer or suffer the disappointment of managers. Management was not very blunt



about it, but the message got through to the staff. Thus some QC members were asked to join by management, others by their friends and colleagues, whilst others 'volunteered'. Similarly, some of the circle leaders were asked to volunteer, some were chosen by management and others, especially the senior nurses, emerged from the volunteers to take up the positions. Initially there was little awareness of the circle concept. Just like the members, neither the facilitator nor the leaders had any practical experience in QCs, but all were prepared to devote some time to performing their roles whilst learning it along the way.

Like the sceptical nurse managers, some of the workers thought that QCs were not needed in the Countryside. This was based on the belief that QCs were a management ploy to get them to do the managers' dirty work for them. Some employees also perceived QCs as a managerial strategy aimed at promoting a multi-disciplinary approach to work without paying the commensurate wages. However, management was able to refute such allegations and convinced some of the employees to 'volunteer' to become members of the circle.

Similarly some middle managers were opposed to the QCs. This was partly because they were not involved in the initial discussions. Senior management accepted the idea of QCs proposed by senior nurse managers, and they in turn successfully sold the idea to the lower ranking employees. As a result, middle managers felt extreme pressure from both above and below to get involved in the QCs. The middle managers' resistance to QCs was rooted in their fear of losing their control if QCs were implemented.

Initially middle management did not want to be associated with failure, and believing that QCs would fail, wanted to stay as far away as possible from them. Senior management, however, convinced some of the middle managers of the need for bottom up management. It also partly eliminated the threat middle management felt from the implementation of the circles by involving them in staff education programmes, steering groups and the implementation of the programme. This involvement removed much of the antagonism and outright hostility of the middle managers to the circles. Some of the middle managers therefore joined the circle. With enough 'volunteers', the circles



needed a facilitator to train the leaders and to teach the members about the roles of members, leaders and facilitators.

The nursing researcher -the present CNA -became the first facilitator. Although he had no practical experience of QCs, he had a fairly good understanding of the concept. He also had a good knowledge of the organization, both politically and socially, and therefore decided to perform the role. As the originator of the concept in the health authority, he was committed to the programme. In his capacity as a middle line manager, he was a perfect liaison between management and staff and was able to alleviate some of the fears of the middle managers, who perceived him as one of them.

The facilitator was required to train the leaders of the circles. Using a consultant's manual, he trained the leaders in QC techniques of problem-solving, and subsequently, with the assistance of the facilitator, the leaders in turn trained the members. The training in QC techniques included brainstorming, pareto analysis, fishbone diagram (cause and effect analysis), data collection, data analysis, developing solutions and giving presentations.

Since the facilitator himself was not trained it was later realised that the QC training for both leaders and participants was inadequate. The members received very little training; in some cases, they were not trained at all. Those trained had barely one to two hours of training. This seriously hampered the ability of circles to solve problems, resulting in members using a very limited range of QC techniques. Some participants thus expressed the need for the retraining of all participants to help them solve problems effectively.

The implementation of QCs in the initial period relied solely on internal resources. The view was that members would acquire the skills by practising, ie., through experience. The facilitator -a line manager -was the only person initially involved with the implementation and coordination of the programme. Again, in the initial stages the facilitator helped and guided the QCs in the selection of problems; once a problem was selected they tried to solve it on their own. Sometimes a circle leader, with the support of the facilitator, steered the circle through each problem solution. The



facilitator attended circle meetings and gave the circle leaders feedback on their performance at the meetings; he was involved actively in resolving potential problems. The facilitator was also actively concerned with publicizing the QC programme. As the circles matured, the facilitator's role became less crucial than at the inception because they developed a sense of autonomy. The leaders' role became one of guiding the circles to achieve their tasks, and the facilitator's one of maintaining the circle.

In Countryside, the circles generally meet fortnightly or monthly, during work time, with minutes of proceedings recorded. Management provided resources, such as meeting rooms, notice boards for QC news, flip charts, etc. The following discussion of one project indicates some of the features of QCs in practice.

The CNA indicated that as part of the management objective of improving quality, it was decided that all new senior managers in the DHA should spend some time in the wards as part of their induction training. They were required to report back to the district training officer on a weekly basis. One of the managers on induction training reported some inefficient practices in the mental handicap ward. When the staff at the ward were sensitized to these issues, management offered them a QC as a means of investigating the causes and possibly resolve the problems. The staff at the ward were thus more or less obliged to form a QC. At the inception of this QC the ward had 20 permanent patients comprising of eight men and twelve women. In addition it had two temporary patients. Both hyperactive and physically handicapped patients were placed together in the ward. Two patients were incontinent. Sixteen of the patients attended school from 9 a.m. to 3 p.m. The ward had two wings with a day room and an open dormitory with a bathroom and toilet attached. In all there were four wash basins and four toilets, only one of which was capable of taking wheelchairs. There was a boxed-in bath and a shower closet without a shower. For sleeping purposes the patients were allocated to rooms depending on clinical condition rather than gender.

The staff felt that they were providing the best care possible under the prevailing circumstances. Senior nurse management, however, felt that this level of care was below acceptable standards but could



not hold the staff totally responsible in view of the inadequacy of facilities in the ward. Management, however, felt that there was inefficiency and low staff morale in the ward. The staff at the ward attributed the causes of these problems to management practices and difficulties arising from disciplines other than nursing which contribute to care in the ward. In view of this, the circle co-opted staff from other disciplines who had a shared responsibility for the delivery of care in the ward. The circle membership therefore included a doctor, clinical psychologist, administrative staff, nurses and an employee of the works department.

The QC identified a number of problems in the ward, established their priorities and determined the order in which the problems were to be tackled and resolved. One such problem was the perpetual lateness in preparing the school bound patients for school. Sixteen patients -six men and ten women -were supposed to attend school at 9 a.m. but they were almost always late and arrived at school at 9.30 a.m. The school staff resented this state of affairs.

The QC analysis of the problem showed that two hyperactive women patients had been inappropriately placed in the ward. They were therefore transferred to a more appropriate ward. The number of patients then dropped to 18 and with two incontinents, the staff had to concentrate on the 16 school bound patients in the morning.

It was necessary to bath all the 16 school bound patients before going to school. The ward had 4 day staff and 2 night staff. The day shift began at 7.45 a.m. but the patients breakfast arrived at about the same time. The night shift ended at 8 a.m. Breakfast finished between 8 - 8.15 a.m. and the day staff were left with 45 - 60 minutes to toilet, bath, dress and prepare the 16 patients for school. With this tight schedule each of the 4-day staff had between 10 - 15 minutes to prepare one patient for school. This was inadequate.

The QC members set themselves the task of finding an optimum way to prepare the patients for school. Their research revealed that each staff needed at least 20 minutes to adequately prepare each patient for school. In the light of this finding the QC attempted to find out whether the solution to the problem is to create more time, employ additional staff or both.



After an extensive analysis it was decided that since only two patients were left behind after the rest left for school, it was not necessary to employ even part-time staff. Rather the existing staff decided to resolve the problem by being more flexible with their shift patterns. The day staff decided to take it in turns for one member of staff to come on duty at 7 a.m. and assist the night staff to make an earlier start with breakfasting, bathing, dressing and giving medication to patients. In addition the QC suggested some restructuring in the bathroom. A shower was to be installed in one bathroom and the other bathroom was to be fitted with a shower suitable to the needs of the physically handicapped. Some modifications were also suggested for the dormitories. The objective of these modifications was to make it possible for the sexes to be separated for toileting, bathing and sleeping.

The QC presented its findings to management which approved them. The changes were made by the works department. After a three-month trial period this arrangement was evaluated as successful and therefore management made it permanent. Management did not seek union approval because in their view it did not conflict with the existing agreement as the nurses who arrived 45 minutes earlier left the ward 45 minutes earlier than the shift end period. The restructuring of the bathrooms and the dormitories made it possible to separate the sexes for toileting, bathing and sleeping. The patients therefore now have privacy in these areas. The QC recommendations doubled the time and also the facilities available for bathing. At the same time they provided more efficient and effective means of bathing the patients. The restructuring of the bathroom provided the staff with the means of bathing patients without bending. This frees the staff from the risk of back injury. Management claims that quality of care, staff motivation, morale, satisfaction and participation in decision making have improved (see Johnson and Clarke, 1984 for QC details). This QC has also supposedly improved relations and communications between the staff at the ward and other employees who contribute to care in the ward. As one management official put it, 'it showed us how inadequate our management skills are'. This project gave the stimulus for the growth and development of QCs in the DHA. It is, however, important







6. Postnatally would you have liked to go out for an evening meal and leave us 'holding the baby'

56% answered no  
44% answered yes

After analysing the results of the survey the QC recommended a 'help yourself' type of breakfast. It sought and received the cooperation of the catering department. The circle presented its findings to management which gave the approval for a pilot project. The 'help yourself' breakfast was thus introduced in February 1989 and in April of the same year, the deputy catering manager, attended the QC meeting to give a report on the project. As the report was favourable management decided to make the 'help yourself' breakfast permanent at the ward. A facility for patients to make hot drinks was installed at the ward.

The QC members reported that both staff and patients like it because it is a flexible arrangement which allows the patients to have their breakfast anytime between 6.30 to 9.30. in the morning. The staff now do not have to wake up the patients in the morning for breakfast. The QC members claimed that they derived a lot of satisfaction from their input in work reorganization at the ward. Since these projects the QCs have undertaken various other projects, some of which are mentioned later.

These QC projects raise a number of questions regarding management motive for promoting the circles. Moreover if QCs provide so much benefits to staff, patients and the organization in general then one wonders why the QCs in the mental handicap section collapsed a few years after their formation. These issues will be discussed later, but for now the discussion will focus on Countryside's QC structure which incorporates the QC steering committee.

#### Quality Assurance Structure.

Figure 8.2 below is the current structure of QA and QCs in Countryside. Figure 8.3 is the future structure.



Quality Assurance and Quality Circles Structures in Countryside

Figure 8.2

STAGE ONE

STRUCTURE (QUALITY)

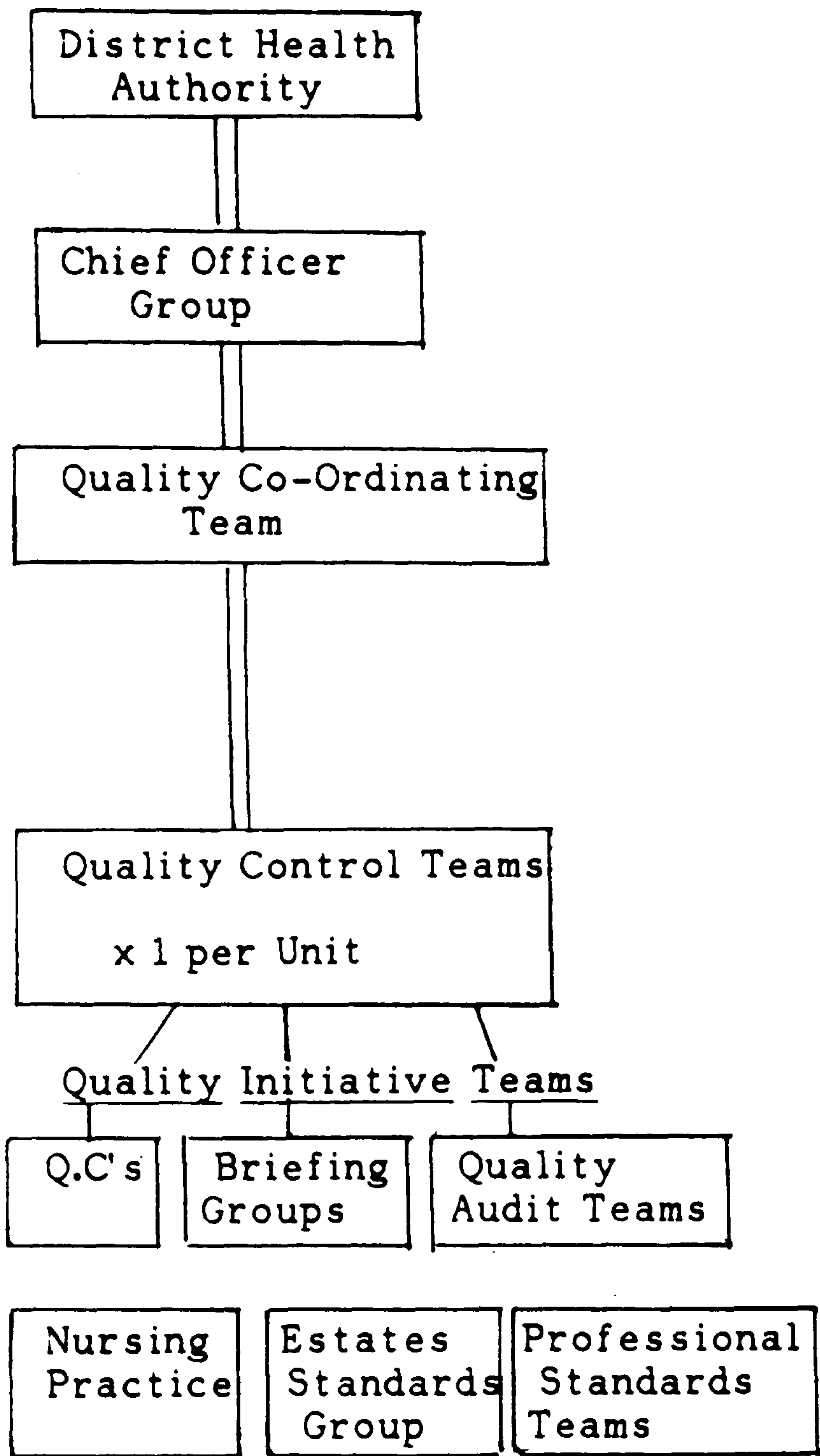
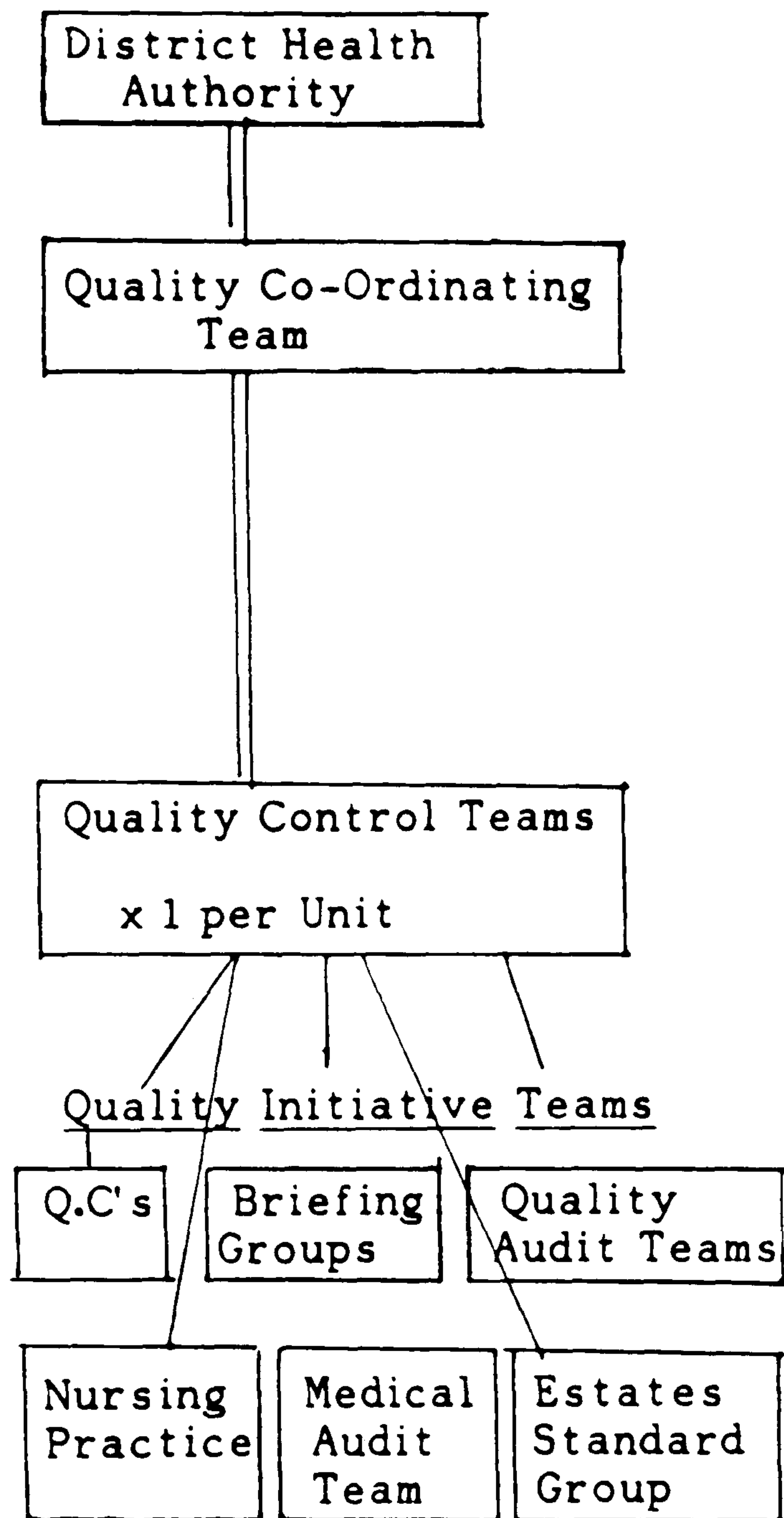


Figure 8.3

STAGE TWO

STRUCTURE (QUALITY)



As figure 8.1 shows, the apex of the structure is the DHA which comprises of the health authority members. Here the DHA's role is to monitor the delivery of care, evaluate progress towards improving health care delivery and monitor customer/ consumer satisfaction.



Directly below the DHA is the Chief Officer Group. This group is made up of the DGM, UGMs CNA and Medical representatives etc. They set the overall objectives of health care, set standards and come up with the process for monitoring the achievement of objectives, standards and service. This group reports to the DHA. Further down the hierarchy is the Quality Co-ordinating Team. This comprises of the CNA, Director of Estate, Unit QA Officers, Medics, ad hoc members and appropriate experts. Their duty is to monitor and evaluate systems used to measure quality and achievement of standards, and to support service areas in maintaining standards. They are also required to implement quality improvement initiatives and to monitor and evaluate them, and to undertake quality inspection and report to the Chief Officer Group.

Directly below the Quality Co-ordinating Team are the Quality Control Teams. These are in fact the steering committees for the Quality Initiatives Teams. There is one in each unit. Each team is made up of Unit QA officers, department heads, finance officers, personnel officers (if there is a personnel department in the unit), QC members, leaders and facilitators. They are thus made up of cross-sections of the organization's workforce. The Quality Control Teams oversee the activities of the QCs, briefing groups and Quality Audit Teams. These Quality Initiative Teams therefore come under the Quality Control Teams. At the bottom of the structure are: Nursing Practice Group; Estates Standards Group and; Professional Standards Teams. The last set of teams are not at the moment linked to the Quality Control Teams but they are expected to be linked by 1990/91. At the time of the research, only the QCs were fully in place but management was developing the Briefing groups and Quality Audit Teams. Like the QCs, the members of these groups will comprise mostly staff at the local workplace and local management. The QC, in management view, is a bottom-up approach to problem solving. The briefing groups are expected to be both bottom up and top down approaches; that is, they will work essentially like a QC but can be directed by management to solve some specific problems. The Quality Audit Teams are essentially a top down approach. Middle and junior managers will lead teams to improve quality.



The QA structure in Countryside, at the time of the research was still evolving and it is expected that by 1990-91 a new structure, will be in place -Figure 8.3. The essential differences between Figure 8.2 and Figure 8.3 are that the Chief Officer group will be dissolved and the bottom level of the QA hierarchy will be linked to the Quality Control Teams.

The QC structure evolved along with the circles. In the early stages there was no steering committee as management was content with the QC's position under nurse management. Recognizing the need for better co-ordination, however, three QC steering committees, one in each unit, and the other at district headquarters were formed. The steering committees were later reorganized and given the name -Quality Control Teams. They are intended to provide strategic direction and support for the QCs' activities. Furthermore they are charged with the responsibility of developing and encouraging QCs. Other duties of the Quality Control Teams include: developing systems for setting standards and measuring quality; to implement standards and quality initiatives; to monitor change and report to UGM. Each Quality Control Team meets about once every month. In their meetings they discuss the progress of the various QCs in each unit. They also discuss forthcoming presentations to management, the problems the QCs have resolved and their recommendations for implementation.

In 1989 there were 13 circles in total - 8 in the Acute unit, 1 at the district headquarters, 2 at the Community Unit. These were the active circles. There were 2 circles in the Community unit which were moribund. Also the QC programme in the community unit was undergoing some restructuring because about 4 failed altogether. The QC members formed about 15-20% of the workforce. As indicated earlier several tasks have been completed, with others still in progress.

The Countryside programme has a policy of not financially rewarding the circle members for their effort. Rather, the Quality Control Teams hold that the satisfaction from problem solving should be sufficient reward. The Quality Control Teams also organize study days on QCs and invite people from within and outside the health authority to attend. Each participant from outside the health authority is charged £50. On a recent study day, there were as many



as 200 participants, of whom half were fee-paying delegates. The revenue generated from these study days are ploughed back into QCs. QC members can use some of the money for trips or conferences on QC, or for visits to organizations with QCs. Some of the money is also set aside to provide gifts (e.g. pens with 'Countryside QC' written on them) to the members and non-members alike. The QCs are financed with these self-generated revenue, as they have no allocation in the health authority's budget. Money generated by QCs is also used for the implementation of QC recommendations. Recently a management consultant has been hired by Countryside to help develop the QC programme. This consultant is paid partly from such self-generated income.

#### Union-Management Relations.

It is interesting to note that the unions have played no major role in the QCs programme at Countryside. At the inception of the QCs, management did not invite the formal participation of the unions. The unions had merely been informed that their membership was certainly welcome to participate. Management claims that since QCs are given clear guidelines regarding 'no-go' areas, it is appropriate not to invite the unions. In view of this, management is trying to stay clear of areas that might conflict with union objectives, such as collective bargaining issues. Asked why unions were not invited to participate, one management official replied:

Why worry about unions... You create a problem when you officially invite their views on QCs.

He went on to give a commentary on the problems that unions can create. Coming from a nursing background, and recalling the days when the matron was responsible for most personnel issues in the health service, he commented that:

There was no problem in industrial relations and personnel management in the health service until personnel officers were appointed in the NHS.



He implied that the emergence of PM in the NHS has to some extent produced a 'they and us' attitude in IR because personnel managers look for IR problems even when they do not exist.

The unions are not worried about their lack of formal participation in the QCs. The staff side view is that they would have liked to be consulted on the QC programme before it was implemented in Countryside, but that did not happen. In spite of this, the union officials have neither approached management to participate nor opposed the QC programme. They maintain that union members are free to participate in the QCs if they want. The union representatives argue that so long as the QCs do not conflict with union objectives, they are fine. In practice, QCs for the most part have concentrated on nursing issues at the ward level. These issues fall in the area of the RCN, and the RCN sees improvement in quality as a valuable exercise and therefore has no problem with the QCs concept. However, as the circles spread to non-nursing areas, there could be potential problems with the unions.

The director of PM explained that the staff side has not reacted adversely to the QC idea because Countryside is a robust district in terms of IR and employee relations. He pointed out that since Countryside is predominantly rural, IR tends to assume a lower profile than in a conurbation, where employees are more likely to take aggressive positions on IR issues. He maintains that in Countryside there are a few IR problems, most of which are resolved at the unit level. These views were confirmed by the union representatives, shop stewards and other management personnel who were interviewed.

The director of PM, however, cautioned that less conflict (both organized and unorganized) in Countryside does not necessarily mean that employees are happier than their colleagues in other DHAs with relatively higher labour conflict. He argues that it is too easy to say that less or no conflict implies a cosy IR relationship. Although employee relations and IR in Countryside are better than average in the NHS, management believes that the QWL and motivation of employees can still be improved. It is partly for this reason that QCs have been introduced. If there is a harmonious labour-management relationship in Countryside then one wonders why there is the need to



introduce QCs. In such a relatively cordial labour-management relations, management motives for introducing QCs become suspect. This issue is examined more fully in the next chapter.

### Conclusion

This is a rather brief discussion of the QA and QC programme in Countryside as chapter nine deals with a more critical assessment and comparison of the programmes in the two case-studies. This chapter has dealt with the origins of QA and QCs, the reasons for their establishment, their characteristics and two QC projects in Countryside. It has shown the links between QA and QCs and argued that both strategies have been considerably influenced by national and regional strategic priorities. For instance, the Midlands RHA's 1983-1993 strategic plan emphasized quality enhancement in service delivery. Following the RHA, Countryside has agreed specific policy statements on the philosophy of the district on quality. Countryside sees quality improvement as its prime objective and for this reason it is planning to include QA in IPRs for qualified staff. The need to examine quality of service is being included in job descriptions. It holds seminars and study days on QA and QCs and training programmes have been designed. These include a district facilitator course designed to enable identified staff to facilitate QCs effectively. Moreover a management consultant has been hired to help in the further development of QCs. QA is now part of most internal management training courses.

The QCs have been developed with the objective of improving staff participation and to provide a better service for both staff and patients. In view of this Countryside is attempting to build quality into most review processes, with units and individuals being measured against targets and performance indicators. Quality is also incorporated into the annual unit review. This includes discussions about complaints, workloads, QA and QCs. In spite of these attempts by Countryside the measures used for these evaluations are subjective rather than a systematically developed objective evaluation system.

As indicated earlier, the QCs in the Mental Handicap section in



Countryside collapsed entirely and have only recently been revived. It is during the post-Griffiths period that QCs in Countryside have received the most support. As the chief nursing adviser put it:

QCs at the mental handicap unit hibernated for a while but under general management, outside facilitators were brought in to revive it... General management has put its weight behind the circles and are prepared to spend money on them.

While the circles at the acute unit have been running relatively smoothly, those at the mental handicap unit have not been that successful. Some circles stopped meeting because there was no time or there were staff shortages, as a result of competitive tendering and job losses. Ironically, QCs had been encouraged by management to mitigate some of these problems. There was also a lack of enthusiasm for QCs by staff who were ordered by management to form circles. Furthermore, with the cutbacks and financial constraints, some of the circles' recommendations requiring substantial additional resources were not implemented by management. Members of the QCs interpreted this as a lack of management commitment; consequently, morale fell and enthusiasm was dampened. Others attribute the pitfalls in the QC programme to the lack of initial training.

Since the revival of the QCs, however, circles have tackled projects with little cost implication because of past experience. This tactic seems to have paid-off because management now implements all circle recommendations either fully or partially. For this reason, the circle members see their managers as supportive of their activities. This creates an atmosphere of cordial relations between management and staff.

In spite of these developments, the Countryside QC programme, like its counterpart in Metropolis, seem to be facing many problems. For instance, management efforts to develop more QC in the Community unit have resulted in the development of only two active QC. Management claims that its attempts to revive the circles in this unit are still in progress and with time will be able to develop more circles. They attribute the lack of success in this unit to restructuring which affected QC members and leaders. Some of these



people's job roles changed and they lost interest in the QCs. Other reasons include hospital closures and amalgamations which resulted in a lot of anxiety on the staff's part and consequently loss of interest in the QCs. Job losses have also resulted in loss of interest in QCs. Other staff members claimed that they solved all their immediate problems, at least those within their control, and there were no more problems that the QC could resolve. It appears that both Metropolis and Countryside face the same problem of getting more staff interested in the QCs. Although there has been no overt opposition from doctors to the QCs in Countryside, some middle managers have resisted the programme.

In spite of these difficulties both QC members and management reported that the QCs have resulted in improvements in staff morale, and increased employees' involvement in decision-making. Both QC projects discussed in this chapter show employees input to work reorganization. The QCs have improved working conditions and health care delivery. In the view of management the QC projects have resulted in increased efficiency and effectiveness. For instance QC projects have resulted in complete re-signposting of the units, improved complaints response process, upgrading of patient reception and waiting areas and the creation of garden areas in hospital grounds.

Senior management and line managers have strongly supported the development of QA and QCs in Countryside. The personnel department has played only a minor, perhaps negligible role, in the formation and implementation of the QA and QC programmes. QCs are part of the broader objective to achieve a strategic change in service delivery. The QA and QC programmes are attempts to make quality consciousness a significant aspect of the culture of the organization. The question as to how successful management has been in achieving this objective will be addressed later.



## CHAPTER 9

A COMPARISON OF THE QUALITY ASSURANCE AND QUALITY CIRCLE PROGRAMMES IN THE TWO CASE STUDIES.

This chapter compares and assesses the Metropolis and Countryside QA and QC programmes. It is divided into two sections. The first is a discussion of the need to evaluate the QA and QC programmes, and the emphasis is on QCs. The second section addresses management's main motives and objectives for introducing the QA and QCs. This is followed by a discussion of management style in handling labour-management relations. The final section is the summary and conclusions.

Evaluation of the Quality Assurance and Quality Circle Programmes

There is apparently no consensus in the literature on the need to evaluate QCs. Those opposed to any formal evaluation argue that since QCs are mainly for 'people-building', any attempt to evaluate their performance might undermine the trust and confidence being built up between circles and management (Sherwood et al. 1985:27). An evaluation which emphasizes cost-savings as a criterion of success, for example, could give the QC members the impression that management is mainly interested in the QC programme so long as it is able to cut costs.

This argument, however, ignores the fact that QCs often have multiple objectives (i.e., the 'soft' and 'hard' versions), which include quality control, the desire to increase participation and communication, increase productivity, improve morale and QWL. Therefore even if it is not appropriate to evaluate a QCs' cost savings it is essential to evaluate the other benefits attributed to it by the QC advocates.

Following the latter view point, Sherwood et al. (p. 27) point



out that it is mandatory to evaluate a QC programme. They argue that decisions that are made to continue the QCs, to introduce more circles, or even to introduce QCs in the first place are based, at least to some extent, on an evaluation of their potential or actual effects. If we accept this view, then, the question arises as to what form the evaluation should take. Should evaluation be an informal or intuitive exercise, based on casual observations and subjective judgements or should it be based on some kind of quantifiable measures?

While intuitive measures of evaluation, such as the number of years a QC has survived, can indicate some degree of success (Cox 1981, Metz 1981) it does not indicate why the QC is still functioning or its value to the organization, although it may indicate the motivation and ability of circle members to sustain the programme. Consequently, while these subjective and informal measures may be an insufficient determinant of QC success or insufficient measures of evaluation, they cannot be dismissed outright. Often these informal measures can be useful even though they can also be superficial, distorting and misleading.

This being the case, some measure of systematic and formal evaluation of QC is needed. Arguing along these lines, Sokol and Hurwitz (1982) maintain that there is the need for a planned and systematic evaluation of circles to provide convincing evidence of their effectiveness. Moreover, such an evaluation can indicate the conditions under which circles may succeed or fail (Dale and Barlow 1984:25). Quite logically therefore, Dewer (1980) and Goodman (1982), point out that in the absence of a systematic evaluation and feedback mechanism, QCs are more likely to fail.

While the usefulness of formal and systematic evaluation of QCs cannot be denied, its desirability in theory is not always matched by practicability; it is often difficult to carry out in practice. In Cox's view systematic objective evaluation is impossible because, whilst cost-savings can be measured, changes in attitude can only be assessed subjectively. Similarly the measurement and evaluation of quality in health care is a difficult task, as chapter six showed if we accept the definition of QA as the process of assessing the quality



of health care, with the aim of improving it, then it presupposes that there are established criteria for carrying out this sort of assessment. This brings us to the question: how are these views illustrated by the practice observed in the case-study DHAs?

In both cases, no formal, systematic and objective evaluation mechanism exists either for the QA or QC programmes. Although the Countryside QC programme was evaluated in 1985 by an external agency there has been no attempt to internally evaluate the programme. At the time of the fieldwork research, Countryside was negotiating with a new external agency to evaluate their QC programme sometime in late 1990. Likewise, Metropolis has not made any attempt to evaluate its programme.

Asked why there are no internal evaluation and feedback mechanism, managers from both DHAs mentioned that since QCs are an integral part of QA programme they are now in the process of developing evaluation methods for QA which can then be used to evaluate the QCs. This means that although the QA and QC programmes have been able to identify quality related problems, identified corrective and planned actions, they critically lack monitoring and evaluation of the corrective actions. The absence of the evaluation criteria seriously undermines QA and QCs as strategic initiatives and makes management motives for introducing both the QA and QCs suspect.

Evidence gathered on the QC programmes relied on members' and managers' subjective and informal assessment. In Countryside, for instance, the CNA mentioned that QCs generally have had some achievements in the health authority. These achievements include improvements in the quality of care and in the working environment; in service provisions, including improvements in the quality and presentation of patients' meals; and improvements in staff duty rosters.

Other improvements mentioned include the emergence of leaders with management potential or leadership skills (that is, circle leaders have developed chairmanship, decision-making and problem-solving skills) and the fact that staff at all levels of the hierarchy have a greater say in decisions affecting their work. Thus staff are now more willing to participate in decision-making. There have also



been cost savings, mainly as a result of a more efficient use of resources. QCs participants and leaders claimed improvements in staff morale and an increase in job satisfaction since the inception of QCs. It is also claimed that QCs have helped define areas of responsibility and that this has reduced the need for senior management to deal with day-to-day problems at the workplace; therefore, management can devote more time to planning and policy formulation.

The CNA also mentioned that it is not uncommon for nurses to call him for help in a research problem because of the open atmosphere generated by the QCs. Other supposed benefits of the Countryside QC programme indicated by managers and members include greater emphasis on team work, and better development of the individual. Similar benefits were reported by QC members and managers in the Metropolis case-study.

In both case studies, members of QCs reported improvements in both intra-group and inter-group (between QCs and non-QC members) communications as well as between management and staff. Moreover management commitment and support for the circles, regular management attendance at QC presentations help to boost the morale of participants.

These views on supposed benefits cannot be uncritically accepted given their speculative and impressionistic nature, as well as the problems facing the QCs outlined in chapters seven and eight. For instance, neither DHA could quantify any change in communication, motivation, morale, turnover, absenteeism or satisfaction. Some managers were rather less euphoric about QCs. One senior manager in Countryside who has been involved in QCs was of the view that some line managers tend to overstate the achievement of the circles, because they have not achieved any significant strategic impact on the organization. In fact the QC programme has only barely been able to sustain itself. He points to evidence in the mental handicap section QCs to support his assertions. As was indicated in chapter seven, the QC programme in Metropolis is struggling for survival. It has been very difficult to sustain some of the circles.



Management Motives and Objectives.

A discussion of management motives and objectives for introducing the QA and QCs requires a reference to the factors discussed in chapter six, particularly the 'hard' and 'soft' versions of QCs and the traditional (professional) verses radical (managerialist) views of QA. It was argued that QA has emerged from the radical (managerialist) perspective. In other words, it is a realization of the need to deal with quality from a managerialist perspective. According to this perspective, quality should no longer be the prerogative of professionals; it should be every employees business. This perspective emphasizes the quality control aspect of QA.

The emergence of QA and QCs have been influenced by many factors, especially the need to achieve efficiency and effectiveness in health care delivery in the face of rising costs and public expenditure constraints. Others are the pressure from the consumer advocacy movement, the role of the government in encouraging private sector initiatives in the public sector and, the Griffiths report's emphasis on quality. If QCs are the operational means for translating quality consciousness and, for that matter, the QA strategy in practical terms then it implies a link between QA and the 'hard' version of QCs.

The evaluation of QCs in the health care sector then should be considered in reference to the 'soft' and 'hard' notions of QCs. The 'soft' version argues that QCs fulfil the role of change agents (Tynan 1980) and form an integral part of a QWL programmes. As Russell (1983) points out, in appropriate applications QCs can be part of, or an introduction to, a broader long-term strategy for change. Since the QC concept is compatible with QWL philosophy it can be an integral part of wider QWL approach to organizational change. The general objective of QWL programmes is to arrange organizations' work procedures and jobs for the maximum deployment of individual talents and skills in order to create more challenging and satisfying work and so improve organizational effectiveness. According to this view therefore, QCs are regarded as contributing to the quality of work as a whole, rather than that of a particular service.

In both DHAs, however, QCs were not introduced for this reason.



The research revealed that in both DHAs QCs were introduced primarily to improve the quality of health care delivery and, if possible, cut cost. Any desire by management to improve employee morale, participation, satisfaction and QWL was secondary to the prime objective. In both case-study DHAs, the initial impetus to introduce circles came from senior managers who had an interest in quality. This is perhaps typical of developments in the health care sector. For instance, Johnson (1984:51) in analysing the evolution of a QC programme in the health care sector in the U.K. mentions that:

Senior nurse management wanted every layer of the organization to work together as a team to improve quality of service.

Almost all the literature on QCs in the NHS (see Lees and Dale 1986, Hyde 1984, Johnson and Clarke 1984, NHS Management Bulletin 1988) emphasize that QCs are essentially a managerial strategy to improve the quality of health care.

Both the Metropolis and Countryside programmes support this view. In the interviews, there was prominent emphasis on improving the quality of health services. In other words the primary initial objective of the QCs was that of improving the quality of patient care. QCs were seen as part of a management philosophy which allows staff to be involved in patient care and to participate in deciding how to improve this care. In both organizations, management emphasized these objectives for introducing QCs. In addition they felt that QCs could potentially encourage employee participation and involvement in the organization and allow them to develop their roles and improve QWL. The CNA in Countryside for instance mentioned that:

QCs are seen as a means to an end, improved patient care and not just a concept in itself.

This implies that the objective of improving employee QWL is secondary to the primary objective of improving quality. It is evident from the case studies that the introduction of the QCs was motivated by the benefits of the 'hard' version, but management pays lip service to the 'soft' version. The hard version is predominantly concerned



about quality issues and the benefits that the organization, rather than the employees, will benefit from the QCs. The 'soft' version is a combination of (i.e. a balance between) an interest in quality and improvement in employees QWL. In the case of the latter, organizations adopt QCs for organizational (economic) as well as employees benefits. That is, the objective of improving quality is at least as important as responding to employees' concerns.

In the case studies, however, the balance has shifted in favour of organizational benefits; that is, in terms of improvements in quality and economic benefits rather than employee benefit. This is hardly surprising in view of the efforts of both organizations to link the QA with the QCs. If QA emphasizes quality control it is perhaps obvious that the QCs would also emphasize the improvement of quality rather than employees' QWL. Although a few QC projects have focussed on work reorganization, this has been done at an essentially low level in the organization. It is not a major attempt by the DHAs to use the QCs to reorganize work in the organization. As the QCs are not aimed mainly at work reorganization it can be argued that they do not really meet the criteria of QCs as a means of redesigning work to ensure either employees satisfaction or the maximum utilization of individual talents.

The development of QCs in the health care sector has been influenced greatly by the need to cut costs. Evidence from the two case-studies indicates that QCs have assumed some importance, as the DHAs are faced with dwindling financial resources, pressures from consumers as well as from the government to improve quality, whilst simultaneously cutting cost. In the face of such pressures both DHAs saw QA and QCs as a means safeguarding quality in an era of rigid financial constraints.

The objective of using QCs to cut cost should be understood in relation to the government's policy of public expenditure constraints. In Metropolis the acute financial problems of the district led to finance-led planning. It also called for a strategy which economizes as much as possible and which makes the most effective use of resources. For example, at the height of its QC programme, Metropolis's overall financial allocation had been reduced by



£609,000. This reduced allocation was caused by regionally imposed efficiency savings and underfunding of the 1986/87 pay awards (Metropolis, 1987b:19). The authority's overspending for the year 1987/88 was between £1.5 to £1.8 million and the 1988/89 deficit was around £873.00. In view of these financial difficulties, Metropolis imposed stringent measures to avoid over-spending. Its prime task for 1989/91 therefore was to achieve cost improvement in services. Failure to achieve this would require service reduction to meet the reduced levels of resources. Since service reductions are unpopular the district has concentrated on cost improvements. QA and QCs are therefore seen essentially as a means of holding the line on cost. It is therefore not surprising that QCs in Metropolis have also refrained from making suggestions which have huge expenditure outlays. Quite obviously they cannot be implemented.

While the financial situation of Countryside is not as bleak as that of Metropolis, the authority nevertheless experienced an overspending of £486,000 in 1987/88 (Countryside 1988c:27). Just as in Metropolis, major sources of cost improvement have already been considered and implemented and thus, continual reductions and cost improvements are becoming increasingly difficult. QCs are clearly seen as an indirect means of reducing cost. Again this explains why the QCs have refrained from making suggestions which involve substantial expenditure. It appears that QCs are a desperate attempt to safeguard quality while cutting costs. This conclusion can be supported by examining the manner in which QCs were introduced in both case-study DHAs.

Management consultants typically recommend that membership in QCs should be voluntary, since this assures the employees that the programme is not being imposed on them by management, and workers will not feel trapped or coerced. Employees desiring to be members should thus nominate themselves. Contrary to this recommendation, in both case-study DHAs, QCs were imposed on the staff. The official version of the formation of QCs at Metropolis maintains that QC are formed voluntarily by a group of employees. When a group wants to set up a QC, it informs the Assistant Director of QA, who then helps them to set it up. It is suggested that staff voluntarily join the circles and



some volunteer to become leaders and facilitators.

The interviews revealed a somewhat contradictory account. For instance, when one group of QC members were asked why they decided to form a circle they unanimously, almost in unison, answered 'we had no choice; there was too much pressure coming from management'. When asked to explain what they meant, they answered that there were too many memos coming from management urging them to form a circle. This point was repeated by other groups that were interviewed.

This is true of Countryside as well. In Countryside management gave a rather blunt ultimatum to employees to form QCs in areas where management had chosen to introduce circles (areas with persistent quality and inefficiency problems). A senior nurse manager partly responsible for introducing QCs indicated that at the beginning management just said to her 'go and introduce a circle'. This tendency was quite strong on the part of management. Moreover management's desire to scrutinize QC proposals, and influence the choice of problems to be investigated, means that the QCs are not free to undertake every kind of project. According to this perspective, projects chosen to investigate must correspond with the organizational objectives.

It is therefore no wonder that in both DHAs projects undertaken so far have emphasized improvements in organizational performance with little consideration for employee QWL. In Metropolis, for instance, such projects aim to reduce waiting time, improve or supplement inadequate health education, and improve patient care. Similarly in Countryside, one QC investigated the establishment of a creche to enable more women who have had family break to return to work, and another investigated the effects of the mobile truck shop which takes patients around the wards. Another project concentrated on effects of the installation of an extractor fan. An Orthopaedic QC worked on recreational facilities for patients. The medical QC studied the effects of notices to patients' relatives and friends about nightwear. A surgical ward QC monitored the supply of sterile materials in the ward areas. Another QC is working on the development of a quality audit system to measure the quality of care to elderly patients. One QC project resulted in a re-decoration and improvement to fittings in



rest rooms in a ward. Another ward used a QC as a tool to facilitate QA within the School of Nursing. Yet another QC looked into the availability of resources and equipment for both patient use and staff training and learning needs. Such projects rarely benefit the staff directly, but they fulfil management's objective of improving the quality of health care delivery. The success of such projects therefore satisfies management self-interest, or at the very least, it gives the appearance that management is concerned about quality as well as the participation of staff in decisions affecting their work.

Yet more evidence of management's determination to achieve its objective can be discerned from the role of the facilitators and the steering committees. The organizational structure in both DHAs have included QA and oversight of the QC programmes was given in both cases to senior managers responsible for nursing and QA. Management choose the initial facilitators who obviously projected the management point of view. Often the facilitator also plays an intermediary role between QCs and steering committees which have the general responsibility for the QCs (IDS 352, 1985:18). In this respect the facilitators are able to influence projects which are of interest to management.

As Wine and Baird (p. 6) argue, the facilitator is probably the single most important person in the programme, since he/she coordinates the activities of individual circles with one another and with the rest of the organization. The facilitator also assists each circle in obtaining the information and resources it needs to complete its projects, and attends initial circle meetings to ensure that the activities are proceeding well. Quite apart from this monitoring, the facilitator also plays a key role in overcoming employee and management resistance to the QCs and often helps workers get their ideas past hostile supervisors.

In both organizations, the steering committees' membership comprised senior managers, particularly those concerned with quality. Similarly, in both organizations, management made an all out attempt to control middle management resistance and negative attitudes. In fact, in both organizations, senior managers have used the powers at their disposal to win most of the middle managers to their side; the



non-believers have refrained from causing any problems. For the managers who are still reluctant to join the circles, management is planning to overcome the problem with educational campaigns. Senior managers were not very much concerned about, middle management resistance hoping that it was a temporary phenomenon which will be overcome in due course. In both organizations, senior managers showed strong commitment to the programmes. The interviews and the literature on QCs revealed that the prerequisite for success is management commitment. Both QC members and management officials warned about the dangers of management paying lip service to the QCs without real commitment. One management official commented that:

Without management commitment the circles will die. Workers will say why worry about them. Nobody cares about them anyway. Management support makes them grow stronger.

In both case-study DHAs senior management personnel have shown up at circle presentations to listen and offer advice if needed. Senior management recognizes that the survival of the QC programme depends to a great extent on its commitment and support. This management commitment to ensure the survival of the QCs has influenced labour-management relations in both case studies.

#### Management Style in Labour-Management Relations.

An important issue which has been highlighted in the case studies concerns management and union views regarding the introduction of the QCs. In both case studies the unions' role in the QCs have been minimal. In Metropolis the unions have adopted a tough stand against the QCs but in Countryside there has been very little opposition. In both case-study DHAs the senior management are not very concerned about the non-participation of the union representatives in the QC programme. Although none of the managers interviewed regarded the QCs as a counterforce to the unions, they nevertheless indicated that the QCs could potentially improve labour-management relations and communications, and such an improvement could, in turn, lead to greater acceptance of managerial decisions by employees. Management



conceded that this was a secondary consideration in the introduction of the QCs; that was why they did not actively seek the unions formal participation.

This raises a number of issues; for instance, if management was genuinely interested in improving labour-management relations and communications then why were the unions by-passed? Evidence from Countryside indicates that management already enjoys relatively good relations with the staff side, so management's desire to by-pass the unions leaves some room to doubt the sincerity of their intentions to improve the QWL of employees. In Countryside union officials raised the issue that if management admits that the consultative process is working well then why the need for QCs if they are not fulfilling managerial interest? Managers argued that the consultative committees are rather too formal and do not allow individual employee participation. They are therefore interested in developing a different form of participation, one which presumably allows the individual to contribute to decision making at the workplace level. QCs are, thus, an attraction for managers but a source of anxiety for unions because they challenge the established form of consultation. Management can consciously or unconsciously use QCs as an alternative to the established formal consultation process; for instance, management used QC projects to alter working hours without consulting the unions. Under the guise of the 'no-go' areas of policy, management uses the QCs to legitimize changes in areas where they should properly consult the unions. The alteration of the working hours could in fact be negotiated with the unions, so the 'no-go' policy cannot be sustained in all situations. The approach of the management of both organizations to the QCs reaffirms the union officials' belief that even if QCs cannot be considered anti-union they certainly have anti-union undertones. That is, they were introduced to undermine or water-down union influence. In spite of this conviction, the staff sides claim not to be threatened by the QCs which they see as management fad which will soon evaporate. Whether or not this will happen is a subject of considerable debate which will be explored in the concluding chapter.

The determination and commitment of management in both case-study DHAs to ensure the success of the programme confirms the union



officials conviction that in an era of tight finances management has intensified its activities in the QCs to enable staff take responsibility for quality; as the union activists' see it, to 'do management's dirty work for them'. Similarly it also confirms the union representatives' belief that management is keen on pushing QCs because they fulfil management's interest and objectives, otherwise they would not have introduced a system which involves approximately 30 per cent of the employees (workforce). Furthermore, they argue that the QCs are in management's interest that is why they have committed money and resources (however, little they may be) to them. For instance, in Countryside management has recently hired a management consultant who is partly paid from the DHA's resources to rejuvenate the QCs in the community unit and further develop the whole QC programme in the DHA.

In both DHAs the union officials maintained that they could help to improve morale if they were consulted. On participation the union representatives mentioned that since it is an uphill battle in Metropolis for them to gain anything for the staff, it is doubtful whether management genuinely intends to use the QCs to encourage participation. As the union officials pointed out, if management was willing and committed to participation and also to improve the QWL of employees then this commitment should have been reflected in the existing consultative process. In the absence of such commitment to the consultative process, the union representatives believe, perhaps correctly, that management will be all too happy to replace the consultative process with the QCs if it can. Perhaps this is a correct assessment of the developments in both case-study DHAs. Management indirectly sees the QCs as a substitute for trade unions and the consultative process, a means whereby it can get its wishes fulfilled. Ironically, QCs were set up in Countryside to encourage more employee participation and to prevent management fixing the agenda of JSCC, but the QCs have also become a management instrument for getting the employees to resolve problems identified by management. The QCs, like the JSCC, have come to be identified with management objectives. They have, thus, assumed the form of management instigated participation.



The QC programme in both DHAs are management-led participation. Management through the facilitators and leaders invariably influence the choice of project to investigate. Moreover management reserves the right to reject or accept a QC recommendation and subsequently implement it. As the case-studies indicate the tendency on the part of management to reject recommendations involving substantial financial expenditure has made the circles refrain from making such recommendations. Furthermore management determines 'no-go' areas. This means that QC participation takes place within the limits set by management. Consequently such a participation is limited in scope and differs significantly from that of QWL innovations. As Bradley and Hill point out:

QWL innovations establish real employee decision making over a range of work-related issues, either on a group basis, as in the case of semi-autonomous work groups...or on an individual basis, as a few cases of job enrichment. In comparison, QCs are quite limited. They do provide participation, in the form of involvement in the decision making process and consultation with management, but they do not provide an area of autonomous decision-making which allows members both to formulate and to implement 'need-satisfying' 'work-related' decisions (Bradley and Hill, 1987:77).

In both case-study DHAs, the QCs did not make or implement any decisions on their own. All QC suggestions required managerial approval. Therefore the QCs had no right in decision-making, which remained the prerogative of management. Seen from this perspective, QCs dealt mainly with management-instigated quality issues and employee involvement was viewed as a means of achieving that objective. In any case some additional involvement has occurred.

The limited scope of QCs participation in decision making in both DHAs can be attributed to the organizational culture. Although general managers tend to believe that they have a bottom up management approach (see NHS Management Bulletin 1988;14) and tend to see employees as important, the culture of the NHS somehow does not allow low ranking employees to participate in the making of higher level decisions. This probably is the reason why QCs have remained essentially at the lower levels of the DHAs unlike in some U.S.



organizations where QCs have been involved in decision making at higher levels.

One management official in charge of QA in an Inner London RHA explained that a QC in the health service, is an involvement of employees at the grassroots level which has potential for improving relations between management and employees, if management shows interest and commitment. QCs allow grassroots employees to present their views to management, and by so doing encourage employee development. This grassroots support, however, should be supported by management commitment. In this sense QCs should be seen as a form of bottom-up management.

She sees QC as a grassroot mechanism because generally it is the lower level employees who are normally enthusiastic and euphoric about QCs. This lower level interest, particularly auxiliary nurses' enthusiasm, is seen as an anti-thesis of the NHS hierarchy. As she puts it:

Auxiliary nurses are the missionaries or, if you wish the apostles of QCs. To some extent it is a religion to these people.

She maintains that there is a high level of satisfaction among auxiliary nurses where QCs have succeeded. This is because they are the least qualified among nurses and often have low esteem in the NHS; at least the QCs give them the opportunity to demonstrate their skills to their senior colleagues..

In both DHA senior managers pointed out that although professionally qualified staff have participated and achieved some benefits from participation, auxiliaries are often most enthusiastic about the circles. It allows them to show their abilities and share their ideas. As the CNA at Countryside pointed out;

The QCs give the auxiliaries assurance and job satisfaction. Moreover their effective participation proves to other members of staff that they are not just lowly employees

QCs in the DHAs deal with job-related issues at the bottom of the hierarchy, but the scope of participation is severely limited by



management. The union activists and shop stewards alike are therefore sceptical of management intentions in promoting the QCs. Somewhere along the line, management will have to come to a common ground with the staff side (declare their intentions) to avoid mistrust, misgivings and the belief that QCs are in place to subvert the existing consultative process.

For effective participation in decisions to occur there is the need to change the culture of the organization. The Countryside corporate objectives for 1987-90 on quality of service recognizes this need and plans to do just that (Countryside 1987-90:1). Metropolis has also attempted to do that but as one manager pointed out, these attempts have not been very successful because NHS culture tends to be resistant to change. This is partly responsible for the difficulties that the QCs are facing. Evidence from the case-study DHAs does not support Kochan et al.'s (1984, 1986) view that QCs in unionized organization promote cooperative and pro-active relationship instead of the traditional adversarial relations. In both DHAs unions have stayed away from the QCs programmes, and are sceptical of management intentions. In any case the QCs have not made any significant impact on the existing climate of IR in the two organizations as the QCs have stayed away from issues with IR implications.

### Conclusion

This chapter has dealt with the evaluation of QA and QCs in Metropolis and Countryside, the motives and objectives for their establishment, and the impact, if any, on union-management relations. The case studies point to a number of pressures emanating from the national and regional levels on the DHAs to adopt initiatives on quality. In the post-Griffiths period quality initiatives have become an essential part of the annual review process. In an era of short-term contracts and performance related pay for general managers, it is not surprising that they are so keen in pushing QA and QCs initiatives in the DHAs. The development and implementation of these quality initiative programmes are looked on favourably in the annual reviews.



Evidence from the case-study DHAs indicates that QA and QC programmes were set up primarily as a response to environmental pressures. The primary objective is to improve the quality of health care delivery. They are attempts to improve management delivery of health care within financial constraints. Management is trying to defend the quality of care against criticisms from consumers. They show managerial strategies in managing within budgetary constraints. All these are in the interest of senior managers, although it cannot be denied that an improvement in the quality of health care delivery benefits both staff and patients. Management, however, takes credit for any such improvement.

Since management does not want to be accused of merely satisfying its self-interest in developing QA and QC programmes, it often emphasizes the possibility of benefits to employees. In reality, however, both the QA and QCs are management-imposed strategies without any major benefits for employees. The QA and QCs strategies are aimed at achieving efficiency and effectiveness through a new kind of participation, involvement and communication. They allow only token participation by employees and are not seriously aimed at reorganizing work. Seen from this perspective the QCs may not have long-term significance. As Bradley and Hill (1983:294) warn, QCs can succeed if they are part of a process of long-term shift from conflictual to a more participative Japanese type of management. If this is not the case, QCs may have no more long-term significance than previous movements to establish joint consultative and productivity committees. In view of the opportunistic objectives of the QCs in the case studies they cannot be considered as strategies aimed at improving employees' QWL. They perhaps improve employees morale in so far as they improve health care delivery.

As a management strategy the QA and QCs in particular have been marginally successful. Where employees have embraced the idea, the organizations have derived some benefits from the QC projects. It is marginally successful because only a few employees have accepted management's definition of the purpose of the QCs. These employees believe that their participation, communication, and involvement have improved. QCs are firstly contributing to quality in delivery and



involve employees previously uninvolved in participation. Management has persuaded these employees to deliver.

The research into the QC programme has shown the influential role of line managers in the formulation and implementation of the concept. Since the circles have by and large concentrated on nursing issues, nurse managers have been most influential in the programme. The facilitator, leaders and almost all the officials involved in the circles have been line managers.

The role of the personnel department in the QCs has been very limited. The training and staff advisor in the district personnel department in Countryside advises on how to start a QC. Countryside has a unit personnel representative on the Quality Control Team but it is not clear what role he/she plays. In Metropolis the personnel department has virtually no role in the QC programme. This, then, raises the issue of the effects of the post-Griffiths quality initiative on the personnel function in the two case-study DHAs. In order to determine this, an analysis of the personnel role in the two case-study DHAs will be undertaken.



## CHAPTER 10

THE PERSONNEL MANAGEMENT FUNCTION IN METROPOLIS AND COUNTRYSIDE.

This chapter explores the PM function in Metropolis and Countryside health authorities. It analyses the influence of the Griffiths-inspired general management on PM in both authorities. In particular, it examines the practical implications of the two seemingly contradictory recommendations of the Griffiths Report. The Report recommended the development of general management with strong emphasis on strengthening the line management role in personnel issues. At the same time, it also recommended the strengthening of the personnel function. It is argued that these recommendations have had two distinct effects.

The first recommendation has resulted in an increase in line management involvement in personnel issues and has made it possible for them to play leading roles in the formulation and implementation of the QA and QCs strategies in the DHAs. This has in turn heightened the ambiguities in the personnel role. In view of these issues the chapter attempts to explore what role, if any, the personnel departments played in the development and implementation of the QA and QC strategies in the DHAs.

The second recommendation has resulted in the personnel departments' greater emphasis on specialist personnel functions, thus shedding some of the day-to-day 'people management' issues to the line managers. Put simply, the personnel departments at both the district and unit levels in the case-study DHAs have adopted a more specialized focus and perspective, leaving line managers to deal with more routine personnel issues, such as hiring and dismissal of staff.

In discussing these issues the chapter is divided into three sections. The first traces the evolution of PM from the 1970s, and explores the post-Griffiths PM function in both DHAs. The second section addresses some of the main challenges which PM had to deal with in the 1980s. These included the changes in line and staff issues



in PM as a result of the emergence of general management. It explores the division of labour and changing balance between line and staff functions in PM; in particular, how line and staff functions in personnel are developing in the post-Griffiths period. Having looked at QCs and QA strategies in comparative focus, section three analyses the PM/HRM interface. In light of the evidence from the case studies, this section attempts to determine whether or not PM is moving towards HRM. It searches for evidence from the case studies which can be classified as HRM. In this regard it raises the issue whether PM is involved in any strategic initiatives which in any way resemble HRM. The chapter ends with a brief conclusion.

#### The Development of the Personnel Management Role.

Prior to the 1970s there was no formal PM department in either case study authority. However, as the NHS environment began to change it became necessary to establish personnel departments. The personnel function developed in both case study authorities predecessor AHAs in the 1970s following the general development of PM in the NHS. This development was mainly a response to state initiatives to promote the growth of PM in the health service. As Chapters three and five show, other factors which contributed to the development of PM in the health service included changes in labour-management relations and in the political and economic environment of the NHS during the 1960s and early 1970s. The case study DHAs were affected by these developments but the immediate factor which precipitated the development of PM in both authorities was the 1974 reorganization which required the AHAs to appoint personnel officers.

The crisis in the traditional system of IR in the NHS in the 1970s inevitably contributed to the further development of PM in both case study authorities. The interviews revealed that the centralization of negotiations to a large extent hindered the development of local bargaining. Although JSCCs were formed in both authorities in the 1950s, they mainly dealt with management initiated issues and were generally considered as ineffective and of little value to the employees. In this period neither authority had a



significant union membership and the unions were reluctant or unable to contemplate industrial action. This state of affairs contributed to stability in the IR system in both authorities during the 1950s and 1960s.

It was in the 1970s that the stability in IR in the case study authorities just as in the NHS in general was shattered. The fieldwork revealed that the introduction of the incentive bonus scheme for ancillary staff was a major factor in the growth and development of unions in the case study authorities. Evidence from both Metropolis and Countryside suggests that it increased trade union consciousness as job specifications and performance were more tightly defined and supervised. It contributed to the growth of workplace representation, and employees' anxiety about the scheme resulted in an increase in trade union membership in both case study authorities. Initially, this trade union consciousness was limited to the ancillary employees, but it soon spread to the non-ancillary staff who were equally concerned about their jobs and the possibility that the scheme might be extended to them. In both case study authorities the workers exhibited confrontational and militant attitudes in the 1970s as the ancillary workers participated in the 1973 national ancillary employees' strike.

The development of PM in the case study authorities also reflected wider IR developments in the 1960s and 1970s, especially the increasing importance of workplace bargaining and the potential impact of legislation. The employment legislation enacted during the period emphasized the formalization of workplace IR, as a means of strengthening collective bargaining. This encouraged the development of workplace IR in the health authorities. In view of this, the government made an effort to promote the growth of PM in the health authorities to ensure harmonious relations with trade unions and an adherence to the legislation. The employment legislation was thus aimed at institutionalizing conflict and promoting efficiency objectives in IR and PM. The government was determined to promote in the NHS a PM function which would be capable of dealing effectively with industrial conflicts and other IR issues. It was also an objective of the government to separate PM from line management functions.



As indicated in chapter five, the developments in the legislative arena encouraged many professional associations such as the RCN, RCM BMA etc. to seek legal certification as trade unions. Their certification as trade unions was accompanied by the introduction of workplace representation and more sophisticated workplace organizations. In both Metropolis and Countryside, interviews revealed that the emergence of workplace representation in the 1970s changed labour management relations as the union representatives challenged traditional areas of managerial prerogatives in their attempt to influence organizational decision making.

The sudden and turbulent changes in the IR environment in the health authorities required expertise in dealing with personnel and IR issues. It necessitated specialist skills in dealing with legislation, trade unions, and in negotiating and implementing collective agreements. In the wake of the changes in the IR environment, specialist personnel managers were needed to advise and support managers on personnel issues, such as the implementation of the bonus scheme. Quite apart from these issues the 1974 reorganization also required specialist staff to deal with the changes associated with the reorganization. The 1970s therefore witnessed a move towards managerial specialization and professionalization which increased the power, status and influence of PM in the health authorities.

It was against this background that personnel managers were appointed at the AHA level in both authorities following the 1974 reorganization. In Metropolis's predecessor AHA, an assistant personnel officer was also appointed, although in Countryside no such appointment was made. Due to lack of resources the personnel function did not develop beyond the area headquarters in both authorities. The personnel officers appointed at the AHAs were required to provide specialist advice on personnel issues and practices; and the personnel departments were to provide specialist services in respect of recruitment, staff retention, employee motivation, manpower planning and training. The personnel managers were also required to develop effective systems of communication and consultation and to provide personnel services for all staff employed.



As IR problems were emerging in the NHS at the time, the personnel managers concentrated on IR issues. Although the personnel managers were required to perform these specialist functions there was no clear differentiation between the responsibilities of the specialist personnel manager vis-a-vis the line manager.

Evidence from the fieldwork indicates that at the hospital level, personnel work was integrated into the general administration function, with more junior officers performing the more routine personnel work. Some personnel tasks, such as recruitment and staff development, were performed by line managers. This arrangement was essentially no different from what was in existence before the development of formal personnel departments in the AHAs. In the pre-1974 period, personnel issues such as recruitment, terms and conditions of service, training and application of pay rates were the responsibility of the administrator and finance officers of the hospital. In making decisions regarding personnel issues these two officers often consulted the directors of the clinical areas as well as the heads of the ancillary and clerical services.

Personnel was considered as middle management and in both AHAs personnel was not represented on the boards. As the personnel appointments were concentrated at the AHA level, the personnel work could not devolve to the lower levels of the organization. The devolution of the personnel function began only after the 1982 reorganization which stressed decentralization, and created the DHAs. In line with the decentralization objectives of the 1982 reorganization, personnel departments were set up both at the district and unit levels in Metropolis. In Countryside decentralization did not go so far because a personnel department was set up only at the district level, leaving the units without personnel specialists. Thus, in the absence of a personnel departments in the units, the personnel function was integrated into the line management role.

These differences in the development of PM in the two case-study DHAs were due to the differences in the perception of the scope and priorities of the personnel work. The cosmopolitan nature of Metropolis encouraged more militant trade unionism, higher labour turnover, and problems of recruitment and retention which required



specialist attention. On the other hand, IR in Countryside was more harmonious, and there was lower labour turnover, fewer recruitment and retention problems; it was therefore possible for the personnel function to be undertaken routinely by the line managers.

In both Countryside and Metropolis, the 1982 reorganization did not significantly change the functions of the personnel managers. The district personnel departments dealt with the development of policies to ensure effective recruitment, retention and motivation of staff, and also with training, organizational and staff development, IR and manpower planning. The 1982 reorganization, however, boosted the status of the district personnel officers in both DHAs. The district personnel officers were both upgraded from middle to senior management positions. The unit personnel officers, however, remained junior managers. In spite of the boost in their status, personnel officers at both the district and the unit levels were not appointed to their respective boards. This, however, changed with the introduction of general management; after the Griffiths reorganization, the directors of personnel and unit personnel managers in both case study authorities were made members of their respective management boards.

The Griffiths reorganization introduced new PM structures in both case study authorities. Figures 10.1 and 10.2 show, the post-Griffiths PM structures at the district level in Metropolis and Countryside respectively. Each personnel department is headed by a Director of Personnel who reports directly to the District General Manager. The figures show the titles and members of the personnel departments. At the unit level, in Metropolis, the post-Griffiths structure retained the two personnel departments in the two units. As figures 10.3 and 10.4 indicate each personnel department in the units is headed by a personnel manager who is assisted by a small personnel staff. In Countryside only one of its three original post-Griffiths units, set up a personnel department. Since the beginning of 1989, an internal reorganization in Countryside has reduced the three units to two and it is expected that a specialist personnel department will soon be set up in the Community and Mental Health Unit in addition to the existing one in the Acute unit. The personnel officers deal with staff accommodation and issues regarding medical staffing. Figure 10.5



Figure 10.1

District Headquarters-Metropolis Health Authority: Structure of Personnel Function

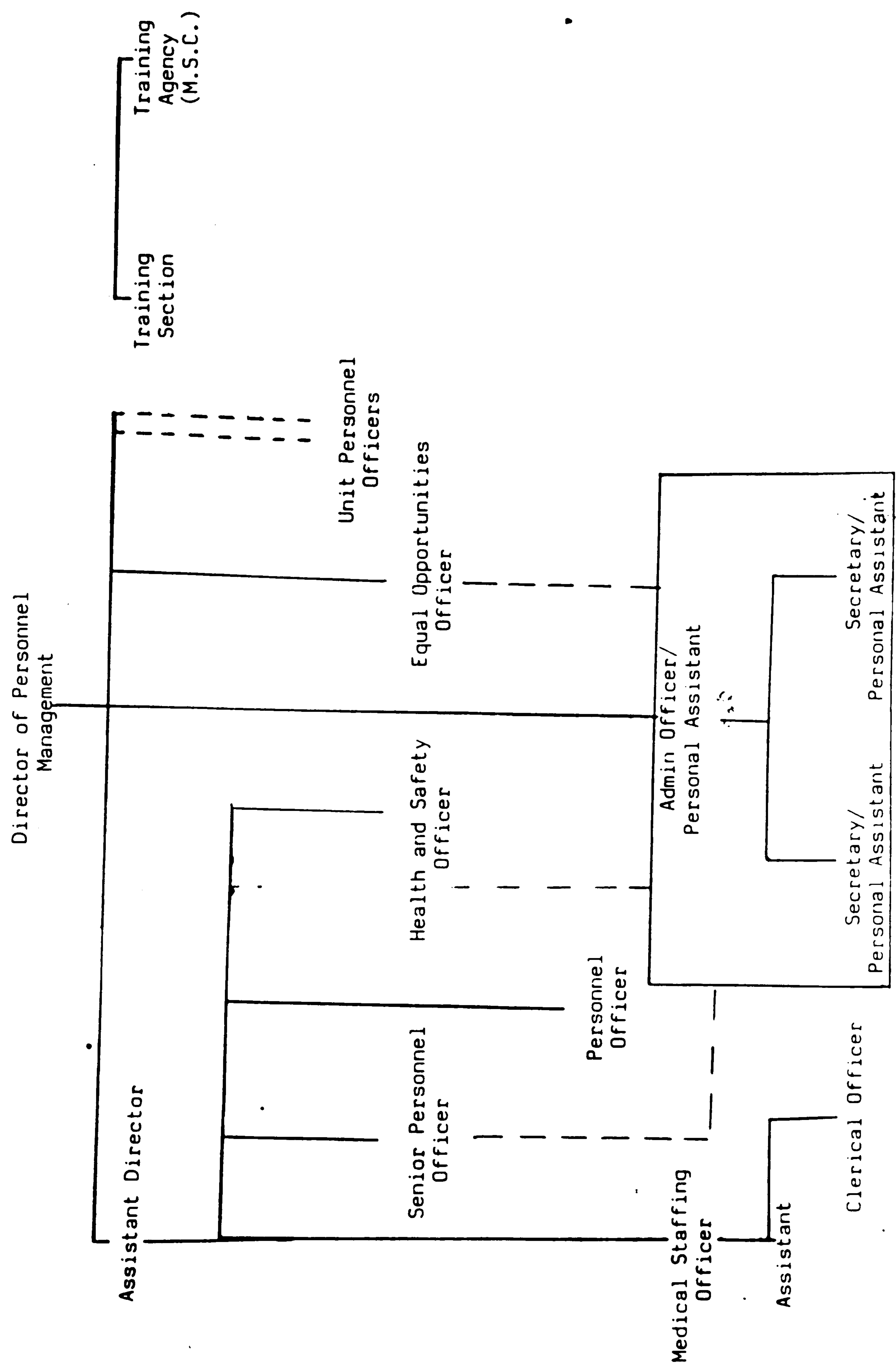




Figure 10.2

District Headquarters-Countryside: Personnel Department Structure

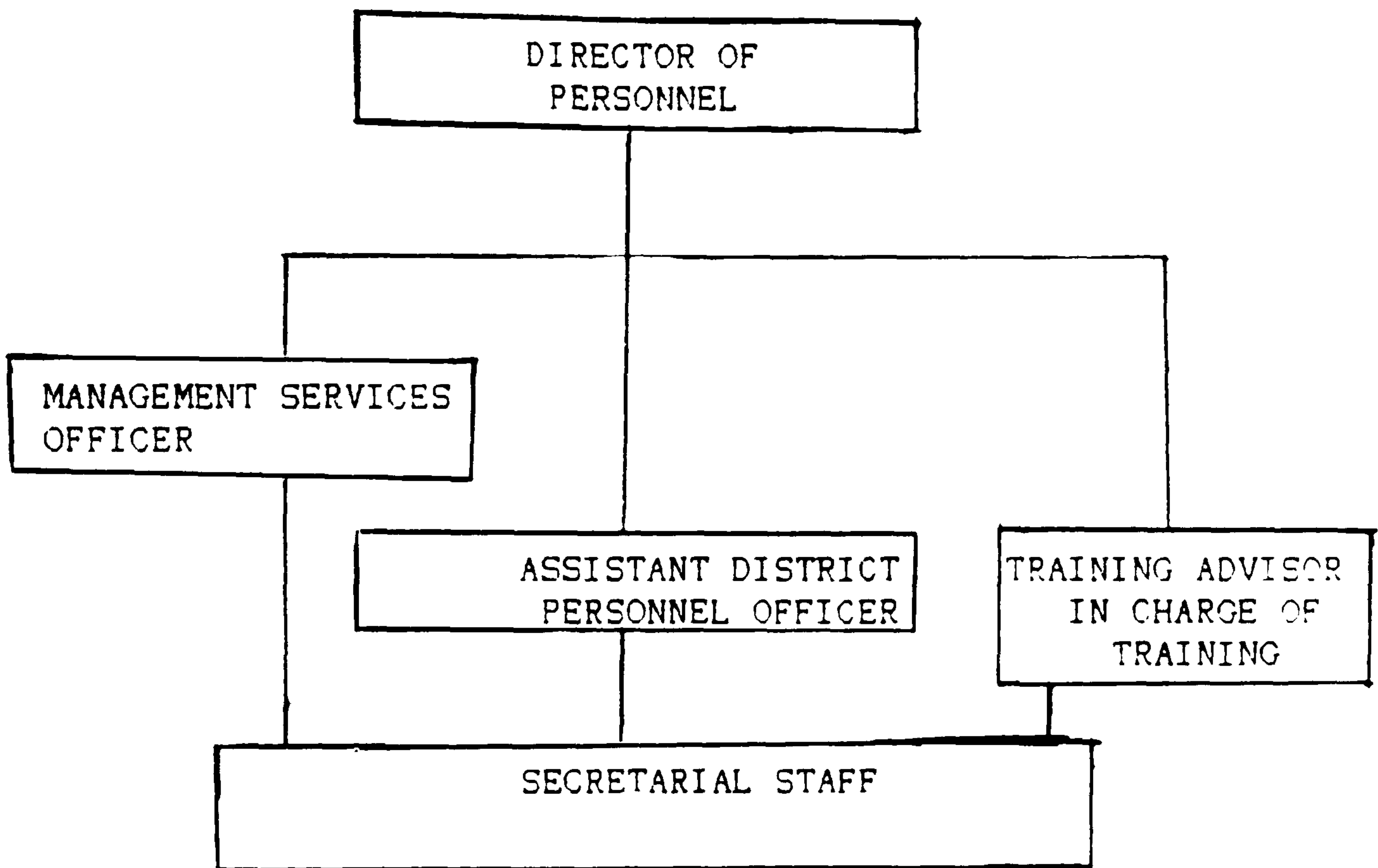


Figure 10.3

Metropolis Acute Services Unit: Structure of Personnel.

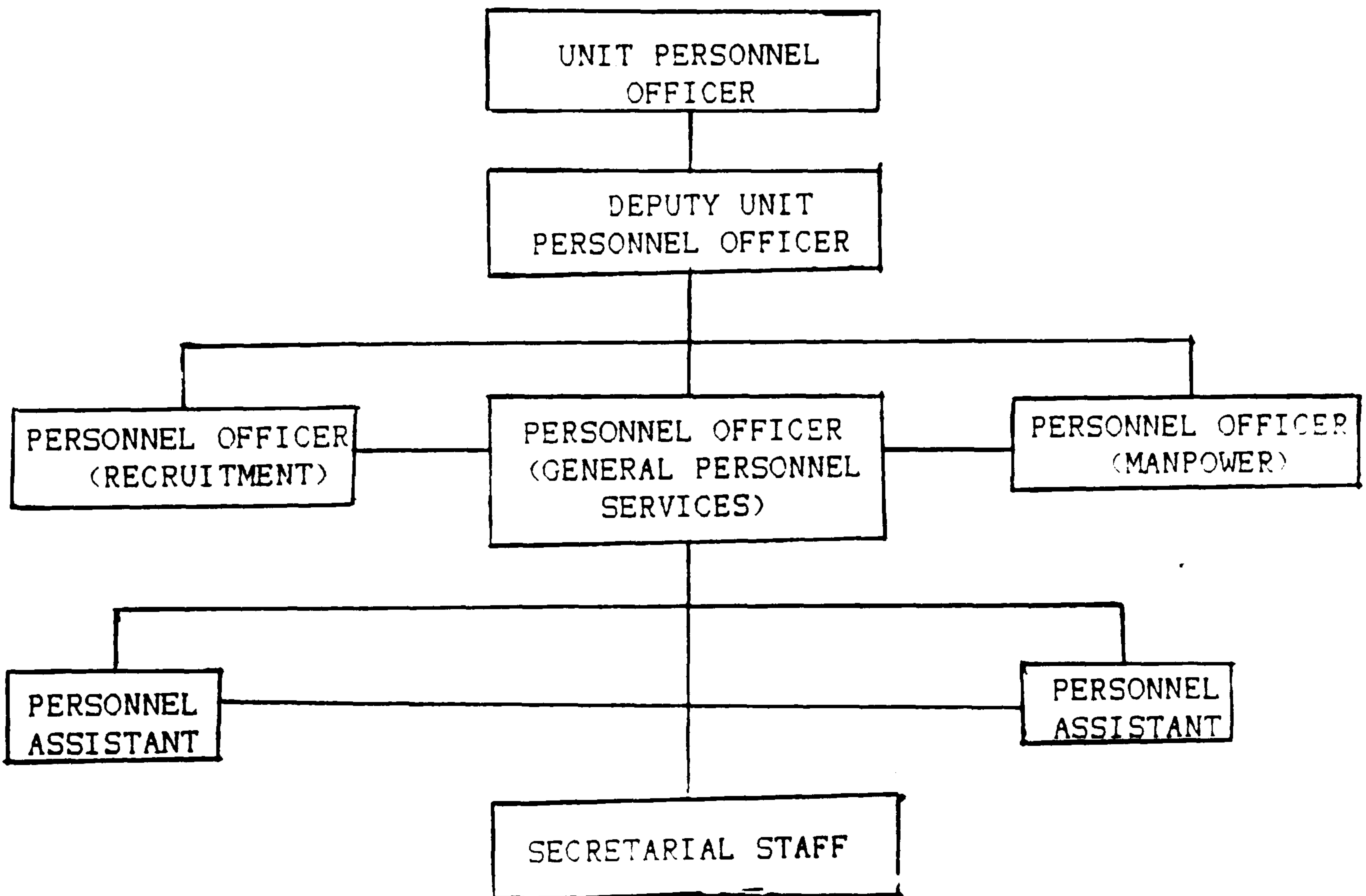




Figure 10.4

Metropolis District Services Unit: Structure of Personnel Function

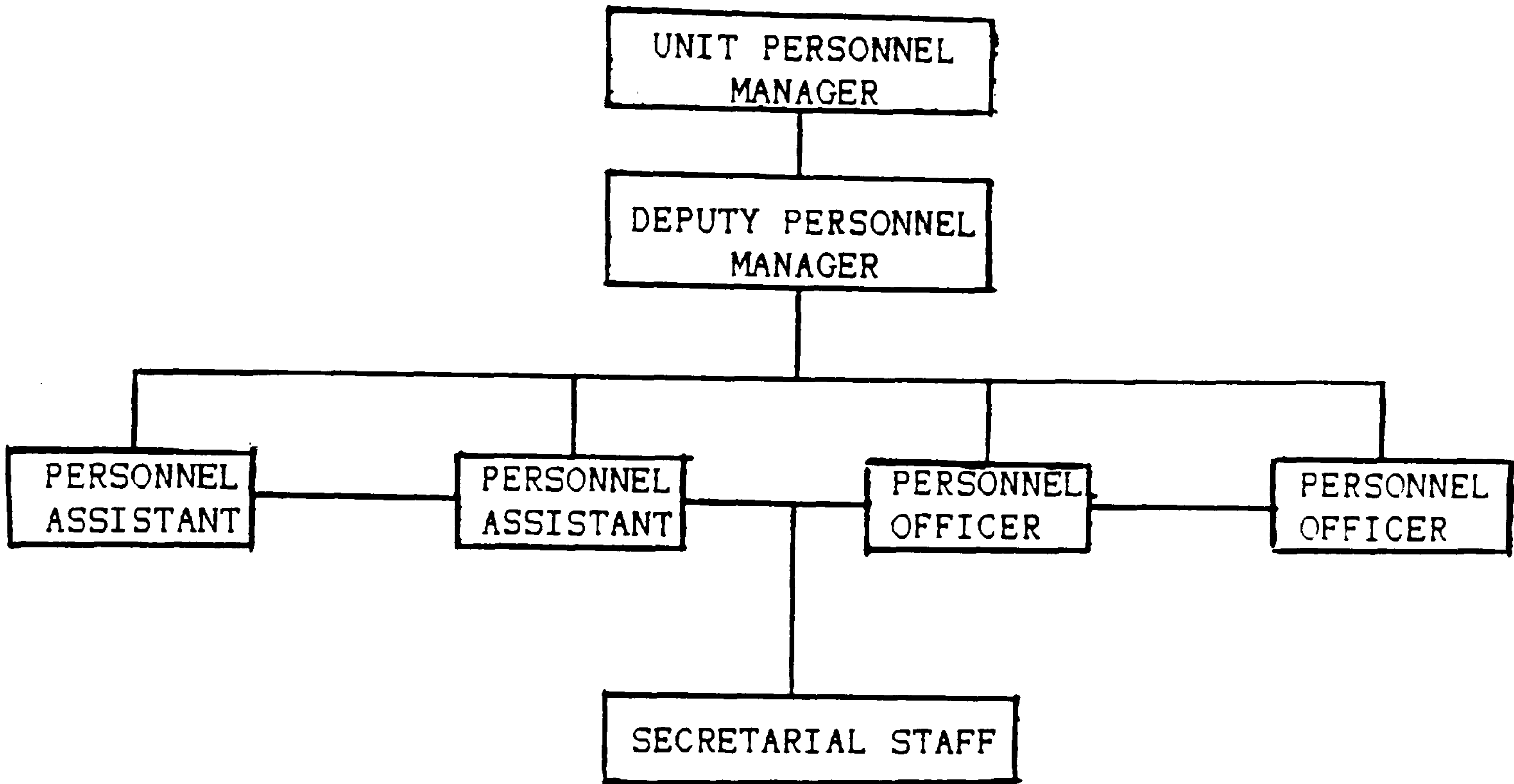
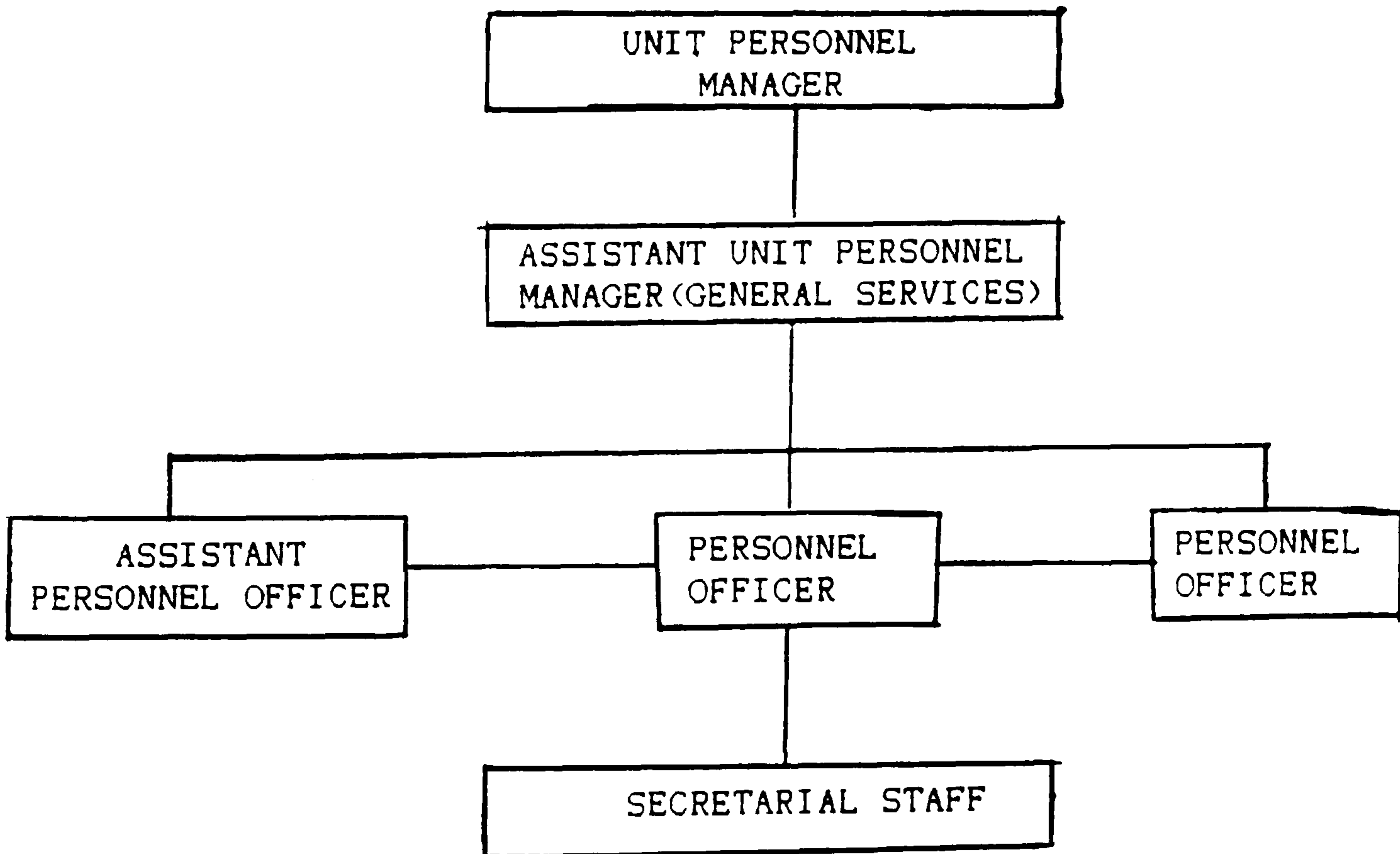


Figure 10.5

Countryside Acute Services Unit: Structure of Personnel Management





shows the titles and members of the personnel department. In the other unit without a personnel department the personnel function is integrated into line function with district personnel providing the specialist service to the line managers who deal with the personnel issues.

Having mentioned the structure of PM in the case study authorities it is necessary to discuss some of the post-Griffiths developments in PM in Metropolis and Countryside. The Griffiths restructuring coincided with a near demise of the personnel department in Metropolis, since there was a total change or turnover of staff at both the unit and district levels. Countryside did not experience such turnover in personnel staff and therefore has had a more stable and continuous department. For instance its present Director of Personnel has been in post for nearly a decade. The high levels of turnover of members of the personnel department in Metropolis adversely affected the development of the personnel function. Interviews revealed that personnel officers below the level of director stay in Metropolis for only a year on average. At the time of the fieldwork in June 1988 some significant personnel positions were vacant, including the post of Director of PM. It is worthwhile noting that the new Director of PM has a background in line management rather than PM. The personnel manager posts at both units were also vacant; therefore personnel officers at the district headquarters were acting in those positions. Both positions in the units have now been filled. The heavy turnover of personnel managers and staff in Metropolis is attributed to the poor salaries for non-executive positions in the NHS. The fact that Metropolis is an outer London district and is not entitled to inner London allowances, the difficulty in finding reasonable accommodations because of the high cost of housing and rent in the district, and the greater and better opportunities for personnel managers in the private sector all contribute to retention problems.

Although the Griffiths restructuring required the Directors of Personnel in both DHAs to assume responsibility for strategic issue, the resource constraints have effectively limited their ability to do so. The Directors of Personnel now deal mainly with the formulation



and implementation of routine personnel policies. They advise their respective DGMs, DHAs and management boards on personnel and IR issues, organizational and management development issues, any significant changes in employment law or NHS conditions of service and their effects on the organization. The Personnel Directors also provide personnel assistance to the units. It is also the responsibility of the Personnel Directors to make sure that the districts have comprehensive and effective personnel systems, and, together with the UPMs and others responsible for personnel, monitor the work of the personnel departments. In addition, they develop and coordinate the districts' personnel related policies and procedures, and monitor their use and consistent application.

It is also the duty of the Personnel Directors to undertake manpower planning for both the district and the units by taking into consideration the strategic and operational plans as well as the financial guidelines. This includes a medical manpower plan which is also developed within the framework of regional and national priorities and directives. In both DHAs, the Personnel Directors prepare job descriptions and contract arrangements for the appointment of consultant medical staff and coordinate these appointments with the RHAs. The actual hiring of the permanent consultants is done by the RHAs but the district personnel departments have the overall responsibility for hiring hospital doctors and locum consultants for the districts. The personnel departments in both DHAs advertise vacancies at the district level and shortlist the applicants. They also provide personnel service for the staff at the district level.

The Directors of Personnel, together with the UPMs and others concerned with personnel, develop recruitment procedures and monitor the recruitment and selection process, taking into consideration current legislation and current practice. The district Personnel Directors develop communication and consultation procedures and arrangements and are involved in IR and employee relations issues. This includes making sure that the arrangements are running properly. The consultation process involves Whitley Councils and district and unit JSCCs. The Personnel Directors educate staff and managers on how to use these arrangements effectively. They also consult with the



chairman of the staff side, note the agenda and make sure that there are officers who can debate the issues. In effect, they ensure support for district joint-staff committees. The Personnel Directors also advise on IR issues, such as disciplinary and grievance matters, and provide senior managers with presentations and administrative assistance. Again, they ensure support for disciplinary hearings, grievance procedures and appeal committees.

The district personnel department is also responsible for the management of occupational health and safety. In Metropolis this is the main responsibility of the health and safety officer. In Countryside this is the responsibility of one of the personnel officers. In both DHAs, district personnel is also responsible for the formulation, implementation and monitoring of EOP. The district personnel departments also act as the interface between the DHAs and the RHAs, referring personnel problems and issues of importance locally to the region.

In summary the personnel function at the district level is to make sure that the authority has effective policies and procedure in respect of the employment of employees. This includes the formulation and interpretation of employment policies, grievance and discipline, procedures, training and organizational development. Whilst the districts are responsible for such policy formulation and strategic issues, the task of the units is to implement those policies. That is, the units have responsibility for operational issues.

In both DHAs the units tend to manage people according to each unit's operational needs and the interest of the UGM. In the units with personnel departments, the personnel managers perform specialist and advisory services to the line managers in the day to day management of the staff. Line managers are thus responsible for personnel administration in their departments. In both DHAs there has been a devolution of the recruitment and selection function to the unit level; both hiring and firing are done by line managers. The unit personnel departments are, however, responsible for the preparation of job and person specifications, advertisement of vacancies and the shortlisting of applicants. The unit personnel departments are also responsible for dealing with the payroll and other remuneration issues



at the unit. In addition they collect and collate information on such issues as health and safety, IR, grievances and discipline, appeals etc. and pass them on to the district personnel department. In Metropolis it is the duty of the unit personnel department to assist the line managers in identifying the training needs of the staff and to recommend to the district training department the training required. The training department also acts as a training agency for the Manpower Services Commission's Youth Training Scheme. In Countryside, the personnel department at the acute unit performs the same function for non-nursing staff. The personnel departments also assist in the design and implementation of appraisals. Analysis of interviews indicates that at both the district and unit levels, the personnel role mainly involves the provision of support and specialist advice to line management on all issues relating to personnel.

The above discussion indicates the divergent and uneven development of PM in the two case-study DHAs. Also the organization of the personnel function varies from unit to unit, and from district to district. The development of PM in Metropolis and Countryside supports Chaplin's view that personnel work is not uniformly organized in the NHS and that different patterns have emerged. The extent to which the personnel function is comprehensively integrated into the line management varied from Metropolis to Countryside and is contingent upon the geographical distribution of the services. In Countryside community services is much more widely spread out in different locations than in Metropolis. Moreover, in Countryside the line managers were required to perform more personnel work than their counterparts in Metropolis. Countryside, which has historically had to rely less on specialist personnel managers, has allocated a great deal of personnel work to line managers. This partly explains why there is a PM department in each unit in Metropolis but there is only one unit with a personnel department in Countryside. It is clear from the way the personnel function is set up in the two DHAs that PM is not an exclusive function of personnel managers.

It is evident from the case studies that there is no clear differentiation between the specialist personnel function and the line management responsibilities for personnel in the DHAs. The uneven



development of PM: with personnel managers performing some of the personnel function and line performing others tends to create ambiguity in the line and staff function in personnel.

The case-study DHAs confirm the NHS Management Board's view that PM is not fully developed in the service. The NHS Management Board is now attempting to correct the deficiencies in PM in the NHS, but the approach adopted by the Board while useful, is lacking in a fundamental way. Although the training of personnel managers needs to be strengthened, as the Metropolis case-study shows, it is mainly pay which is the crux of the matter here. If personnel managers are going to be able to deal with recruitment and retention of qualified staff in the NHS, and if there is to be continuity and stability in the development of policies, then as Chumbly (1988) rightly points out, personnel managers must be better compensated. Their pay must compare favourably with their counterparts in the private sector. If the people who are supposed to develop policies to motivate staff are themselves demoralised then they cannot deal effectively with the crucial employment issues. Evidence from the Metropolis case-study at least confirms Chumbly's (p. 592) view that the understaffing and undeveloped nature of the personnel function in the NHS is a reflection of the poor salaries and conditions.

The institutional efforts to strengthen the personnel function has not had much impact in the case study authorities. In spite of the appointment of personnel directors, resource constraints and budget cuts have resulted in the marginalization of the personnel function. The Griffiths restructuring has not delivered the promise of a boost in morale and status of personnel officers. As the Metropolis's case indicates the poor pay of the personnel officers makes the recruitment and retention of qualified personnel officers difficult. It seriously undermines the effort of the NHS Management Board to help the personnel managers to acquire the expertise in organization development and change management, the skills necessary to provide advisory service to line managers on HRM issues, to contribute to strategic management, and to develop the specialist skill in staff information, planning, recruitment and retention.

Moreover the NHS Management Board's desire to make the



personnel function capable of redesigning jobs, scrutinizing skill mix and providing training and retraining to match the supply and demand data generated by the application of sophisticated staff planning techniques, cannot probably be achieved under a regime of financial and resource constraints. As indicated earlier, the cutting of budgets, efficiency savings, and cash limits all make it extremely difficult for the personnel departments to undertake any proactive policies and undertake any forward planning in manpower. The resource constraint has resulted in the marginalization of personnel issues. When PM is marginalized it allows line managers to play active role in the performance of the personnel task, thus increasing the ambiguity in line and staff functions in personnel.

Although the NHS Management Board would like to see personnel managers focus more on strategic and development issues, evidence from the case-study DHAs indicate that this is rarely done. For instance, in spite of the extensive discussion about the coming crisis in recruitment, particularly, affecting nurses in the NHS, neither DHA has yet developed any long-term strategies to cope with the situation.

In Countryside there is at present no serious shortage of staff except in a few specialist nursing areas which are filled with agency staff from the neighbouring cities. Countryside has its own nursing school and it is able to retain most of the students it trains because the staff most often prefer to live and work in the locality. It is expected that the crisis might hit Countryside in about five years' time, but as yet no long term strategies have been developed. Both the nursing and personnel departments are counting on EOP, the development of child-care facilities and creches as a means of bringing former nurses back to work.

In Metropolis, which has a far more serious problem with staff turnover and shortages, no meaningful strategies have been developed either. Here the district personnel department, in collaboration with the nursing department, run an internal nurse bank system and also uses agency nurses to alleviate shortages. Like Countryside, it is expected that the EOP will improve their competitiveness in the local labour market.

Interviews revealed that in both DHAs no serious attempts have



been made to develop a recruitment and retention strategy because they believe that such a strategy will be just a stop-gap measure; the real problem arising from pay and financial restraints. Under present conditions therefore it is likely that personnel managers will continue to deal with day-to-day issues in a reactive rather than a proactive manner. Personnel, as well as some nurse managers, argued that if the pay of health care staff is improved substantially then it is more likely that the DHAs will be able to attract enough qualified staff. This assertion follows the NAHSPO view that low pay is the direct cause of the widespread recruitment and low morale problems throughout the NHS (PM, 1989: 19). The personnel managers interviewed were somewhat pessimistic about any substantial improvement in the pay of health care staff. They therefore argued that under the present government's public expenditure constraint policy, no meaningful long-term personnel strategies can be developed and implemented.

The problems in PM in the case study authorities were compounded by the emergence of general management under the Griffiths restructuring. It ushered in a new era which has witnessed an increase in line management involvement in personnel issues in the DHAs. The next section therefore is devoted to the discussion of this issue in the case study DHAs.

#### Ambiguities in the Personnel Management Function.

In the case study authorities the shifting priorities within the PM agenda have in some cases increased the ambiguity in the PM function. It is, however, argued that the ambiguity in the PM task is due to the lack of clarity in the definition of the personnel function rooted in the development of PM in the health service. In the use of personnel to pursue organizational goals the personnel function goes beyond the personnel department and involves line managers. This has made it difficult to clearly distinguish between what Legge (1978) calls the specialist personnel function carried out by personnel managers and the general personnel function carried out by line managers. There is always a tension between between line and staff functions in personnel and it appears that PM in the NHS is no



different. This does not, however, mean that every post-Griffiths development in personnel results in ambiguity.

It appears that in the case study authorities the ambiguity revolves mainly, but not exclusively, around the functional definition of PM, that is the optimal use of employees to achieve organizational aims and objectives. This includes planning, organizing, directing and controlling the functions of procuring, developing, maintaining and utilizing human resources with the objective of satisfying organizational goals. In the view of Tyson and Fell, it is the function which they see as every manager's responsibility—the function that transcends the personnel department. There is also some ambiguity in the specialist PM function in areas such as management development and training. Some of these specialist personnel functions are undertaken with the assistance of line managers and management consultants.

As the analysis of the work of personnel managers in the case studies indicates, the ambiguity results from the indeterminate nature of the personnel task in the DHAs. The ambiguity in the line and specialist function in PM results from the underlying trends and developments in the nature of personnel work. As Sisson (1989a) points out, the complex and fragmented nature of personnel work generates demand for experts. This results in the encroachment of line managers and management consultants into the personnel specialists domain. This in turn results in ambiguities in the line and specialist personnel functions. Evidence from the case studies indicates that in the 1980s there seems to be a change in the reliance of line managers on the expertise of the personnel managers as the personnel managers themselves rely on management consultants in the training of staff, for example, in such areas as EOP. This then poses a fundamental challenge to the specialist status and authority of the personnel managers.

To discuss the ambiguities in each and every personnel function in the two DHAs would be an overly laborious process. In light of the above analysis of the role of personnel managers in the case studies, however, the discussion of ambiguities in line and staff functions in personnel will be done in relation to the specific topic of manpower



development -i. e. EOP training and training in general, Individual Performance Reviews (IPRs), and Clinical Grading.

The discussion here begins with EOP training. In line with recent developments in the health service both DHAs have developed EOP policies. On the formulation, implementation and monitoring of EOP, Metropolis is far ahead of Countryside. Although the initial push came from the King's Fund and Community organizations, the high interest in EOP in Metropolis is clearly due to its multi-racial character. As a major employer in the area, Metropolis has realized the need to develop EOP in order to be able to recruit more ethnic minorities and to ensure that those already employed in the DHA are treated fairly. Any unfair treatment of ethnic minorities, it is believed, might adversely affect the quality of the delivery of health care because they will be discontented with the conditions of service in the DHA. In Metropolis racial equality policies brought policies for gender equality onto the agenda.

The Metropolis EOP policy was ratified in 1985, but the code of practice is going through the consultation process. Application forms have been redesigned, and person specifications and job descriptions have all been re-written to reflect the EOP. Ethnic, gender and disability monitoring are now in progress.

In Countryside, where the population is predominantly white, there has not been much interest in EOP. The Director of Personnel mentioned that it has become a priority issue in recent years because of the push from the King's Fund, Secretary of State for DHSS, and also because of the coming crisis in staff recruitment, especially nursing staff, which necessitates the development of strategies to make effective use of existing staff and to attract former staff back into the service. In this respect sexual equality policies brought policies for racial equality onto the agenda.

Countryside's Personnel Director contends that EOP is now an essential aspect of the review process and for this reason managers now pay attention to it. Apart from the legal implications the Personnel Director argues that EOP is above all else, a fundamentally good employment practice. He maintains:



One cannot argue that it has to be done anyway. It is a moral issue. It should be done, not it has to be done. It is a basic human right. It should be a factor we employ and treat people irrespective of laws.

In Countryside the EOP has been accepted by the DHA but will not be implemented until the administrative processes are in place. Meanwhile, the review of application forms and training of managers is in progress.

In both Metropolis and Countryside the personnel directors have to develop systems to monitor the effectiveness of EOP and in addition ensure that the system and all procedures follow the principles of equality of access to the DHA's employment and promotion policies. The effective implementation of the EOP programme requires training. This sort of EOP training is organized by the district personnel departments. In both DHAs the training is done on site, but is mostly conducted by management consultants. These training sessions often deal with drafting job descriptions, job specifications, interview techniques etc. Training initially began with the managers but it is expected that everybody in the organization will eventually undergo some training in EOP, which will include at least EOP awareness.

Senior managers in both DHAs claimed that they take management and staff development seriously. In this respect training is seen as essential. Both line and personnel managers indicated during interviews that staff are considered as an asset rather than a cost, and for this reason, training is seen as an investment. Both DHAs aim at making the optimum use of their staff in the effective delivery of health care, and training plays a crucial role in this. The training programmes in both DHAs focus mainly on the management of change encouraged by the emergence of general management. Training is therefore focused on various aspects of general management and the emerging role of health care managers. It also includes, as indicated earlier, training necessary for the effective implementation and monitoring of performance indicators, value-for-money initiatives, administration of performance appraisals and the identification of training needs, career development programmes, information system and health and safety needs.



It is these types of issues which intensify the ambiguities in line and staff functions in personnel. While the personnel directors can make arrangements for training, it is the prime responsibility of the line managers to identify and meet the training needs of their staff. In this respect the personnel directors provide specialist assistance only in terms of specifying the internal and external training needs in consultation with the line managers. In both DHAs the training function is centralized at the district level, but the acute unit in Countryside has its own training department.

Even where there exists an on-site training centre, the training staff do not have adequate resources to meet the demands of their respective DHAs. This creates a further ambiguity in the training issue. As in the case of EOP training indicated above, the training departments often only organize the course and contract out the training to management consultants. In some cases the districts have to rely on regional training expertise and facilities. In Metropolis some management training is conducted at the regional training centre. Similarly, other management development training at Metropolis is conducted by the King's Fund management development college. In addition, consultants from the King's Fund are also brought on site to conduct on-the-job training in the area of general management. In both case study authorities the in-house (on site) training mainly involves modifying staff attitudes towards patients, supervisory training, shop-window training, preparation for retirement courses, induction training, on-the-job training for ancillary, administrative and clerical staff and disciplinary training.

In Metropolis, unlike in Countryside, the training function was neglected for nearly ten years; however, with the commitment of the management board to improving the quality of staff (staff development) and the quality of care in general, it has revived both the district training centre and the library. This is thus a change from the practices of pre-Griffiths administrations that tended to see training solely in terms of sending staff to external courses which, in any case, was not done very often. The training effort undertaken by the present management, however, is threatened by the cash limits policy which has already manifested itself in the cutting of budgets,



including that of training. In both DHAs cash limits have also affected personnel planning, since both the training and advertising budgets have been cut. In Metropolis the cut is as much as 40 per cent since 1987, whilst it is about 20 per cent in Countryside. This also makes it extremely difficult for the personnel department to do any forward planning in manpower; consequently, the filling of vacancies is reactive rather than the result of progressive planning. This is in fact the real situation, in spite of the development of formal manpower plans which detail the authorities plans to ensure effective use of existing manpower and to ensure that the DHAs' future planned projections of manpower are in line with the projections of revenue available, the service required and the labour available. As indicated earlier, although the district personnel departments are supposed to play a strategic role, they are still often bogged down in solving day-to-day personnel issues and the training of staff in new and emergent issues affecting the authorities..

Another ambiguity in line and staff function in the personnel role arises from the development and implementation of performance appraisals in the case study authorities. In the view of Watt and Anderson (1988:27), with the introduction of general management at both the unit and district levels, there has been an emphasis on the cost-effective use of resources, including human resources. In order to ensure the effective utilization of human resources, a performance appraisal and career development procedures has been introduced in the NHS since 1986 to meet the aspirations of both staff and management. In both case study authorities the appraisal system is referred to as Individual Performance Reviews (IPRs) and it is hoped that all members of staff (other than nurses, who have had relatively long experience with performance appraisals) would eventually be appraised. The introduction of IPRs in the case study authorities is part of what Brown (1988:618) refers to as the grand strategy of promoting a results-oriented management culture, with clear responsibilities and accountabilities for managers, in some cases complemented by performance related pay.



It is the development and implementation of these appraisals which tend to increase some ambiguity in the line and staff functions in PM. In both Metropolis and Countryside personnel managers have been required to work in conjunction with line managers in the design and implementation of the IPRs. The management of the appraisals is therefore a joint responsibility between personnel and line management. The IPRs are linked to the annual training plan which is aimed at both professional and management development. It in various ways helps to identify and address individual needs by giving feedback on the staff's performance. In both case study authorities only managers are now appraised. Under the existing arrangement the personnel managers perform the advisory and specialist role whilst the appraisal itself is done by the line managers concerned. In Metropolis the district personnel department organizes appraisal training courses. Appraisal implementation seminars for senior managers are also planned.

In the development and implementation of appraisal system-IPRs- in Countryside, the district's personnel manager has been assisted by the management services officer and other members of the CMG, in particular, the management adviser. The latter acts as an adviser and counsellor to all managers, as an internal management consultant, and as the focal point for management and organizational development. He came to Countryside in 1983 as a district planning officer, acting for some time as a unit administrator and later deputy UGM. In October 1987, he became management advisor. He is therefore essentially a line manager who is very well acquainted with the DHA's values and organization development. In recent years he has done considerable work on the IPRs. In this regard he works with the district training department and attempts to link training with organization and staff development.

The management advisor helps departments draw up their programmes and works with UGMs and consultant medical practitioners on many issues. His activities in IPRs creates potential ambiguity for the personnel function in the sense that he is usurping some of the personnel role. This indicates some form of contested authority, expertise and status of the personnel specialists, particularly the



management development officer in the district personnel department. The management advisor does not see his role in this sense and argues that Griffiths was good in breaking what he calls the 'tribes' in the administration of the health authorities; for instance the medical tribe, the nursing tribe, etc. General management, in his view, has freed the professions from administrative duties; people with abilities can now take up managerial jobs regardless of their clinical or non-clinical backgrounds. In the same fashion, line managers can help develop 'people skills', identify the training needs of their subordinates, and help them undergo the necessary training required to improve themselves. In the management advisor's view, the identification of staff training needs and the development of performance appraisals are no less the prerogative of personnel managers than that of line managers. Line managers are able to do this, he says, 'thanks to Griffiths'.

These views were echoed in Metropolis as well. Several line managers interviewed indicated that the Griffiths restructuring has made it possible for line managers to manage human resources, play influential and leading roles in training, guide and motivate staff. Some line managers argued that it is the duty of the personnel department to identify career development to enable staff to identify their training needs and responsibilities; however, line management has to handle the management of the people. These line managers see no conflict between this role and that of the personnel departments. According to this thinking, line managers should give the staff the conditions to do their work, advise, criticize, praise, guide and support the staff. In the view of the line managers, then, it is the duty of personnel managers to advise the staff and management on specialist issues, whilst line management take the responsibility for career development. The conclusion is that if line management does not manage human resources it will be abdicating its responsibilities.

It appears that some personnel managers share this view. In discussing the personnel function, personnel managers interviewed indicated that line management has the prime responsibility for managing staff and this includes the training of staff. In other words the line managers have to ensure that the staff are well trained for



the work they are performing. Some personnel managers argued that although training expertise is maintained mainly at the district level, line management should be taught to train their staff through appraisals and by so doing develop their departments. These personnel managers argued that only line managers can review their staff performance; the specialist personnel role is to give support and training in staff development, IPRs, and in the development of the performance review systems.

Personnel managers interviewed indicated that PM is every managers function, and in this respect the personnel manager merely offers specialist advice to line management which is supposed to deal with the day to day management of staff at the workplace. The Director of PM at Countryside, however, explained that when he says PM is a every managers function, it means that line managers need to take some responsibility in PM, for instance appraising and assessing the training need of the staff. This does not, however, mean that PM is not a specialist function. What this means, for instance, is that once the training needs of the staff have been identified the personnel specialist will provide the necessary training.

In his view, line managers will always seek advice from personnel managers. For instance, in preparing a case for tribunal, the line manager does not have the expertise he/she needs and therefore must turn to the personnel manager. In consultation, for instance, the staff side discusses issues on behalf of its members, whilst personnel managers do the same for their managerial colleagues. The line management involvement in people management is important, but the role of personnel managers is to assist and support line managers. The Countryside Personnel Director cited the following examples to illustrate his point. He argued that on dismissal issues the line managers seek advice from personnel. For instance, to dismiss a person on racial grounds the personnel manager will advise the line manager that:

You cannot do this because of the legal implications...the DHA will be taken to the cleaners.

By so doing the personnel manager is advising, assisting and



supporting the line management role.

Another area where line and staff ambiguity in personnel resulted in contested authority, expertise and status of the personnel managers was the recent clinical grading exercise. It resulted in some problems in both case study authorities but more so in Metropolis. Initially there was serious contention as to which department's duty it was to carry out the review. In Metropolis personnel managers argued that it was the duty of the nurse adviser. The nurse adviser in turn argued that it should be a shared responsibility between the two departments. After a delay in the review process which the staff attributed to the lack of cooperation from the personnel managers, the management board determined that the personnel managers and the nurse adviser should share the responsibility for the development and implementation of the grading exercise.

The personnel department did not want to get involved in the grading exercise because it perceived that it was going to lead to a lot of problems. The nurse advisory department argued that perhaps the real reason for the personnel department's reluctance to participate in the grading exercise was that it did not want to exhibit its incompetence in that area. After a truce was established the personnel officers worked in conjunction with the nurse advisors. In both case studies the personnel departments developed consultation procedures, set up committees to discuss the issues, provided management and union guidance on how to handle grading grievances, and coordinated the transmission of unresolved grievances to the RHAs. In a sense the personnel departments were responsible for overseeing that everything was done properly. The personnel directors worked in conjunction with the nurse advisers to make sure that the units know what to do and how to apply the criteria consistently throughout the districts. Line managers assumed the responsibility for interviewing staff, and making decisions on grading. The personnel department at the district level handled the appeals of the staff who were dissatisfied with their grades. It arranged the appeal hearing and brought together all those who were involved in the decision making process. The personnel department handled all the appeals which were not resolved in the internal appeal process, passing them on to the RHA.



This section has shown the lack of clear distinction between the personnel and line management roles in the management of people in the case study authorities. As the case studies indicate, line managers and management consultants have been actively involved in personnel issues. This has intensified in the wake of the Griffiths Report which recommended that personnel managers should ensure with line management, the operation of a policy of performance appraisal and career development. This development in many ways heightens the ambiguity in the personnel function. It is argued that the new problems arising from general management have compounded the perennial ambiguity of line and staff functions and relationships in the case study authorities. This amounts to what Tyson refers to as 'balkanization of the personnel role'.

#### Quality Circles and Human Resource Management: An Assessment.

Having discussed the changes in personnel function it is appropriate at this point to discuss whether the implementation of the QA and QCs initiatives in the case study DHAs in any way precipitated a shift from PM to a broader conception of HRM. It is also necessary to determine whether the QA and QCs can be considered as strategic initiatives. In the attempt to analyse these issues the discussion will first focus on the role of the personnel managers in the development and implementation of the QA and QCs initiatives. As was shown in chapters seven and eight, the personnel departments have not played any significant role in the QA and QC programmes. In Metropolis the personnel departments have not in any way participated in the QA and QCs programmes. In Countryside, on the other hand, the district training officer gives some limited training advice on QCs. This role, however, is due to be transferred to a management consultant. In both case study authorities the QA and QCs are managed by the nurse advisory departments.

The argument by the personnel managers that the present government's public expenditure constraint policies inhibit the development of strategic policies, seriously undermines the QA and QC developments. The personnel managers tended to see the QA and QC



strategies as mainly service quality initiatives with little, if any, QWL benefits. Such a perspective stems from the personnel managers' argument that employee QWL can only be improved by improving pay and conditions of service for staff. The personnel managers do not see the QA and QCs programme as a PM issue. Neither do they think they can play any effective motivation role in the QA and QCs programme under the present regime of financial constraints. Having adopted such a perspective the line managers are left on their own to deal with the QA and QC programme. Thus line managers assume the role of motivating employees.

Yet the personnel specialists could potentially play pro-active roles in the QA and QC programmes. McAndrew (1987), for instance, argues for strong personnel specialist participation in customer care programmes in public sector organizations. He warns that:

If personnel is not a key part of the move towards consumer orientation, it could signal that the function is regarded as part of the old order from which the organization is trying to escape (McAndrew, 1987:21).

The point here is that personnel specialists possess many skills that can promote QCs and other HRM initiatives.

Most importantly, Hendry and Pettigrew (1987:32) maintain that the personnel function can play a key role in managing organizational culture by balancing training and development with recruitment, individual careers, and job satisfaction. This can happen through reliance on reward and disciplinary systems and appraisals to reach strategic objectives. Although the personnel function does not by itself create the organizational culture, it can reinforce or modify it. The organizational strategies have to work through a mission-shaped culture.

Tyson and Fell (p. 38) acknowledge that personnel policies frequently perform latent functions for organizations. Management development policies, for example, can be used to create a common management culture. In this respect training can be used to inculcate a common management ideology. Personnel policies are thus significant determinants of culture. Tyson and Fell (p. 38) argue that:



The promulgation of corporate values is a central role of PM in establishing the 'clan' on which the policies depend for their acceptance. Corporate values are pervasive, and are central to the creation of organizational cultures. Such values when expressed through organizational cultures prescribe appropriate relationships and specify the legitimacy of actions.

According to this line of argument since an organization's reward and discipline systems, promotion, and appraisal and development policies reflect its central values and since these are often prepared by the personnel specialists, these specialists can be influential in changing organizational culture. By playing such a role, they can carry out changes in an appropriate way. They can also use the personnel function's representation at the strategic level to influence decision making and thus integrate human resource strategy into the organizational strategy. It is also argued that a meaningful personnel role in the QCs programmes could even be beneficial to PM. The QCs could help to integrate diverse functions including recruitment, selection, appraisal development etc into the organization's strategy. It could as some writers have suggested help personnel specialists to learn new skills in identifying organizational missions and the kind of human contribution required to reach that goal.

Whilst the above suggestions are prudent, they may not necessarily apply to every organization. In the ideal world personnel managers could potentially gain from their participation in QCs, however, their participation may be contingent upon many factors; not least is their ability to control reward packages. In both DHAs the personnel managers mentioned that their lack of control over pay determination impedes the formulation of strategic objectives and limits their ability to integrate human resource policies into the organizational strategy. It is partly for this reason that the personnel specialists have not played pro-active role in the QA and QC programmes and for that matter, the cultural change which the QA and QCs strategies are aimed at.

The case studies show that the implementation of these strategies have not had any significant impact on the personnel function, although they have increased line management involvement in personnel



issues. The introduction of the QA and QCs initiatives added another 'people management' structure to the existing PM (including IR) apparatus. This amounts to what Storey (1987) refers to as dualism in management's approach to the workforce. That is, the personnel management structures are quite different from QA and QC structures. The dual existence of QCs and PM practices means that the QCs do not even represent Walton's (1985) transition stage between control and commitment strategies. These developments hardly indicate a shift from PM to HRM. This then raises the question, can the QCs (the supposed involvement and communication programme) be considered as HRM?

Both QCs and HRM are people oriented, with a respect for the individual. They involve the maximization of individual talents, employee participation, consultation, and involvement. The advocates of HRM and QCs maintain that both emerged from the discovery of interest in corporate culture and its influence in organizations, and the resurgence of interest in excellence, which in the health care sector is equated with quality. QCs are managerial responses to environmental changes to improve the performance of their organizations. They are thus a revival of interest in customer satisfaction, innovation etc. They emphasize individual relations as opposed to collective relations, and have encouraged the development of direct forms of employee involvement and communication at the workplace level. All the above characteristics are part of the characteristics of HRM so it can be argued that potentially QCs at least partially share some of the features of HRM.

When assessed in relation to Guest's HRM goals of (1) flexibility/adaptability, (2) integration, (3) quality and , (4) employee commitment, however, it becomes clear the QCs in the case-studies lack these goals. On the goal of flexibility/adaptability, there is no real evidence of flexibility. The DHAs cannot easily adapt to changes in their environment and therefore the QCs do not allow any real functional or numerical flexibility. QCs do not allow the workers to practice real functional flexibility, although it to some extent allows them to move freely between tasks in some non-essential areas of their work. Moreover, the bureaucratic nature of the DHAs make it extremely difficult for them to meet the conditions necessary for



flexibility to occur. In a sense the organizational structures make it difficult for them to use the QCs to encourage devolved and organic roles. This perhaps effectively limit the ability of the DHAs to pursue HRM policies.

On the goal of integration, although the DHAs recognize the importance of human resources, the government financial restraint policies in the 1980s, particularly cash limits, have prevented human resources from becoming part of the strategic planning process. There is no consistency in human resource policies (in view of the dualism in management of human resources discussed above). Human resource policies do not cohere with other policies. For instance, the policies on selection and rewards do not complement each other and therefore are not geared towards the achievement of strategic goals.

On the goal of employee commitment, it can be argued that not all the middle managers are committed to the QCs and have accepted their responsibility to practice QCs. Not all the employees are fully integrated into the organization through the employee involvement and commitment strategies. There is no real indication of an increasing employee willingness to accept change. Whilst some degree of commitment to jobs and organization exist there is no widespread desire for involvement, and less than 30 per cent of the employees are involved in the QCs. Even this marginal organizational commitment is threatened by the widespread dissatisfaction with pay and other conditions of service.

On the goal of quality, although the QCs emphasize the importance of setting and maintaining high standards, the QCs were not integrated into the organization's recruitment and selection process whereby it would be possible to recruit, develop and retain staff with high levels of ability and at the same time interested in involvement and participative schemes.

In both case studies the QCs were struggling because there was no genuine commitment on the part of management to develop a system of work reorganization which gives maximum scope for genuine participation, involvement and commitment. In both case studies the QCs did not provide a genuine opportunity for staff to become more involved in decision making. They did not give all the employees in



the organization the opportunity to develop their skills and to make their own contribution to the improvement of work practices and the solution of work related problems.

Both DHAs are not ready to genuinely modify their management philosophies to a change-oriented one. This is evident from the way management uses the steering groups and a host of other mechanisms as a disguised form of external control on the activities of the QCs. On the other hand, there is perhaps no widespread desire among a majority of the employees to participate in the QCs, because external pressures/constraints do not allow a reasonable degree of job security for employees. The low pay of health care employees and the threat of lay-off as a result of hospital closures and reorganization, does not encourage participation in QCs. The DHAs need also to change their culture to one which encourages genuine participation and involvement. This is difficult in health care environment where professionals play a major role in decision making.

The evidence from the case studies is contrary to Kochan et al.'s assertion that QCs increase participation, involvement and commitment. In both case study DHAs, the QCs do not provide any genuine participation, involvement and commitment. The QCs neither altered the organization of work nor increased flexibility, and there is no evidence that they have simplified work rules or lowered costs. The QCs are divorced from such HRM objectives as job design, recruitment and selection, appraisal, reward system. The QCs should have been directed by clear policy objectives which are strategically planned and managed through the organizations culture.

In view of the above findings, Guest's argument that few U.K organizations appear to be practising a distinctive HRM appears to apply to the case study DHAs. As it was argued in the previous chapter the QCs (employee involvement and communications) programmes appear to be management fads -opportunistic rather than strategic initiatives. They are not proactive responses but rather reactive responses to the environmental changes. There was no indication that the existence of the QCs indicated a significant trend towards HRM, because there is no consistency in the QCs as a HRM practice. They are rather a mixture of 'ad hoc', or 'pragmatic', or 'opportunistic'



approaches to manage the workforce.

Although the QCs are unitarist in focus and aim at securing individual commitment and loyalty to the organization, they do not in any significant way undermine the collective and pluralist basis on which the personnel policies are based. As argued earlier the emergence of the QCs does not necessarily mean that personnel managers have to give personnel away; under more favourable conditions personnel managers can contribute to the growth of the QCs. The QCs in the case study authorities do not pose any threat to PM whose most routine functions will always be needed.

### Conclusion

This chapter has analysed the specialist personnel role in the case-study DHAs. The evidence supports Trainor's (1982) view that the government's effort to promote PM in the NHS was a response to the need to fill the gaps in management expertise created by the changes in the environment of the NHS. It has been argued that the introduction of general management has increased the ambiguities in the line and specialist personnel function and relationships. These ambiguities arise from the indeterminate nature of personnel task in the DHAs. In particular the lack of clear differentiation between line and specialist responsibilities in personnel in the DHAs.

The personnel departments in both Metropolis and Countryside mainly provide specialist advice and support services to the line managers on personnel issues including IR. The line managers also deal with the day-to-day management of the workforce. The personnel departments have no significant role in the quality initiatives. The QA and QCs initiatives come directly under the QA and Nurse Advisory departments. The evidence from the two case-study DHAs seem to support Storey's (1987) and Kochan et al.'s (1986) view that the emergence of QCs and other HRM initiatives have increased the line managers' role in PM. Storey's research finding about the existence of a dual people management system in those U.K. organizations which have introduced QC and other HRM initiatives seems to apply to the case study authorities. Evidence from the case studies indicates that the QCs are



reactive, rather than a proactive and strategic responses to the changes in the authorities' environment. The QA and QCs did not justify an expansive HRM element in the case studies. There was no significant evidence that PM is moving towards HRM. PM in the DHAs face problems in solving even short term personnel issues and in sustaining even routine PM functions let alone HRM issues. In this respect PM is a long way away from HRM. HRM has developed in areas where manpower cost is minimal but in the NHS manpower cost is high therefore paradoxically HRM is not developed.



## CHAPTER 11

SUMMARY AND CONCLUSIONS

This chapter provides the summary and concluding arguments of this thesis. The thesis was divided broadly into three parts. The first part (chapters 1-3) dealt with the theoretical and analytical concepts of managerial strategy and strategic choice. It reviewed two seemingly opposing views on strategy. The first view, which has been popularized by managerial strategy theorists, sees strategy as a consciously articulated plan formulated by managers to respond to environmental pressures facing organizations. The second, which is associated with organizational contingency theorists, considers organizational environments as the primary determinant of policies and outcomes and therefore does not allow for an organizational capacity for strategic formulation. The main authors reviewed in this section dismissed the latter view, insisting that in the face of environmental constraints managers still have a choice in shaping organizational outcomes. The managerial strategy theorists therefore argue that managers do not simply react to environmental pressures.

In an attempt to explore the validity of this argument, the thesis reviewed the Kochan et al.'s three-tier model for the application of managerial strategy to the management of human resources. The Kochan et al., and Kochan and Chalykoff, strategic choice frameworks were also reviewed. The model and modified versions of the frameworks were applied later to the case-study DHAs. This model assumes that decisions formulated at the top-tier in organizations affect PM practices at the workplace level. The thesis therefore attempted to explore and explain how the decisions formulated at the top, i. e. district health authority level, influence PM practices at the workplace level, i. e. the unit.

The Kochan et al. and Kochan and Chalykoff frameworks also attempt to explain why such decisions are formulated. The main



argument is that managerial strategies are developed in response to pressures in the external environment and they, in turn, affect employment relations and, more importantly, give birth to HRM initiatives. The authors point out that changes in the external environment induce managers to make adjustments to their organizational strategies. In making these adjustments the range of options considered are heavily influenced by the values and philosophies of the managers - i.e. the key decision makers. These values accordingly influence the strategies that the managers will adopt. Seen in this perspective, management strategies and values play an important role in explaining IR and PM policies. The Kochan et al. framework thus stresses that IR and PM processes and outcomes are determined by a continuously evolving interaction of environmental pressures and responses; choice and discretion of managers.

In spite of the seemingly convincing arguments and illustrations they provide, Lewin on the contrary contends that Kochan et al.'s framework fails to prove conclusively that managers' response to environmental pressures are 'strategic', rather than reactive. Lewin argues forcefully that in adopting QCs, for example, some US and U.K. managers were reacting to environmental pressures and there was nothing strategic in their approach.

Lewin's criticisms notwithstanding, the thesis attempted to apply the Kochan et al. and the Kochan and Chalykoff arguments to the case-study DHAs. This provided an opportunity to assess the usefulness of the framework when applied to a public sector organization which is heavily influenced by political constraints. It was also possible to determine whether the concept of strategy can be used to explain the adoption of the QA and QCs initiatives in the case studies. More importantly, the thesis attempted to explore whether the management of DHAs have any choice in formulating managerial policies or whether they are constrained overwhelmingly by environmental factors.

This part of the thesis focussed also on the changing nature and style of PM and the emergence of HRM. After discussing the origins and traditions of PM in the U.K., and in particular, the consultative and human resource traditions, it examined the inconclusive nature of the discussion of the differences between PM and HRM on the one hand, and



between HRM and strategic HRM on the other. There is some consensus in the literature that PM is often a short-term, reactive approach to people management, that it takes the form of a set of specialist roles in bureaucratic organizations, and that personnel practitioners often espouse more collectivist or pluralist perspectives on employee relations than many of their fellow managers.

The literature does not provide any simple or precise definitions of HRM, but in comparison with conventional PM, it is presumed to embody a more proactive and integrated approach to people management. It is claimed also that HRM encourages a greater involvement and commitment of employees within the organization. It is argued that the origins of HRM can be traced to a number of factors including, the resurgence of interest in 'excellence', the discovery of 'corporate culture' and a greater sensitivity to the demands of customers. In these terms, HRM attempts to change the culture of the organization to improve organizational viability, efficiency and effectiveness.

The ideal-typical model of the goals of HRM outlined by Guest was discussed at some length because it offers a benchmark against which a variety of changes in the NHS in general, and in the two case study authorities, in particular, could be assessed. Has there been a decisive shift from conventional patterns of PM to a more integrated set of HRM policies? Has the relationship between line management and personnel specialists changed with the advent of QA and QC programmes? Has the role of trade unions - and the character of union-management relations - been altered by management initiatives in the HRM area?

The second part of the thesis (chapters 4-6) explored the Conservative government's economic philosophy, notably the public expenditure constraint policies, and their effect on the public sector. The impact of these policies on the emergence of managerial strategies was examined. The changing structure of management in the NHS and the factors responsible for the emergence of general management were reviewed. Prominent among these factors was the need to streamline the management of the NHS by introducing private sector management practices in the belief that they would improve efficiency. It is thus argued that the changes occurring in the NHS



are largely attributable to the policies of the government. The policy making process in the NHS, from the national to the district level were examined. It was pointed out that the QA and QCs strategies in the DHAs follow national policies, especially the simultaneous advocacy of centralization in some areas, and decentralization in others. Managerial strategies at the district level seemed to be driven by changes in the NHS environment.

Chapter 5 traced the development of PM in the NHS and analysed the changing balance between line and staff functions and relationships in personnel. The simultaneous pursuit of two policies in the post-Griffiths period was noted. The first is the attempt to increase line management authority and responsibilities, and the second is the attempt to strengthen PM in order that it can provide more effective specialist services and contribute to strategic initiatives. The practical outcome of the implementation of these two policy objectives is inevitably in doubt; what role can personnel managers play in the formulation and implementation of the managerial strategies, and will increasing line management involvement in personnel issues pose any threat to PM?

Chapter six examined the origins and content of QA and QCs. It was noted that QCs developed in Japan under a managerial philosophy and employment system which was different from that which prevails in the West, and the debate over the need to modify Western management practices and philosophies was reviewed. The conditions for the success of QCs were also discussed. Similarly, the reasons behind the introduction of these strategies in the health care sector were explored. The decline of the traditional (professional) view of QA and the emergence of a more radical (managerialist) view was examined.

It was noted that both QA and QCs policies require the commitment and support of top management and that the implementation of a QA strategy requires practical policies which translate the resulting quality consciousness into concrete changes. The advocates of QA emphasize that QA programmes should incorporate employee participation, communication, involvement, and problem-solving groups and if the management style of the organization is favourable, the implementation of QCs. In this respect QA has important links with



QCs. The advocates of such commitment programmes argue that management could use the QC programme to communicate its quality strategy to the employees at the lower levels of the organization. It is argued that QCs provide an opportunity for all members of staff to provide an input into discussions regarding improvements in health care delivery.

In the analysis of the factors responsible for the emergence of a QCs programme, the 'soft' reasons were differentiated from the 'hard' ones. The 'hard' version of QCs emphasizes mainly quality issues without much consideration for employee welfare. The 'soft' version, on the other hand, indicates that QCs are adopted for employees' benefit as well as for organizational efficiency. That is, there is a balance between organizational economic gains and improvements in employees' morale and well-being. There is an apparent similarity between QA and the 'hard' version of QCs because they both emphasize quality control.

It was argued that both QA and QCs are responses to the potential deterioration in health service delivery arising from the cuts in health care expenditure. Put more bluntly, they are both opportunistic approaches for managing under financial constraints. As such they are both management control initiatives to improve effectiveness, efficiency and quality in the delivery of health care.

Chapter six thus provided the analytical focus for the examination of the QA and QCs initiatives in the case study DHAs. It provided the framework for the empirical chapters to explore the reasons for the introduction of the QA and QCs programmes in the DHAs; to determine whether the employee commitment programmes are consciously articulated strategies developed by senior managers; to discover how these strategies were implemented in the lower levels of the organizations; to identify the role of both personnel and line managers in the formulation and implementation of the programmes; and to examine the impact of the strategies on PM.

The discussion also questioned whether the QA programmes were a means of evaluating the performance of professional health care providers, and thus a potential attack on professional autonomy, or more narrowly, a new approach to quality in the face of resource



constraints, that is, a means of dealing with persistent problems in health care delivery.

These issues set the agenda for the examination of the relationship between QCs and HRM in the empirical chapters. It raised the question whether QCs in practice can be considered as part of the HRM strategies or whether they are ad hoc, piecemeal, short-term operational issues of more limited significance.

The main fieldwork contribution was made in the third part of the thesis (chapters 7-10) which explored data collected in two case study health authorities. After discussing some specific QC projects, chapters seven and eight also explored the failure and moribund nature of other QC projects. The role of general managers, line managers and management consultants in the development and implementation of the QA and QCs initiatives, was analysed. In the evaluation of the Metropolis and Countryside QCs and QA programmes, management motives and objectives for introducing these strategies were critically assessed.

When asked about the reasons for the introduction of QCs, the management of both case study authorities claimed that they were introduced as part of an effort to improve health care delivery and to involve health care employees in decisions relating to their work. That is, QCs were aimed at achieving customer satisfaction, cost-effective schemes and improved QWL of employees. These wide-ranging objectives and intentions of management have not been sufficient to motivate them to evaluate the programme in recent years. This omission, coupled with the desire of management to by-pass the unions in the QC activities, casts some doubt on the priorities of management. Both management and employees involved in the QCs pointed to some benefits, but in the absence of a systematic evaluation and hard data to back up these claims, the overall success of the initiatives remained in doubt.

It was argued that government policies, such as cash limits, competitive tendering, and annual review processes have increased centralization in the NHS. The appointment of general managers and Chairmen of DHAs on short term contracts, and the introduction of performance related pay for senior managers, have made it less likely that these officials will depart from government policy. Government



policies have encouraged a centralization of financial control and decentralization of management accountability. Regional and national priorities have also had a very powerful influence on the development of managerial strategies in the case study DHAs. These are seen as external factors that influence the development of the managerial strategies, including those of QA and QCs initiatives. In both case study authorities, it appears that the managers were responding directly to environmental changes, and that the 'environment' was dominated by government financial constraints.

The management of the DHAs under pressure have adopted new strategies in the management of their organizations in order to achieve their objectives and to show that they can manage the DHAs effectively and efficiently. The district general manager, for instance, needs to show results in order to get his/her contract renewed and to receive his/her performance related pay. As part of the government's centralization process, the annual review process requires the DHAs to demonstrate action and plans for improving service quality. In view of these findings it was argued that the development of the QA and QCs programmes were motivated primarily by managerial self-interest in seeking to demonstrate improvements in the delivery of health care.

It was argued also that the increasing priority attached to quality issues arises from the need to achieve satisfactory levels of efficiency and effectiveness in health care delivery in the face of rising health care costs. The QA and QCs strategies were developed to help the two authorities meet financial targets without suffering a visible decline in standards of service delivery. Such policies call for some degree of employee involvement in quality improvement, as part of 'total quality management' initiatives.

Other reasons for the introduction of the quality initiatives include the pressures from the consumer advocacy movement, the CHCs and other interest groups; the emphasis on value-for-money; the need to respond to the government's initiatives in extending commercial management practices into the public sector, and the Griffiths report's emphasis on the enhancement of quality. It is also part of the patient-centred organizational development effort by senior



management to change employees' attitudes to patient care in general. In the absence of evaluation and monitoring criteria for the QA and QCs programmes in both case study authorities, it was argued that the initiatives were essentially responses to the emphasis on quality in an era of intense resource constraints. The programmes show some continuity with the past policies, but also a small step forward in increasing quality awareness. If fully developed, QA could be a valuable means of imposing greater managerial authority on professional autonomy; a means of evaluating the performance of professionals.

The QCs, however, are seen as an essential aspect of the QA programme and both programmes aim at achieving a strategic change in the health care delivery system. Put simply, they are meant to change the attitudes of the employees and to instil a sense of quality consciousness in the organization. In practice both initiatives are aimed at achieving cultural change in the organizations. The research findings revealed that any desire to use the QCs to encourage employee participation and involvement in decision making, and to improve the morale and QWL of employees, were secondary to the primary objectives of improving quality. In the light of the research findings it was argued that the QA and QCs as HRM strategies are only marginally successful as a few workers only are involved.

The empirical chapters also examined the PM function in the case study authorities. They revealed an increasing line management involvement in personnel issues, especially since the introduction of the QA and QCs strategies. They noted that at the same time that line managers are encroaching into the personnel arena, there have been some institutional attempts to strengthen the PM function. This effort is geared towards making PM a specialist function concerned with strategic issues, thus leaving lower level line managers to deal with routine issues such as hiring and firing.

These developments have, however, increased the ambiguity between line and staff functions and relationships in personnel. The ambiguity is attributed partly to the particular development of the function in the NHS, and partly to the indeterminate nature of the personnel task which tends to spill over to line managers arena and



calls for the services of management consultants. The increasing involvement of line managers and management consultants in personnel issues tends to make the personnel function diffuse and results in the 'balkanization' of the personnel function.

With regard to the QA and QCs programmes, the empirical evidence indicates that personnel managers did not play any significant role in either their development or implementation. The personnel managers did not regard the QCs as part of their function. Evidence from the case study authorities indicates that the QCs do not pose any threat to PM. It was argued that under the present regime of financial constraints, the personnel managers could not play any pro-active role in the QCs. Under more favourable conditions the personnel departments could actively participate in the cultural change at which the QA and QCs initiatives are aimed.

In view of the failure of the management in both DHAs to involve the trade unions in the QCs it was argued that the QCs were meant to undermine or marginalise the existing consultative arrangements; that is, they were an attempt by management to by-pass the unions and interact directly with the employees. By so doing management added a human resource approach to the existing consultative arrangement.

### Conclusions

The case studies showed that the QA and QCs programmes were part of general management initiatives to respond to changes in the management of health care since the Griffiths restructuring. The new structure of general management provides opportunities for the formulation of strategic initiatives at the district level. Whilst the general managers are expected to develop initiatives on quality, the precise form that these initiatives take is left to the managers themselves to decide. The adoption of the managerial strategies of QA and QCs contained limited choice within constraints. The choice revolved around what kind of quality strategies to adopt. As managers are required to develop strategies on quality, and as quality initiatives are assessed in the annual review process, then it is clear that the general managers do not really have a choice as to



whether or not to adopt strategies on quality enhancement.

This means that the opportunity for strategic innovation is limited in scope. Evidence from the case studies indicated that the strategies formulated by the DGMs were heavily constrained by environmental factors, mostly arising from government policies. The enormous influence of the national and regional priorities on the formulation of strategies at the district level reinforces the view that district general managers do not have much choice in the formulation and implementation of the QA and QCs strategies. Seen from this perspective, the QA and QCs programmes are short-term, reactive responses to environmental changes and for that reason cannot be considered as strategic initiatives. In a sense they are an opportunistic means of making improvements in the quality of health care provision. Evidence from the case-studies confirms Storey's (1987) view that QCs and other managerial strategies develop in response to environmental changes and the need to improve the viability and effectiveness of organizations.

The case studies indicated that the public policies of the government exert immense pressures on the management of the NHS. These pressures in turn initiate changes in NHS management priorities, especially the need to improve managerial efficiency and to meet tighter spending targets. This was the reason behind the Griffiths inquiry which initiated changes in managerial values on quality. It was this resurgence of interest in quality which gave birth to the QA and QC strategies. The government's decentralization of management accountability and centralization of financial control, together with the introduction of new contracts for general managers, leave the general managers limited choice in the management of the service.

Having examined the application of managerial strategy theory to the case study authorities, it is suggested that the development of the managerial strategies of QA and QCs can be explained more in terms of organizational contingency theory than the managerial strategy theory. In spite of the claims of senior managers, and the strategic plans, that the QA and QCs are strategic initiatives, evidence from the case studies indicate the contrary. The QA and QCs developments reflect reactive and short term responses to the environmental



pressures and, as such, the QCs cannot be considered as significant HRM initiatives. As the NHS is influenced by a complex political environment the concept of strategy is not easily applied in the analysis of the management practice. There is very little evidence to believe that district managers are capable of formulating strategies since most strategies are actually initiated at the national level and are heavily influenced by political considerations. For this reason the concept of strategy may have to be abandoned or redefined because of the sheer weight of political pressures impinging on the development of policies at the district level.

In both case study authorities financial constraints, buttressed by distinct political and ideological factors, have effectively marginalized the contribution of QA and QCs initiatives and consequently undermined the possible development of HRM. The effectiveness of the QA and QCs policies which are meant to overcome the the potential deterioration in the quality of delivery of health care arising from resource constraints, have paradoxically been undermined by these same constraints. The resource constraints have limited the participation of personnel managers in the QCs; the problems of recruitment and retention of specialist personnel staff severely undercut the personnel departments' ability to participate in the formulation and implementation of quality policies.

Furthermore the QC programmes in both case study authorities are struggling for survival. The QCs programme in both Metropolis and Countryside face some degree of resistance, and a lack of commitment, from middle managers, trade unions and employees. The trade unions indicated that they would have liked to be informed about the introduction of the QCs; as the management in neither case study authority informed the trade unions, they have not given the programme their official blessing. If the trade unions had recommended the QCs programme to their members, perhaps more employees would have joined. The failure of the trade unions to officially approve the programmes has reinforced some employees' scepticism about management's motives for their introduction. The attempt by the management to by-pass the unions is viewed by some employees as an indication of lack of management commitment to participation. This view is supported by the



evidence of management control over QCs activities; management influences the agenda and makes the final decision regarding the implementation of projects. In other words management allows only a limited form of participation; one that is management-led.

Some middle managers have resisted the idea that employees are capable of taking initiatives to solve work-related problems; they believe that managers should offer leadership and make decisions. This reflects the general anti-participative nature of Western managerial culture, and the specific management culture in the NHS where it is expected that the managers make decisions with advice from relevant professionals. After many years of professional domination of decision making, general management has emphasized the need for managerial professionalism in decision making. This view, which considers managers as the only competent and legitimate decision-makers, marginalizes the potential contributions of lower ranking employees, and for that matter, the role of the QCs in the organization. The QA and QCs initiatives were introduced, in part, to change the organizational culture, i. e. to make the organizations more quality conscious, yet the emergence of a new culture which emphasizes managerial control over decision making has been influential in undermining their effectiveness.

The conclusions of the study raise the question of the usefulness of the modified Kochan et al. and Kochan and Chalykoff frameworks for explaining the emergence of managerial strategies and HRM in organizations. As the case study DHAs indicate, it is the interaction of the environmental pressures and managerial strategies which give birth to QCs. This essentially supports Kochan et al's. and Kochan and Chalykoff's assertions about the origins of QCs as an aspect of HRM. The main difference is that QCs in both case study authorities cannot be considered either as a strategic initiative, or a significant shift to HRM. It is true that the QA policy was developed at the DHA level, and integrated with QCs at the unit level, and that the QCs were the product of the interaction of environmental pressures and managerial values. The QA and QCs programmes cannot be considered as strategic, however, because they did not have much impact in terms of organizational outcomes on employers, employees,



trade unions, customers, and the personnel function. Equally, the QCs did not arise from, or give birth to, HRM. To repeat an earlier point, the QCs do not fully meet the HRM objectives of flexibility/adaptability, integration, employee commitment and quality. It is argued that the QCs did not provide any significant evidence of a possible shift from PM to HRM.

This suggests that the analytical frameworks have a limited value only in explaining the impact of the QA and QCs programmes on the PM function in the case study authorities. On the Kochan et al. three-tier model, it can be argued that the implementation of the QA and QCs programmes show an interaction between the top tier and the bottom tier (workplace level) only. The QA and the QCs developments do not have any impact on the middle tier. Evidence from the case studies, thus, raises a question mark against the utility of the Kochan et al. framework and model, or its relevance to the particular circumstances of the case study health authorities.

In spite of these shortcomings the application of managerial strategy theory to the case study authorities has clarified some of the debates about the role of managerial strategies in the management of people in organizations. The qualitative case study methodology used in this study has helped in clarifying some of the debates about the application of managerial strategy theory to PM in public sector organizations. It has shed some light also on the supposed effects of employees commitment programmes on PM and has suggested that these programmes do not always pose a threat to PM. It has also contributed some evidence to the debate on the conditions that may facilitate or impede the transition of PM into HRM. As it was pointed out in chapter one, however, the qualitative methodology seldom yields precise definitive conclusions and the findings from these case-studies cannot be generalized.

It is necessary to be cautious about the conclusions. Fieldwork data, in particular, are limited to the period in which they were collected. Data were gathered from two main case studies and the QA and QCs initiatives are not the only illustrations of management strategies that could have been used. It may be argued that they are not the best litmus test for exploring management strategy in the NHS.



In the 1980s, the potential benefits of these commitment programmes were not realised. Other issues, such as recruitment, or hospital closures, could have been used. This together with the role of organizational culture in marginalizing the effects of the QA and QCs objectives are areas that can be taken up in further research.

The research has some policy implications. Most of the analysis of the case study material shows the marginal role of PM in the quality initiatives, and the absence of a serious move to HRM. As it is a key objective of the DHAs to achieve improvements in quality, quality must be central to the management of human resources in the NHS. In this respect quality should form an essential part of training. It is argued that personnel managers should be persuaded to modify their views on the quality initiative programmes. In particular, the personnel managers should be sensitized to the potential motivation role of PM in quality initiative programmes.

In a labour intensive organization such as the NHS it is desirable to encourage personnel managers to provide assistance and advice to line managers on how to motivate employees in employee commitment programmes in order to maintain high standards in the delivery of care. Despite the fact that the quality initiatives are structurally located in the Nurse Advisory departments, personnel managers could contribute to the programmes if the value and desirability of the personnel managers's contribution is recognized throughout the organization, and if the management directs that the personnel department should play a more formal role in the programmes. Such an approach could perhaps prevent any potential power struggles between the PM and Nurse Advisory departments for the control of the programmes. The personnel managers would then have the power and authority to participate in the QA and QC programmes. Thus the personnel managers would be able to overcome the power and structural constraints. It is unlikely that such developments can take place at the district level unless the NHS policy makers encourage a shift towards this direction. This could be part of the institutional effort to boost the personnel role in the NHS. This means that the concerns of the personnel managers about the the adverse effects of the government's public expenditure constraint policies could be addressed



whilst simultaneously encouraging them to play a more active role in employee commitment programmes.

Personnel managers could play a more important role in quality initiatives if training is viewed as a key resource in seeking to change the values and culture of the organization. More resources should be provided also to facilitate the hiring of highly qualified staff: if more resources were available, then personnel managers could participate more effectively in quality initiatives, help to overcome the resistance to change, and contribute to the exercise of cultural change.

The QA and QC initiatives can potentially be more successful if a serious approach is adopted to change the culture of the NHS and the attitudes and behaviour of the employees. This falls squarely in the realm of the personnel managers and every support should be provided for the personnel managers to push through the required change. Such support is required for the personnel managers to communicate the quality initiative to the staff, discuss the quality initiative with the trade unions and seek their support in the programme, and to shape the new culture of the NHS.

The personnel role in the quality initiatives could be increased substantially. NHS policy makers should encourage the effective performance of this role if they are genuinely concerned about the improvements of quality in the NHS and, for that matter, the success of the quality initiatives. Of course this development should be backed by a meaningful pay policy which will improve substantially the pay of NHS employees. It is only when NHS staff are satisfied with their pay that they will take keen interest in the commitment programmes. In other words the motivation and reward systems must be consistent with the new culture. Policy makers should thus abandon the strategy of using the commitment programme to improve the delivery of health care without improving the pay and conditions of service of employees.

Whilst the government continues the resource constraint policy, employee commitment programmes are less likely to succeed in halting the deterioration in the provision of health services. Under the government's current public expenditure constraint policy it is



unlikely that more funds will be allocated to the districts to enable them to promote personnel and training issues. The dangers involved in the pursuit of such a policy should not be overstated, but it is suggested that if this remains in place the districts should try to raise funds through other innovative means to support the quality initiative programmes as well as for personnel and training programmes. At the very least the districts could try to avoid the cutting of PM and training budget even if it cannot be increased.

It is perhaps desirable to increase resources for PM because even if management strategies change, quality and human resource issues would still be important in the health service. Personnel managers will still need more resources to overcome recruitment and retention problems.

Of course, all these policy recommendations should be considered in relation to the 1989 White Paper on the NHS - a major structural proposal that may have a far-reaching impact on management strategy and HRM. This research has dealt with the period from 1983 to 1989. The emergent issues regarding structural reorganization in the 1990s could influence the way management strategy and quality issues are dealt with.



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APPENDIX A: RESEARCH METHODS AND DATA SOURCES

Chapter one generally discusses the methods and methodological issues. It outlines the links between the debates about management strategy, human resource management, Quality Assurance and Quality Circles and the evolution of management in the National Health Service. It also addresses the strengths and weaknesses of the case study method and the choice of more qualitative rather than quantitative forms of analysis. Naturally the early phase of the research processes were concerned mainly with exploring literature sources in each of the four areas mentioned above. The purpose of this appendix is to provide further information on research methods and sources of data.

The research on national and regional strategic decisions in the National Health Service was based on both secondary and primary sources of documentation. Quality Assurance policies - and the practice of Quality Circles - were chosen as appropriate illustrations to explore some of the issues arising from the debates about HRM, so letters were written to relevant organizations seeking information on national quality initiatives. These organizations included among others, the Department of Trade and Industry and National Society of Quality Circles, and the documents they supplied supplemented the sources found in the library research.

The fieldwork research was based mainly in district health authorities, including the units. The focus was on the planning and implementation of personnel and employment policies generally, and, in particular, the area of employee involvement and participation in decision making. It was intended to compare managements' human resource policies and practices in two district health authorities. The purpose was to examine whether the management in different health authorities responded differently to environmental pressures. It was also to determine whether there is any congruence between what the managers say and what exists in practice.

The fieldwork research was based on interviews with people



involved in human resource policies, people involved in employee commitment programmes and trade union representatives. Respondents can be grouped into the following categories: (1) senior management comprising members of the management executive boards; (2) middle managers; (3) Quality Circle members and (4) trade union representatives. Below is a diagrammatic depiction of these categories indicating the number of people interviewed in each of the case study health authorities:

	<u>Metropolis DHA</u>	<u>Countryside DHA</u>
Senior Management	5	4
Middle Management	11	9
Quality Circle members	24	21
Trade union officials	3	3

In the senior management category the officers interviewed included a District General Manager, Chief Nurse Adviser/Quality Assurance Officer, Personnel Director, Unit General Manager and Management Adviser. The middle managers included a Unit Personnel Manager, Administrative/Operational Services Manager, Assistant Quality Assurance Manager, Nurse Practice Facilitator, Nurse manager, and an Equal Opportunity Officer. The Quality Circle members included some members of the individual circles as well as their leaders. These were made up of mainly non-managerial staff. On the staff side both nursing and ancillary union representatives were interviewed and these included branch secretaries

Quite apart from the interviews at district and unit level, a personnel officer at the regional level, regional nurse managers, members of a Community Health Council, and a Director of Personnel from one of Metropolis' neighbouring health authorities were interviewed. The Personnel Director, in particular, gave informative views about the emergence of the personnel function in Metropolis



since he was a former employee of the Area Health Authority which was disbanded to create Metropolis. This helped to trace the historical development of the personnel function in Metropolis as there was no one in that health authority who could give that information because of the high turnover of personnel officers.

The members of the Community Health Council provided a good insight into the development of managerial policies since the Griffiths restructuring and the general policy making process in the district health authorities. Interviews with the personnel officer at the regional level explored national human resource strategies, the way that these strategies are pushed down to the regional level and subsequently passed on to the district health authorities. The regional nurse managers were asked about the evolution, formulation and implementation of national, regional and district policies on Quality Assurance and Quality Circles. It must be noted that employees who were not Quality Circle members were not interviewed.

Every effort was made to select a representative sample of the people in the organization who, in one way or another, were involved in employee commitment and consultation processes. The respondents were carefully selected to include those who formulated the policy, those involved in its implementation, those directly involved in the operation of the Quality Circles and those who represented the interests of staff in consultation processes in the case-study authorities.

The interview categories were chosen to tap managerial motives and objectives for introducing the Quality Assurance and Quality Circle programmes in the case-study health authorities. It was believed that interviewing these people would bring to light the various tensions, conflicts and themes in the formulation and implementation of the employee commitment programmes. It was also hoped that the interviews might help in capturing the various views and objectives in setting out the programmes. More importantly, data collected in the interviews was used to assess (a) the relationship between the Quality Assurance and Quality Circles and (b) the role of the Quality Assurance and Quality Circles as part of the move towards human resource management. That is, Quality Circles were



evaluated within the framework of managerial strategy theory. This means that the achievement or success of the Quality Circles were considered not only in terms of the criteria for the success of Quality Circles per se, but also in terms of their general contribution towards the cultural and organizational change in the case-study health authorities. In other words their contribution to the management strategy of moving the organizations as a whole towards a human resource management approach and an employee involvement oriented culture. It was also meant to determine the role of personnel management in the employee involvement programmes. The interviews with the personnel and line managers were to determine the extent to which employee involvement programmes posed a threat to personnel management in the case-study health authorities, and to assess the role of line managers in personnel issues.

In the search for answers to these questions, semi-structured, open-ended flexible interview schedules were used. The questions were posed in an exploratory manner. On the Quality Circles and Quality Assurance, for instance, the interviews explored why and how the policies were formulated and implemented, the problems and achievements in their implementation, and the role of managers, employees and trade union officials in the process. Similarly, the interview questions explored the reasons for the origin of the various Quality Circles in the units, the achievements and problems in the operation of the circles and the benefits the members derive from the circles, if any. This was done as part of the general assessment of the role of the Quality Circles in the move towards human resource management.

On the role of personnel management in the employee involvement programmes, the interview questions explored the role of both line and personnel managers in the quality initiatives. It revolved around the roles and responsibilities of the personnel managers in the organizations as a whole, and the role of line managers in human resource issues. It also explored any frictions, conflict, ambiguities, antagonism and competition between the line and personnel managers.

On many occasions the interviews yielded documents which were



equally important in providing information on the issues which were being researched. The documents included minutes of Quality Circle meetings, Quality Circles presentations, and Quality Circles files on the various projects undertaken. These together with other documents and data derived from the interviews formed the basis of the case-studies and projects reported in the research, and evidence for the assessment of the success of Quality Circles in the thesis.