

Develop an Improved Strategy for Achieving the Health Change

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Abstract: *This assignment aims to identify the environmental and internal pressures for change, the desired outcomes of the change process, and the progress made in relation to achieving these outcomes. It will also evaluate the effectiveness of the change strategies and associated leadership interventions adopted by the organisation, in order to develop an improved strategy for achieving the change. The organisation chosen for this assignment is NHS. The National Health Service (NHS) is the name commonly used to refer to the four (England, Wales, Scotland and Northern Ireland) publicly funded healthcare systems of the United Kingdom, collectively or individually (Wikipedia, 2009). NHS provides all the health care service required.*

In relation to the service improvement opportunity / change issue:

1.1 What is Service Quality?

Quality of a service is considered a necessary strategy for success and continued existence in today's competitive environment (Dawkins and Reichheld, 1990). In relation to the service improvement opportunity there are many criteria's that could be used to define a quality service or product. Lehtinen and Lehtinen (1985) "*spoke about the physical, corporate and interactive quality of a service/product*" while Grönroos (1984) referred to "*technical dimension, a functional dimension and the firm's image as a third dimension*" (Chowdhary and Prakash, 2007).

Physical quality argued by Lehtinen and Lehtinen relates to the tangible aspects of the service while interactive quality refers to the interactive nature of services and refers to the two-way flow that occurs "*between the customer and the service provider, or his/her representative, including both automated and animated interactions*" (Kang and James, 2004). And corporate quality involves the image accredited to a service provider by its current and potential customers, as well as other stake holders.

Nevertheless Parasuraman *et al.* (1988) published empirical facts from five service industries that recommended that five dimensions more suitably capture the "*perceived service quality construct*". Parasuraman's *et al.* (1988) five dimensions include tangibles, reliability, responsiveness, assurance, and empathy. Each dimension can be examined as follows,

- a) *Tangibles*: Physical facilities, equipment and appearance of personnel.
- b) *Reliability*: Ability to perform the promised service dependably and accurately.
- c) *Responsiveness*: Willingness to help customers and provide prompt service.
- d) *Assurance*: Knowledge and courtesy of employees and their ability to inspire trust and confidence.
- e) *Empathy*: Caring, individualized attention the firm provides for its customers.

In service industries of public sector and particularly NHS the above five dimensions are distinctly present at times. For

example, the way nurse, GP's, and the chambers/office/rooms of GP's appear before the patients is tangible and makes an influence on the patients satisfaction. The outpatient service of NHS has the reliability dimension in it, for example, how reliable is appointment time and how accurately doctors are aware of the patients medical history. How far the NHS call centres and primary care can exceed customers satisfaction or deliver quick and responsive service shows the responsiveness dimension of NHS. The hospitalised patients under the care of nurse experiences the assurance and empathy dimensions of NHS. Although the five dimensions could be present in many forms, the examples is only to illustrate how five service quality dimensions Parasuraman's *et al.* (1988) are present in NHS.

Gronroos (2001) argued that contrary to goods quality, in service quality, "*a need-satisfying equivalent of a product emerges gradually for the customer throughout the consumption process. Hence, a service is a process that leads to an outcome during partly simultaneous production and consumption processes*". Therefore the service quality is not same as goods quality, rather the service quality starts before the consumption of service starts, continues during the consumption of the service and sometime ends long time after the consumption finishes. This distinctive feature is due to the intangible nature of services. Similarly at NHS although one can find goods, such as, medicine prescriptions, yet the service element is more prominent. For example, the patients judges the doctors diagnostic capabilities (quality before service consumption), than the patients judges the doctors treatment (quality while consuming the service), and long time after the treatment the patient judges if he/she has recovered fully and how good was primary care's service (quality after the service).

Stephens and Juran (2004) service quality definition is also interesting, according to them service quality is simply meeting and exceeding customer's expectations from the service. Nevertheless, Scheuing and Edvardsson (1994) argues that although service quality is not an uniform concept and there are "*great differences, for instance, between professional consultancy, telephone, transport, healthcare and cleaning services, yet despite these differences, services quality and the conditions under which they are delivered have certain generic characteristics in*

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common". For example, the customer often participates in a direct and active way in the production process as co-producer by carrying out parts of the service himself or herself, services are largely intangible, (such as, NHS's nurses care and doctors regular check up of patients) and hence not easy for the provider to explain and tricky for the customer to assess before buying, many services are strongly tied to employees and thus inseparable from their performers and lastly, services often "consist of a market offer composed of various value-bearing elements, sometimes referred to as core service and support services" (Scheuing and Edvardsson, 1994). Therefore service quality is very important in public sector, especially NHS.

1.2 Quality Measurement Frameworks - strengths and weaknesses

1.2.1 SERVQUAL

The research approach of Zeithaml et al. (1993), i.e. SERVQUAL is inclined on the belief that service quality is measurable, even though due to intangibility it might be more difficult to measure than goods quality (O'Neill et al. (1998). While the SERVQUAL technique has gained a lot of attention for its "conceptualisation of quality measurement issues", it has also attracted criticism, for example, some researchers have debated whether the dimensions of SERVQUAL are constant across industries while others have argued that better wording for some of the scale items (Babakus and Boller, 1992).

Referring to Buttle (1994), Jabnoun and Chaker (2003) suggests the following advantages of SERVQUAL

- It is accepted as a standard for assessing different dimensions of service quality.
- It has been shown to be valid for a number of service situations.
- It has been demonstrated to be reliable, meaning that different readers interpret the questions similarly.
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- The instrument is parsimonious in that it has a limited number of items. This means that customers and employees can fill it out quickly.
- It has a standardized analysis procedure to aid interpretation and results.

Therefore SERVQUAL can be useful to public sector and particularly to NHS because it is accepted as a standard method for assessing different dimensions of service quality, it is more reliable as it takes into account different readers perceptions and lastly but not the least, easy for respondents to fill it (SERVQUAL questionnaire) out quickly.

However from a measurement perspective, SERVQUAL technique has three psychometric problems associated with the use of difference scores: "reliability, discriminant validity and variance restriction problems" (O'Neill et al. (1998). A study by Brown et al. (1993) found evidence that these "psychometric problems arise with the use of SERVQUAL; they recommend instead use of non-difference score measures which display better discriminant and nomological validity". Therefore public sector and

particularly to NHS should be careful in relying solely on SERVQUAL techniques.

However, Zeithaml et al. (1993) responded to SERVQUAL criticisms by arguing that the alleged psychometric deficiencies of the difference-score formulation are less severe than those suggested by critics. However despite "their argument that the difference scores offer researchers better diagnostics than separate measurement of perceptions and expectations, from a theoretical perspective, there is little evidence to support the relevance of the expectations-performance gap as the basis for measuring service quality" (O'Neill et al. (1998).

1.2.2 SERVPERF

According to Cronin and Taylor (1992), SERVPERF is a better predictor and technique to measure service quality than SERVQUAL. For example, Jain and Gupta (2004) found that "SERVPERF was more strongly correlated to overall service quality than SERVQUAL". But on the other hand Quester and Romaniuk (1997) reported that SERVPERF does not exhibit a stronger relationship with overall service quality than SERVQUAL.

The distinctive characteristic of SERVPERF is that it uses only performance data (unlike SERVQUAL which directly measures both expectations and performance perceptions) because it supposes that respondents offer their ratings by automatically comparing performance perceptions with performance expectations (Carrillat, et al., 2007). Thus, SERVPERF assumes that directly measuring performance expectations is unnecessary. Therefore in case of NHS it can be very useful because it can focus on only performance data and saving much time by avoiding measuring expectations because it assumes that performance expectations has automatically been taken into account by respondents.

However Abdullah (2006) argues that whilst SERVPERF's impact in the service quality domain is undeniable, SERVPERF being a general measure of service quality might not be a completely sufficient device by which to measure the perceived quality in specific service sectors, such as, education or health sectors. On the other hand, SERVPERF (performance-only) results in more "reliable estimations, greater convergent and discriminant validity, greater explained variance, and consequently less bias than the SERVQUAL scales" (Llusar and Zornoza, 2000). Therefore NHS should be very careful in using SERVPERF methods.

2 What are the key quality management frameworks used within your organisation?

2.1 The quality management frameworks used in NHS – Clinical Governance

The department of health's website www.dh.gov.uk (2009a) states that "Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care". Similarly Donaldson and Gray (1998) too has described clinical governance as a "framework through which NHS organisations are accountable for continually improving the quality of their

services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Nicholls *et al.*, 2000). Clinical governance is rooted at the core of the UK government's blueprint for quality assurance at a local level (Miles *et al.*, 2001) as a mechanism by which organizations ensure a comprehensive program of quality improvement and have strong arrangements for identifying and remedying risks and poor performance (Walsh *et al.*, 2000).

The term clinical governance was first used by the World Health Organisation (WHO) in 1983 to summarize the conditions of high quality health care on four important dimensions: "professional performance, resource allocation, risk management and patient satisfaction" (Penny, 2000). In reaction to frequent system failures resulting in a series of unpleasant incidents, the Labour Government introduced clinical governance in 1997 in NHS to encourage an integrated approach to reduce risk and develop the quality of clinical care (Gray, 2001).

However McSherry *et al.*, (2002 p24) argues that clinical governance is prone to several criticism, such as, it can be time consuming, cost incurring, could be seen as a policing mechanism, potential to reduce innovation, openness to criticism, it is a long term strategy and potential of increased litigation cost. McSherry *et al.* (2002) further criticises that clinical governance places more demand and unrealistic expectations from busy people and ground level NHS professionals could lack in knowledge to execute clinical governance effectively.

But on the other hand, according to Lewis *et al.*, (2002) "... rather than being a cumbersome activity that must be added to the endless list of tasks health professionals are expected to undertake, it (clinical governance) provides the opportunity for staff to acknowledge that a lot of what they already do contributes to the clinical governance agenda, bringing together work as part of a common aim to improve the quality of patient care." Therefore from this perspective clinical governance takes a wholesome approach to deliver quality service. Nonetheless, the introduction of clinical governance, as a framework through which NHS Trusts are responsible for constantly improving and upholding high standards, has raised a challenge for management teams across the country to deliver quality service (Lewis *et al.*, 2002, referring to DoH, 1998).

Theoretically clinical governance is different from broad uses in that it relates particularly to continuous quality improvement and is now a policy instrument for modernising health care (Gray, 2001). Som (2004) illustrates this further by arguing that the structure of clinical governance recognizes the clinical complexities and tries to overcome some of the obstacles and challenges by encouraging an integrated and organisation-wide approach towards constant quality improvement. The process of clinical governance also involves "multi-disciplinary teamwork, partnerships and co-operative working practices that will have far reaching implications for clinical relationships, the behaviour of medical professionals and ultimately the delivery of care" (Som, 2004).

2.2 Alternatives to Clinical Governance – TQM and ISO9002

2.2.1 TQM

TQM is fundamentally a total collection of "techniques, management principles, technologies and methodologies" which are put collectively to work for the advantage of the end customer, besides TQM intends to improve the service quality by making "better planning, better external focus, better design and prioritization" (Zairi, 1994). Moreover it is also aimed at strengthening weak processes and protecting strong areas which give the organizations concerned an edge over their competitors (through continuous improvement and benchmarking). All these are to improve the service quality within an organisation, such as, NHS.

Nonetheless, Babbar and Aspelin (1994) argue that TQM is not an easy process because it is not similar to a "mechanical process or a piece of equipment a firm can buy", for example, "a firm cannot have a contractor install TQM over a weekend, then make it operational on Monday morning". Instead TQM is a philosophy (a firm adheres to shape the way things are done within that firm) which has to be absorbed, believed and followed by the people (employees) of the company therefore TQM is a way of things to do. Therefore TQM can be time and resource consuming, challenging and difficult quality management framework. NHS has limited resources (see section 4.1.2) hence TQM might not be appropriate for NHS.

2.2.2 ISO9002

ISO 9002 directly focuses upon organisational systems and processes, particularly for the purpose of quality assurance (Hamilton, 1994). ISO 9002 ensures quality because it involves management of an organisation to define its policies and objectives for quality, explain responsibilities and authorities for managers, employ someone with responsibility for the quality system, make sure the quality system is effective, and display its commitment to quality (Peter and Wills, 1998). Moreover ISO 9002 also involves suitable system to guarantee that customer requirements are met by products and services shall be "established, documented and maintained" (Peter and Wills, 1998). Therefore ISO 9002 can be very beneficial for NHS.

However Hamilton, (1994) argues that "adherence or certification to ISO 9000 doesn't ensure that a company will be a quality leader ... when you look at companies which have achieved quality leadership, you find that some of the things they did – training the hierarchy in how to manage quality, revolutionary rate of improvement year after year, providing for participation from the work-force" and none of these things is present in the ISO 9000 standards. Therefore if an organization adheres to ISO 9000 but still doesn't go any further with respect to quality it could be due to the above reasons argued by Hamilton. ISO 9000 could therefore result in only a certificate for NHS, because using only ISO 9000 will mean lack of the following at NHS: quality management training, high rate of quality improvement, innovation and participation of NHS employees.

3 Analysis of the Change Issue

Why do we need to change?

3.1 Pestle

3.1.1 Political and Legal

According to The department of health's website www.dh.gov.uk (2009b) the Health Bill was introduced into Parliament on 15 January 2009; it proposes ways to "improve the quality of NHS care, the performance of NHS services, and to improve public health". The Health Bill has completed its way through the House of Lords and was introduced in to the House of Commons on 13 May 2009.

According to the British parliament website (www.parliament.uk, 2009) the key areas of the bill are (as stated),

- Places a duty on providers and commissioners of NHS services to have regard to a new NHS Constitution, which will set out the responsibilities of patients and staff
- Introduces direct payments for health services with the intention of giving patients greater control over the health care services they receive
- Introduces quality accounts, which would provide information on quality for patients, clinicians and managers, with the aim of improving local accountability for services
- Makes provisions to protect children and young people from the harm caused by smoking. These provisions relate particularly to advertising and sales from vending machines
- Extends the remit of the Local Government Ombudsman to consider complaints from people who have arranged their own adult social care
- Introduces a scheme by which prizes for innovation in health service provision may be awarded.

3.1.2 Economical

According to Gold, Englander and Seligman (2008) the collapse of the housing market and the related financial crisis has and will continue to hurt the health-care facilities, medical equipment, and managed health-care organizations till the market and the economy recovers. Lister (2009) the health editor of The Times writes in her article that NHS faces its biggest cash crisis, with £15bn shortfall and refers to Nigel Edwards', (NHS Confederation's director of policy) statement that "Quality improvements through greater efficiency and redesigning services can provide the budget savings necessary to navigate this crisis."

3.1.3 Social

According to British Heart Foundation (BHF) Britain not only spends extra per head on healthcare fighting heart diseases (£3.4bn) but also loses more than £2bn through patients and carers being unable to work, compared to its EU neighbours and a further £2bn is lost when victims die (Bloomfield, 2005). UK has the highest number of patients with heart disease in EU due to alcohol, cigarettes and fatty foods, which costs around £7.5bn a year.

3.1.4 Technological

The Committee on Public Accounts' statement has offered fresh doubt on a 2015 deadline for the ambitious £12bn NHS IT project. Moreover the NHS Programme for IT in UK, which aims to allow information about patients to be shared securely between hospitals and GP practices, has been criticised for being still dogged by problems since its launch in 2002 (BBC, 2009). These criticisms by external stakeholders, creates bad reputation and questions the credibility if NHS IT project.

3.1.5 Environmental

The European Parliament is preparing to vote on a proposal to revise the directive on Integrated Pollution Prevention and Control (IPPC), which means that around 70 NHS hospitals could face "draconian costs" for their boilers (Helmer, 2009). This could cause further strain on the current financial; situation as discussed above (under the heading Economical).

3.2 Internal strengths and weaknesses of the organisation

3.2.1 Strengths

Primary care is the term for the health services that plays a crucial role in the local community: GPs, pharmacists, dentists and midwives, moreover primary care providers are usually the first point of contact for a patient (The department of health's website - www.dh.gov.uk 2009c). They also follow a patient throughout their care pathway; primary care trusts (PCTs) in UK receive budgets directly from the Department of Health. While Helen Darling, president of the National Business Group on Health, argued that while "primary care is foundational to a high-quality, efficient and effective health care delivery system", primary care also helps in reducing costs and improving health care while underscoring the impact of payment policies on the provision of primary care (Arvantes, 2007).

NHS Connecting for Health is a national programme for IT to bring modern computer systems into the NHS, this IT initiative is expected to improve the quality of services provided to patients while helping NHS to save millions of pounds (www.connectingforhealth.nhs.uk, 2009). NHS Connecting for Health is expected to deliver better and faster quality service while saving costs at the same time.

3.2.2 Weakness

Government documents obtained by the Conservatives show that total liabilities for the *NHS pension scheme* have hit £165.4 billion, while the FTSE 100 companies have been reducing their pensions black hole the public sector NHS is running up huge unfunded deficits (Jones, 2008), especially at a time of recession and financial crisis (see above 4.1.2). Moreover in October 2005, the labour government dropped plans to rise the retirement age from 60 to 65 for "existing health, civil service and education scheme members" (Jones, 2008).

Moreover another weakness of NHS is (as discussed in section 4.1.4.) the NHS Programme for IT in UK which was supposed to save cost and increase quality and efficiency

(see section 4.2.1) has been still dogged by problems since its launch in 2002.

3.3 SWOT Analysis

Internal	External
<p>1. STRENGTHS</p> <p>1.1. Primary Care – reduces cost, saves money, better quality service (Section 4.2.1)</p> <p>1.2. NHS Connecting for Health – saves cost, time and improves quality (Section 4.2.1)</p>	<p>2. Opportunities</p> <p>2.1. Health Bill (Section 4.1.1)</p> <p>a) Defined and clear responsibilities of patients and staff</p> <p>b) Direct payments for health services</p> <p>c) Introduces quality accounts - with the aim of improving local accountability for services, i.e. better quality services</p> <p>d) Ban on advertising and sales of cigarettes from vending machines – will improve local health and reduce cost</p> <p>e) Prizes for innovation in health service – will lead to innovation and address the criticism on clinical governance’s limitation for innovations (3rd paragraph section 3.1.)</p>
<p>3. Weakness</p> <p>3.1. NHS rising retired employees and pensions – increased cost (Section 4.2.2)</p> <p>3.2. NHS Programme for IT dogged by problems since its launch in 2002 and delay in its completion (Section 4.1.4)</p>	<p>4. Threats</p> <p>4.1. NHS faces its biggest cash crisis, with £15bn shortfall (section 4.1.2)</p> <p>4.2. Increase in consumption of alcohol, cigarettes and fatty foods by Britons has lead to increase in the number of heart disease in UK – increases cost, strain on resources and time of NHS (4.1.3)</p> <p>4.3. Initiative to revise the directive on Integrated Pollution Prevention and Control (IPPC) – increase cost on NHS (section 4.1.5)</p>

Therefore as we can see above PESTLE and SWOT can help a public sector, such as NHS to find out and analyse the external and internal environment competently, although the competence of successful analysis will depend on the researcher.

3.4 Summery

From the SWOT analysis in section 4.3 we can conclude that NHS needs to change. There is a need to change not only to address its weakness and prepare for future threats but also to get the maximum benefit out of the future opportunities.

NHS needs to change for its weaknesses

NHS needs to change to save costs incurred due to increasing number of retired employees and increasing pensions. The crisis is more serious because the British government has dropped plans to rise the retirement age from 60 to 65 for existing health professional. NHS needs to change to address the delaying of complete implementation of ambitious £12bn NHS IT project and to address the current problems in its IT system which is incurring further costs.

NHS needs to change for the threats

Due to recession and financial crisis NHS could face £15bn (the much needed) shortfall in its budget. Moreover since the consumption of alcohol, cigarettes and fatty foods is

increasing in UK, so is the number of heart diseases. NHS should prepare itself to address this social change and high amount of heart diseases. NHS should also prepare to change its aged boilers to a more environment friendly system so that revised directive IPPC in EU parliament doesn’t affect it.

NHS needs to change to make the most out of the opportunities

NHS needs cultural change to bring in a culture of innovation, improve its primary care so that it can address the government’s ban on advertising and sales of cigarettes from vending machines, introduce quality accounts to improve local accountability for services and ensure clarity in responsibilities of patients and staff.

NHS needs to change to strengthen its strengths

The quality of Primary Care has to be further enhanced so that it can reduce more costs and save more money. NHS Connecting for Health which was meant to save cost and increase the quality is being facing problems, these problems needs to be addressed urgently so that Connecting for Health can function to its fullest.

4 How am I going to make the change!

TOWS Strategy Alternative Matrix will be used to analyse and propose change strategy at NHS organisation

	<i>External Opportunities (O)</i>	<i>External Threats (T)</i>
<p>Internal Strengths (S)</p>	<p>SO</p> <p>1) Primary Care (S) will be used on people effected with ban on advertising and sales of cigarettes from vending machines (O)</p> <p>2) Primary Care (S) will be used for the need for innovation and gain incentives under new law (O)</p> <p>3) NHS Connecting for Health - IT system (S) will be used for direct payments for health services (O)</p> <p>4) NHS Connecting for Health - IT system (S) will</p>	<p>ST</p> <p>1) Primary Care and NHS Connecting for Health - IT system (S) will be used to address the shortfall of £15bn (T)</p> <p>2) Primary Care (S) will be used to address the increasing consumption of alcohol, cigarettes and fatty foods (T). Primary Care (S) will be used to educate and raise awareness among Britons and also carry out preventive measures for heart diseases.</p>

	be used to introduce quality accounts	
Internal Weaknesses (W)	WO 1) Policy for innovation in NHS (O) will be used to reduce cost incurred due to pensions and problematic IT systems (W) 2) Introduction of quality accounts (O) will be used to hold NHS managers accountable for IT problems (W)	WT 1) Innovate ways to generate growth of pensions funds and increase retirement age for current employees (W) to address the financial crisis and £15bn shortfall (T) 2) Fix NHS IT problems and manage the IT project efficiently so that 'Connecting for Health' can function to its fullest as soon as possible (W) to address the financial crisis and £15bn shortfall and also to educate & increase the awareness among Britons on how alcohol, cigarettes and fatty foods can cause heart problems.

The strategy mentioned in the TOWS framework is possible with a democratic leadership, because to achieve a new and radical strategy (the strategy mentioned above appears to be radical and urgent due to financial situation of NHS) there is a need for cultural change, and cultural change is not possible until all the employees and stakeholders are ready to accept and implement the changes, and in order to convince employees to participate in the cultural change democratic leadership is important and ideal (Yukl, 1998, Yukl and Fu, 1999 and Yukl, 2002).

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