

**REVIEW OF PUBLIC
ADMINISTRATION IN NORTHERN
IRELAND**

**BRIEFING PAPER:
QUALITY OF SERVICE**

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The views in this report are those of the author and are not to be attributed to the Review of Public Administration team or the Office of the First Minister/Deputy First Minister.

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Executive summary

1. At a general level quality is often referred to as ‘the degree of excellence’ but at the more detailed service level a range of different dimensions have been identified including accessibility, effectiveness, acceptability, equity, responsiveness, reliability and openness.
2. Definitions of quality tend to cluster around technical (conformance to specification), user or value themes. The decision about which approach to take to the definition of quality is influenced by the nature of the public service in question.
3. The application to the public sector of approaches generated for use in the private sector is problematic. This is due to differing aims, the service relationship, partnerships, professionalism, and the concept of the customer as co-producer.
4. Total system approaches include total quality management and business process re-engineering. A model combining elements of both is being promoted in the NHS in England by the Modernisation Agency.
5. Two internationally recognised approaches to external inspection are ISO9000 and the Business Excellence Model. The latter has been widely promoted in public services in the UK by the Cabinet Office.
6. External quality inspection systems are often based upon a peer review model. Attempts are being made in Europe to harmonise standards used in accreditation programmes through initiatives such as ALPHA.
7. Risk management systems aimed at minimising the occurrence of adverse incidents have developed in public services over the last ten years. These involve identifying, assessing, rating, ranking, and then addressing risks. There will be benefit in co-ordinating the development of risk management across different public services because it is likely that a great deal of learning will be transferable.

8. Performance indicators are widely used in public services. A review of progress on indicator development for local authorities in England and Wales concluded that there was scope for further improvement.
9. The importance of the customer perspective, both internal and 'end user', is emphasised in the quality management literature. Several unique features of the customer-provider relationship in public services have led to the suggestion that a citizenship model is better than one based on consumerism. A key feature of this model is that users are involved in decision-making as well as providing views of services.
10. Implementation of quality programmes requires good project management but in the public sector there are additional issues to consider such as acceptance and ownership by professional groups, the complexity of a partnership approach and the requirement that quality improvement programmes are cost effective.

1. WHAT DOES QUALITY OF SERVICE MEAN?

This section will examine definitions of quality, the growth of quality management in the private sector and implications for the management of quality in the public sector.

Definitions of quality

Definitions of quality arise from different traditions, and therefore there is no single definition of what is meant by the term. Definitions tend to cluster around one of the following themes:

1. **Technical definitions:** Here quality is seen as being to do with ‘conformance to specification’ or ‘fitness for purpose’, and there is some implication that the objective measurement of quality is possible.
2. **User definitions:** A number of writers have stressed the importance of taking into account user or customer-based quality criteria, especially when delivering services (Campbell, Roland and Buetow, 2000; Ovrevit 1992; Zeithaml *et al* 1990; Skelcher, 1992). There is considerable agreement on what constitute the key dimensions of quality in public services. This includes accessibility, effectiveness, acceptability, equity, responsiveness, reliability and openness (Donabedian, 1988; Maxwell, 1992; Skelcher, 1992; Wilding, 1994).
3. **Value definitions:** Quality is also defined in relation to value. In the public sector cheapness for a given standard is sometimes taken as an indicator of quality (as in ‘value for money’), while conversely in business transactions quality can be associated with expense (e.g. a ‘Rolls Royce’ service).

The definition of quality thus needs to be related to the type of public activity being undertaken. Technical and value definitions will tend to be more important in infrastructure projects, while user definitions will have primacy in face-to-face services.

The management of quality

The management of quality has emerged as an important theme in business management over the last 50 years. American theorists dominated initially but it was predominantly Japanese companies that applied the concepts in the early years (Beckford, 2002). Uptake of these concepts has been slower in the public sector but government policies have become increasingly concerned with quality over the last 20 years. In health care, for example, the report of the Working Group on the Principles of Quality Assurance convened by the World Health Organisation Regional Office for Europe in May 1983 has acted as a catalyst.

In the UK most of the public sector has seen a move from various initiatives that had the aim of improving services to a more systematic approach to managing quality. This change is inextricably linked to the wider reform of public services which has been accompanied by increased regulation and the greater use of performance indicators.

Approaches to quality management have been strongly influenced by a small number of writers or 'quality gurus'. They have been responsible for generating key concepts such as the centrality of the customer; the use of performance data and statistical process control for the measurement of quality; the 'quality chain' and internal customer; procedures to improve quality such as the Plan, Do, Check, Act cycle; and methods for solving quality problems such as quality circles and fishbone charts. Although these writers differ in their backgrounds, definition of quality and some of their principles, they share many concepts in common (see Figure 1; Beckford, 2002; Pollitt, 1996).

Figure 1: The quality ‘Gurus’ and their key concepts

Philip Crosby	It is cheaper to do it right first time, quantitative measurement to produce zero defects, leadership by management
W. Edwards Deming	Statistical process control charts and the separation of variation into ‘common cause’ and ‘special cause’, the Plan, Do, Check, Act cycle, continuous improvement, leadership by management
Armand Feigenbaum	Total Quality System – organisation-wide systemic approach to quality, leadership by management, team working
Kaoru Ishikawa	Company-Wide Quality Control, Quality Circles, use of quality tools such as Pareto charts, fishbone diagrams and control charts
Joseph Juran	Quality planning, quality measurement, training for quality, quality trilogy of planning, control, improvement, Pareto analysis to separate ‘vital few’ problems from ‘useful many’.
John Oakland	Total Quality Management, quality central to organisation, prevention not cure, leadership by management, long term commitment, eliminate fear

However the application of approaches generated for use in the private manufacturing and commercial sectors is problematic when applied to the public service sector for a number of reasons. These can be summarised as follows:

1. **The aim of quality management programmes in the manufacturing sector is standardisation** – ‘conformance to specification’ - whereas in the service sector, responsiveness to individual needs is important, although equity of provision is also a key principle and so some degree of standardisation is necessary.
2. Unlike the manufacturing sector which focuses on the tangible and easily measurable, **quality in the service sector relies on a relationship between people**. It is difficult to measure independently of the opinions of the people involved in the relationship – it is intangible and instantaneous.
3. **Manufacturing and commercial approaches emphasise the importance of tracking processes from beginning to end**. This is difficult in the public sector where a number of different agencies may be involved. Control of the process may not lie with one organisation. Information systems may differ across the organisations making quality

monitoring and measurement difficult. Staff may have different values and work cultures.

4. **Many commercial approaches rely on a corporate, management based approach to quality** but most public services are split into different departments and rely on professionals to deliver services. Professionals operate in a semi-autonomous way and are accountable to their professional organisations. They do not always respond well to management driven initiatives.
5. **In the commercial and manufacturing sector it is often possible to cease production and reorganise in a radical way in response to problems with quality.** This is not usually possible in the public sector where services must continue during restructuring.
6. The customer is central to quality in the private sector but **the concept of the customer does not fit well in the public sector** (see Figure 2).

Figure 2: Why the 'Customer is King' cannot apply to public services

Equity is a key principle in public services and this means that an individual cannot always have everything. There must be a balance between the needs of the individual and the needs of others in a community. The private sector, on the other hand is based on the principle of satisfying every demand in the interests of profit.

The 'end customer' is not always clear – it could be the parent or carer, the local community, or the agency buying the service - for example in prison services or schools. There may be conflicts of interest between different 'customers'.

There is sometimes a power imbalance between the 'customer' and the provider of services and this may inhibit the use of some quality techniques such as complaints procedures and 'satisfaction surveys'.

The 'customer' of a public service often has a part to play in achieving a good outcome and so contributing to a good quality service. For example, in the health service, the 'end customer' is a 'co-producer' of health. Without the patient explaining symptoms to the doctor, complying with treatment prescribed, administering treatment correctly or engaging in self-care when necessary, the end result will be a poor health outcome.

In sum, the definition of quality in a public service will be based upon the values and expectations of key stakeholders. This may differ between services, especially as a definition moves from the general to the specific level. There are a number of approaches to the management of quality that have been applied in the private manufacturing and commercial sectors with some success. These approaches have a number of core concepts in common. Special features present in public services make the direct transfer of business approaches to quality management problematic and the modification of these approaches will be necessary.

2. APPROACHES TO THE MANAGEMENT, MEASUREMENT AND MONITORING OF SERVICE QUALITY

This section will examine a number of different approaches to quality management and measurement that are currently in operation in the public sector. This includes total system approaches, external inspection, risk management, the use of performance indicators, and service specific approaches.

Total System Approaches

There are two main total systems approaches that have developed from the philosophy and methods of the early exponents of quality management. Total quality management can be traced directly to John Oakland (1993) although it was developed initially in Japan, whilst business process re-engineering was formalised as an approach by Michael Hammer and James Champy (1993). However both approaches have generated a substantial amount of literature and there are many different variations on these two themes.

Total quality management is usually considered to be the same as continuous quality improvement and is characterised by the following features (Locock, 2001):

1. Primary focus on the needs of the customer not the organisation
2. Organisation-wide philosophy of quality as everyone's business
3. Continuous, incremental improvement
4. Responsibility for quality in the hands of front-line staff
5. Collective team responsibility
6. Focus on systems and process rather than individual performance
7. Reporting of errors and defects without fear of blame
8. Culture of open questioning and constant learning

A review of TQM in European healthcare identified a number of reports of successful individual projects and hospital-wide programmes but these had been internally evaluated, often by project enthusiasts (Ovretveit, 2000). An independent evaluation of a pilot of TQM in several UK hospitals in the early 1990s reported only limited success (Joss, 1994).

Problems encountered in Europe and the UK and reported by these authors include:

1. Verbal support but lack of demonstrated commitment from senior staff
2. Management resistance to empowering employees
3. Professional resistance to what was seen as a management imposed initiative
4. Failure to develop model of monitoring continuous improvement in work processes
5. Insufficient training of staff in quality tools and techniques
6. Cost of investment and uncertainty of return
7. The complexity of healthcare, including the multiplicity of customers.

There have been many criticisms of TQM from the private sector also, including the difficulty of taking an approach developed in Japan and applying it in a Western cultural context.

The emergence of business process re-engineering can be seen as a reaction to the perceived failings of TQM. It is characterised by the following features (Locock, 2001):

1. Primary focus on the needs of the customer, not the needs of the organisation
2. Radical transformational change of the whole organisation simultaneously
3. Focus on rethinking and redesigning processes from scratch and stripping out unnecessary steps
4. Led from the top down with an emphasis on visionary leadership and management control
5. The empowerment of teams
6. A requirement for flexible work practices
7. A strong emphasis on information technology.

The approach has been mainly adopted in the private sector although some public services have shown interest in the last few years, particularly the health service. Both the Leicester Royal Infirmary and King's Hospital in London were funded by the Department of Health to pilot re-engineering and both were externally evaluated. In each case quality improvement and costs savings were reported but the extent of change was not as great as originally

planned, particularly in relation to the amount of money invested. Rather than the quick gains expected from this radical change approach, a more sustained long-term effort was necessary and this made the uniqueness of the approach compared with TQM difficult to substantiate (Packwood *et al*, 1998; Bowns and McNulty, 1999).

External inspection

There is a range of different approaches to external inspection and these vary according to four main criteria:

1. whether they have a specific or a general focus
2. whether they are voluntary or mandatory
3. whether they are commissioned by government or independently provided
4. the degree to which they are based upon self-assessment.

There has been little research to either examine the impact of this approach on quality of service or compare the effectiveness of these different approaches in promoting quality improvement in organisations.

Two internationally recognised approaches are the International Organisation for Standardisation (ISO) and the European Foundation for Quality Management (EFQM) or Business Excellence Model. These both have a general focus, are voluntary and independently provided. There is a much greater degree of self-assessment in EFQM where an organisation can choose to remain at this level, rather than enter for the European Quality Award.

The ISO model began with quality standards in the defence industry and the need to standardise products and services to accommodate trade. The ISO 9000 series is a set of five individual but related standards on quality management and quality assurance. They are generic and were developed to document the quality system elements necessary to maintain an effective quality system. ISO 9001 is divided into 20 chapters covering issues such as management responsibility, document and data control, inspection and testing, corrective and preventive actions, internal quality audits and training. The audit of standards to achieve certification is executed by experts in ISO norms rather than reviewers with knowledge of a particular industry or service. ISO certification has been awarded to various public services across Europe, including hospitals (Gourlay, 1998; Klazinga, 2000).

ISO9001 certification provides an internationally recognised assurance that an organisation has a quality management system that has achieved a certain standard. This makes it popular with purchasers and users of services. However, although it was updated in 2000 to address limitations, it is still considered to reflect its manufacturing origins and is not flexible enough to cope with the variability in requirements of individual customers necessary in public services. Also it has a static rather than dynamic concept of how an organisation works based upon a traditional paper record and checklist approach that can result in increased bureaucracy (Beckford, 2002)

The European Foundation for Quality Management (EFQM) does not aim to standardise quality systems, but instead to promote total quality management and EFQM does this through the European Quality Award Scheme and the publication of a model that can be used for self-assessment. This model has nine performance criteria. These are: leadership; policy and strategy; people; partnerships and resources; processes; customer results; people results; society results; and key performance results. An organisation regularly assesses itself against the performance criteria with the aim of achieving improvement. There is also the option of pursuing the European Quality Award, which includes external assessment in competition with other organisations (www.efqm.org; Beckford, 2002).

Since the mid-1990s, the Business Excellence Model (BEM) has been widely promoted in public services in the UK by the Cabinet Office (Cabinet Office, 1998). Government publications, such as the *Guide to Quality Schemes and Best Value* (DETR, 2000) encouraged managers to consider the BEM as a corporate framework for the Best Value policy initiative. It has been estimated that around 50 per cent of local authorities are currently making some use of the model (Bowerman, 2002).

The popularity of this model in public services suggests it is more suitable for adaptation to this sector than ISO9001 although some writers have suggested that it is only suitable for companies that have well-developed quality management systems in place or have already achieved ISO certification. This is because it relies largely on perceptions and on self-assessment and therefore standards set may not be challenging or rigorously applied (Beckford, 2002).

There are also external quality inspection systems with a service specific focus that are based upon peer review and may be government funded or independent, and operate on either a voluntary or mandatory basis. Examples include hospital accreditation programmes (voluntary in the UK but mandatory in the USA) and Commission for Health Improvement clinical governance reviews in England and Wales. In healthcare, attempts are being made to harmonise standards used in accreditation programmes at an international level through initiatives such as ALPHA and the ExPeRT project (Klazinga, 2000).

Service specific external inspection systems have the advantage of addressing quality issues related to the content of service delivery as well as the process. They are based upon peer review and so are more likely to be acceptable to the professionals employed in many public services. However, there is a danger of proliferation of inspection bodies leading to duplication of effort. This is particularly likely in public services where different organisations are working in partnership to provide a seamless service. Harmonisation of standards and approaches to review would avoid inconsistency and over-inspection. The sharing of experience and training for reviewers is also important, as the process of inspection relies heavily on the skills of reviewers. Collaboration between different external inspection organisations operating in the public sector would be useful in progressing learning and development. For example, the Scottish Executive has adopted a charter that sets out principles for public and professional inspectorates whose role includes evaluation of cases in the public interest, including health, education and social work services.

In sum, there are a number of different approaches to external inspection and most public services have experience of several of these, particularly mandatory inspections provided by the Audit Commission, inspections by professional bodies and popular voluntary approaches such as EFQM. One of the values of external inspection is that it provides an independent assessment of the quality management systems within an organisation. This can draw attention to weaknesses in a way that makes it difficult for an organisation to ignore, as well as provide confirmation about standards of quality. Certification can deliver a degree of assurance to purchasers and users of services that quality of service is taken seriously. However, there has been little research on the impact of external inspection or comparative research on the relative effectiveness of different approaches in improving quality.

Risk Management

Adverse incidents that result in injury or death to staff or customers occur in many organisations. During the last 20 years risk management approaches aimed at minimising the occurrence of these incidents have developed in the private sector. Over the last ten years there has been development in public services away from traditional health and safety schemes towards the adoption of risk management.

Clearly, independent inquiries such as those set up to look into the deaths of children under the care of social work departments, or disasters such as the death of football fans at Hillsborough Football Ground in Sheffield, are ways that public services try to learn from adverse incidents. However, such inquiries also serve the function of satisfying the need for justice and accountability of those affected and this can overshadow the process of learning that should follow. In many cases, the report is so long and complex that it is difficult for organisations that might benefit to either find the time to distil and implement the learning or recognise that the learning might be useful to them.

Risk management is a systematic and planned approach to preventing adverse incidents and as such does not take the place of an independent inquiry. Rather, it builds upon existing systems and extends them into a coherent approach. There are five elements to the approach, as follows (Dickson, 1995):

1. The identification of risks through a variety of methods including: observation of environment and process; analysis or audit of records, case notes and client contact; incident reports; complaints analysis; fault tree analysis and failure modes event analysis (examining possible scenarios)
2. Assessing risks through a consideration of how adequate the existing risk control measures are, how serious the consequences of the risk would be and how likely the risk is to occur.
3. Rating the risks in order of severity, likelihood and the strength of existing control measures
4. Ranking them in order of seriousness and priority based on the rating
5. Developing measures to minimise the likelihood that the most serious risks will occur within cost limitations imposed by available budget

Risk management in some public services, such as health care, is developing very quickly. There is a great deal that public services can learn from one another, both about approaches to risk management and also adverse incidents. A report published by the Department of Health *An organisation with a memory* (2001) examines what the health service can learn from industries where risk management is well developed, such as aviation. It considers the large body of research on the causes of human error and the barriers to learning from adverse events. One of the key points made in the report is that although lessons are often drawn from experience of adverse events, they are not always learned. Weaknesses identified in the NHS that inhibit the detection, reporting, analysis and learning from adverse incidents are likely to be present in other public services.

Risk management faces criticism that it is mainly concerned with reducing financial loss, and increased litigation has certainly acted as a catalyst in its adoption. It can encourage defensive practice and this can lead to increased bureaucracy. Unless risk management is linked closely with quality management it is not likely to be effective in improving quality of service.

The Use of Performance Indicators

There is extensive literature on the use of performance indicators in public services. A review of the literature in health care suggested that performance indicators are used in two main ways: either for external control and regulation, or for internal quality improvement. In public services they are mainly used by governments as a way of assessing performance in order to identify poor performance and verify improvement against goals set. In other words they are used for the purpose of quality assurance and accountability rather than as part of a learning process to promote continual improvement (Freeman, 2002). The literature identifies many difficulties in the use of performance indicators (see Figure 3) and suggests that they should be used with caution, particularly when used as a basis for public information, the allocation of resources or League Tables, rather than as a tool for quality improvement.

Figure 3: Summary of difficulties in use of performance indicators (adapted from Freeman, 2002)

1. Indicators appear objective but involve values in selection and operationalisation
2. Selecting indicators can focus attention on some dimensions of quality at the expense of others
3. There is a tendency to measure what data is available rather than what is important
4. Data collection is susceptible to manipulation
5. Data may be misleading and misinterpreted
6. Indicators give rise to perverse incentives and unintended consequences
7. Indicators do not show why particular results are obtained; further investigation is needed before the implications for action can be uncovered

Performance indicators can also be used as a tool for benchmarking. This is a process of comparison between the performance characteristics of organisations with the aim of enabling participants to improve their own performance. The aim is to gain an understanding of how a competitor is successful. This is usually defined as more closely meeting customer requirements, more quickly and more cheaply. Comparison can be across similar functions in different organisations, or across similar types of organisations (Beckford, 2002)

In England and Wales the Audit Commission is involved in developing, collecting, validating and publishing performance indicators in relation to health services and local authorities. It collects national indicator information on behalf of these governments and provides a range of indicators that local authorities can select and use. It works with the Commission for Health Improvement (now the Commission for Healthcare Audit and Inspection) and with the Improvement and Development Agency in England and Syniad in Wales (www.bestvalueinspections.gov.uk).

A review of progress on the development of performance indicators for local authorities in England and Wales came to the conclusion that between 1993/4 and 2001/2 there were more indicators of service quality, efficiency and formal effectiveness, and consumer and citizen responsiveness. However, there was “substantial scope for further development” in areas such as refining the operationalisation of concepts like effectiveness and equity, and adding missing dimensions of performance (Boyne, 2002)

Service Specific Approaches

A combination of approaches is being adopted in many public services both at a national and local level. For example in the health service in England and Wales, there is a national performance assessment framework that relies on performance indicators to measure six dimensions: health improvement, fair access, effective delivery, efficiency, patient/carer experience, and health outcomes. There are the National Institute for Clinical Excellence and National Service Frameworks that set standards of care based upon evidence of what is clinically effective. At the local level there is a system of clinical governance that sets a duty to be accountable for quality of service on all NHS organisations and links together risk management, continuing professional development, clinical audit and quality improvement. There is an external inspectorate, the Commission for Health Audit and Inspection, which carries out reviews of how clinical governance is operating in NHS organisations and makes these reports publicly available. In addition, in England there are a number of redesign projects based upon a combination of total quality management and business process reengineering that are funded by the Department of Health under the guidance of the Modernisation Agency, and are aimed at improving access to services and improving the quality of particular services such as cancer, coronary heart disease and mental health.

In local government in England and Wales, the Best Value policy imposes a duty on local authorities to continuously improve performance and deliver services to clear quality standards in the most effective, economical and efficient way. There are a number of different aspects to the policy. It includes the collection and publishing of performance indicators, notably a new set comprising 18 corporate health indicators on aspects such as management of resources, staff development and partnership working, and 104 service delivery indicators for local authorities. At the local level, authorities must undertake fundamental performance reviews to demonstrate that they have fulfilled the requirements to 'Challenge, Compare, Consult and Compete' and publish annual performance plans that provide details of their objectives and achievements. The reference to 'continuous improvement' and the fact that the Cabinet Office has promoted the Business Excellence Model suggests that quality management concepts underlie the policy. In addition, the Audit Commission will carry out inspections to assess the extent to which Best Value is being achieved (Geddes and Martin, 2000).

3. USER VIEWS OF QUALITY OF PUBLIC SERVICES

The quality management literature emphasises the importance of the customer perspective in achieving improvements in service quality. This includes both the ‘internal customer’, which may be another department or member of staff providing a service and the ‘end user’. In public services the ‘end user’ is not always clear and may be a community, parents, courts, patients or carers etc. They may be more than one customer of a service with perspectives that differ. In most public services the relationship between the end user and provider of the service is different from that in the private sector and so many writers have argued for a different model based on citizenship rather than consumerism. A key feature of this model is that users are involved in decision making as well as providing their views on services.

There are three main stages during which the customer perspective is important:

1. **In service planning** - this includes providing information about community needs and requirements, being involved in decisions about priorities, and contributing to the setting of standards
2. **In the monitoring and evaluation of services** – this includes providing feedback on experience of service use and rating services
3. **As individual users discussing individual needs** - such as service requirements, care plans, and options for treatment.

A range of different methods is being used to elicit the customer perspective. These include research methods such as customer surveys using interviews or self-completion questionnaires and focus group discussions. Research methods are useful for getting information about users views but not for involving users in decisions. Satisfaction surveys are one of the most frequent tools used in public services to elicit users’ views. This tool is difficult to use effectively due to a lack of basic research on what the concept of ‘satisfaction’ means in public services (Williams, 1994). It is also often difficult to get responses from ‘hard to reach’ groups such as non-English speakers and the disenfranchised using this approach.

One of the problems encountered in using research methods is that the implications of the findings are not always clear. This makes it difficult to act on the results. By using survey results as a screening device to identify and prioritise problem areas before further

investigation using quality techniques such as root cause analysis, research can be made more effective (Burroughs *et al*, 2000)

Methods to involve customers in decision-making include:

1. Inviting user and community representatives onto committees
2. Engaging people to work as intermediaries, facilitators and development workers (e.g. linkworkers)
3. Setting up committees, standing groups, forums, panels
4. Going to user and community groups to discuss issues
5. Deliberative methods such as citizens' juries and workshops

All of these methods are being used in public services, and particularly in health services and local authorities in England. Issues that need to be considered when implementing these methods include: embedding user involvement within the organisation as a continuous activity rather than a one-off project; making sure mutual expectations are clear; involving a wide range of different users including those whose views are not often heard; responding to points raised by users; and keeping users informed of actions taken as a result of their input (Cabinet Office, 1999; McIver, 1998). Examples of good practice can be found in the yearly reports produced by the Institute for Public Policy Research of the IPPR/Guardian Public Involvement Awards. However there has been little comparative research into the effectiveness of the different methods, including relative cost, ability to involve a wide range of users including non-English speakers and those with disabilities, and impact upon the organisation.

Citizens' views about public services are recorded in a number of ways. At the local level many services carry out surveys of users views and some involve citizens more extensively in decisions but this information is not generally published. At the national level there are regular surveys that include a number of questions about attitudes to public services, such as the British Social Attitudes surveys. There are also annual surveys commissioned by government, such as the national surveys of patients' views commissioned by the Department of Health in England. There is also a People's Panel set up in 1998 by The Service First Unit in the Cabinet Office through MORI and Birmingham University's School of Public Policy. This comprises 5,000 members of the public randomly selected from across the UK and designed to be representative of a cross-section of the population.

In sum, the customer perspective on quality is a central part of quality management, but where public services are concerned the concept of the customer is more complex. This means that a traditional market research approach is not sufficient and a citizen empowerment model is more appropriate. A variety of methods have been adopted to involve citizens in decision-making but there has been little comparative evaluation of the effectiveness of these methods. There is information about citizens' views of public services but at the local level this is often difficult to access and at the national level this is collected by different agencies using different survey instruments and so it is difficult to collate this information, as questions are not worded the same.

4. THE IMPLEMENTATION OF QUALITY MANAGEMENT INITIATIVES

The literature on public service experience of implementing quality management initiatives highlights a number of issues that impact on success. These include:

1. **The extent to which professionals and similar powerful groups lead the process**, and the extent to which those directly affected by the service, both staff and users, are involved in its improvement
2. **The fact that users experience public services as a whole rather than a series of departments** means that 'seamless services' are an aspect of good quality services and that requires different departments and organisations to work together in partnerships.
3. **The requirement that public services should account for the way resources are spent** means that the cost of quality improvement programmes must be justified. Evidence about which approaches are most effective is necessary and this means that evaluation is important

In sum, the adaptation of quality management approaches for use in the public sector requires a model that facilitates the involvement of professionals, partnership working and evaluation of the impact of the programme on services.

5. CONCLUSIONS

Overall findings

This review has examined approaches to quality management, measurement and monitoring in the public sector in the UK. It has traced the origin of these approaches in the private sector and has pointed out differences in public services that make modification necessary. These include the requirement to be accountable for cost-effectiveness, the role of professionals, the customer as co-producer rather than king and the partnership approach necessary to deliver a seamless service.

Some public services, such as health and local government in England and Wales, have adopted a combination of several approaches in Best Value and clinical governance, without considering key questions relating to the way these approaches may duplicate effort or cause conflict rather than bring about service improvement.

There is scope for transferable learning between different public services on approaches such as risk management and redesign, as well as for evaluative research on issues such as the cost-effectiveness of different methods of citizen and user involvement and approaches to quality management.

Key issues for the Review

1. Is it possible to achieve a consensus between the key stakeholders on the core dimensions of quality that apply across all public services in Northern Ireland and the priorities for different services?
2. What are the implications for quality management of the customer as co-producer of services?
3. How can quality management work across organisations with different cultures and information technologies and what would such a system for a partnership look like?
4. How can managers and professionals best work together, and with users, to manage quality and its improvement?
5. What implementation process will be most effective and what quality skills training (e.g. use of control charts, Fishbone diagrams, quality circles) is necessary to support this?
6. How can duplication of activity both within and between quality approaches be avoided?

7. How might the four commonly adopted approaches to quality (total system, external inspection, risk management, performance indicators) be best integrated together to achieve quality improvement?
8. What is the relative effectiveness in the Northern Ireland context of the different methods of involving users and citizens on dimensions such as cost, equity, ability to engage a wide range of people, acceptability, impact on the organisation and service improvement?

REFERENCES

- Beckford, J. (2001) *Quality*, London: Routledge
- Bowerman, M. (2002) Isomorphism Without Legitimacy? The Case of the Business Excellence Model in Local Government, *Public Money and Management*, 22(2):47-51
- Boyne, G. (2002) Concepts and Indicators of Local Authority Performance: An evaluation of the Statutory Frameworks in England and Wales, *Public Money and Management*, 22(2):17-24
- Borroughs, T. E. *et al* (2000) Using root cause analysis to address patient satisfaction and other improvement opportunities, *The Joint Commission Journal on Quality Improvement*, 26(8):439-449
- Bowns, I. R. and McNulty, T. (1999) *Re-engineering Leicester Royal Infirmary: An independent evaluation of implementation and impact*, Sheffield: School of Health and Related Research, University of Sheffield
- Cabinet Office (1999) *Involving users: Improving the delivery of local public services*, London
- Campbell, S. M. *et al* (2000) Defining quality of care, *Social Science and Medicine*, 51:1611-1625
- DETR (1998) *Modern Local Government: In Touch with the People*, London
- Donabedian, A. (1988) The quality of care: How can it be assessed? *Journal of the American Medical Association*, 260:1743-1748
- Dickson, G. Principles of risk management, *Quality in Health Care*, 1995;4:75-79
- Freeman, T. (2002) Using performance indicators to improve health care quality in the public sector: a review of the literature, *Health Services Management Research*, 15, 126-137
- Geddes, M. and Martin, S. (2000) The policy and politics of best value: current, crosscurrents and undercurrents in the new regime, *Policy and Politics* 28(3), 2000
- Gourlay, R. (1998) Editorial: ISO 9001 certification, *International Journal of Health Care Quality Assurance*, 11(5):146
- Hammer, M. Champy J (1993) *Re-engineering the Corporation: A Manifesto for Business Transformation*, New York: Brearley
- Joss, R. (1994) What makes for successful TQM in the NHS, *International Journal of Health Care Quality Assurance*, 7(7):4-9
- Klazinga, N. (2000) Re-engineering trust: the adoption and adaptation of four models for external quality assurance of health care services in Western European health care systems, *International Journal for Quality in Health Care*, 12(3):183-189

- Locock, L. (2001) *Maps and journeys: redesign in the NHS*, Birmingham: University of Birmingham Health Services Management Centre
- McIver, S. (1998) *Healthy Debate? An independent evaluation of citizens' juries in health settings*, London: King's Fund
- Maxwell, R. J. (1992) Dimensions of quality revisited, *Quality in Health Care*, 1:171-177
- Ovretveit, J. (1992) *Health Service Quality: An introduction to quality methods for health services*, Oxford: Blackwell Scientific
- Oakland, J. S. (1993) *Total Quality Management*, Oxford: Butterworth-Heinemann
- Packwood, T. *et al* (1998) Good Medicine? A case study of business process re-engineering in a hospital, *Policy and Politics*, 26(4): 401-415
- Pollitt, C. (1996) Business approaches to quality improvement: why they are hard for the NHS to swallow, *Quality in Health Care*, 5:104-110
- Skelcher, C. (1992) *Managing for Service Quality*, Essex: Longman
- Wilding, P. (1994) Maintaining quality in human services, *Social Policy and Administration*, 28(1): 57-72
- Williams, B. (1994) Patient Satisfaction: A Valid Concept ? *Social Science and Medicine* 38, 4, 509-516
- Zeithaml, V. A. *et al* (1990) *Delivering Quality Service*, Glencoe: Free Press