



The State of Quality in the NHS in England: a Qualitative Analysis of Interviews With Forty-Three High-Ranking Representatives of the NHS

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**The State of Quality in the NHS in England:
a qualitative analysis of interviews with forty-three
high-ranking representatives of the NHS**

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ABSTRACT

Recent years have seen dramatic changes in the quality infrastructure of the NHS in England. In addition to the large-scale restructuring that occurred under the 2012 Health and Social Care Act, there have been copious changes intended to address well-publicized and scandalous lapses in the quality of care. Meanwhile, the NHS in England is coping with ever-restrictive budgetary demands. The resultant picture is of dynamic and complex development with multiple players. Given this, a key question is how best to move forward? How to develop a balanced strategy for quality that develops short, medium and long term goals, and can accommodate immediate political priorities? This thesis will attempt to give some answers, based on qualitative set of interviews with over 43 senior leaders – from the Department of Health, Arms Length Bodies, health care providers and commissioners, clinical leaders, patient groups and independent organisations. The resultant analysis – originally published as part of a Health Foundation report - provides an experiential-based perspective of the current approach to quality in the English NHS. In a report (59) released in December 2016, the National Quality Board (NQB) utilized a model derived from these qualitative results to announce their intentions to streamline efforts to promote quality in the NHS. This report was followed by one from NHS Improvement announcing their efforts to develop a National Quality Strategy.

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2. GLOSSARY OF ABBREVIATIONS

ALBs – Arm’s Length Bodies

AMRC – Academy of Medical Royal Colleges

ASCOT – Adult Social Care Outcomes Toolkit

BMA – British Medical Association

BMJ – British Medical Journal

CCG – Clinical Commissioning Groups

CDMSP – Chronic Disease Self Management Programme

CIC – Community Interest Company

CPD – Continuing Professional Development

CQC – Care Quality Commission

DH – Department of Health

ECP- Enhanced Clinical Role for Paramedics

EPP – Expert Patient Programme

FT – Foundation Trust

GDP – Gross Domestic Product

GHQ – General Health Questionnaire

GMC – General Medical Council

GP – General Practitioner

HEE – Health Education England

HQIP – Healthcare Quality Improvement Partnership

HSCIC – Health and Social Care Information Centre

IOM – Institute of Medicine

LTC – Long Term Conditions

NHS – National Health Service

NHSE – NHS England

NICE – National Institute for Health and Care Excellence

NIHR – National Institute for Health Research

NMC – Nursing and Midwifery Council

OECD – Organisation for Economic Co-operation and Development

PHB – Personal Health Budgets

POET – Personal Outcomes Evaluation Tool

QALYs – Quality Adjusted Life Years

QEI – Quality Enhancing Initiatives

QOF – Quality Outcomes Framework

RCGP – Royal College of General Practitioners

RCT – Randomised Control Trial

TDA – Trust Development Authority

YOC – Year of Care

3. INTRODUCTION

3.1 Setting the Scene

Most OECD countries aspire to offer their populations high quality and affordable health care. The starting point is to ensure access of the whole population to comprehensive health care, with financing mechanisms to support that. But the next is to work towards achieving high quality care – quality in a number of domains including safety, effectiveness, timeliness, patient-centeredness, efficiency and equitable access (1). Achieving this needs a coherent and constantly developing strategy because of the many factors influencing quality of care, the long lead time needed to develop some of them, and their complex interaction.

At varying points in the history of the NHS there have been attempts at producing some kind of overall strategy. In England, most recently in *High Quality Care for All* – the final report of the Next Stage Review led by Lord Darzi, published in 2008 (2). Scotland, Wales and Northern Ireland have all since published explicit national strategies to improve quality in their respective national health services (4)(5)(6).

In England, the strategy set out in *High Quality Care for All* has never been formally replaced, but since 2008 there have been significant changes to all levels of the NHS. Widespread reform to organisational structures and roles followed the Health and Social Care Act 2012 (the 2012 Act)(7). Annual funding growth for the NHS in England has never been lower – projected to be 0.9% average real terms per annum between 2010 and 2020, against the long term average of 3.7% – with an even more challenging settlement for social care (8). Well publicised scandalous lapses in care and subsequent inquiries have prompted a significant focus in national policy on improving patient safety since 2013 (9-17).

The resultant picture is of dynamic and complex development with multiple players. Given this, a key question is how best to move forward? How to develop a balanced strategy that develops short, medium and longer term goals, and can accommodate immediate political priorities? This thesis will attempt to give some answers, based on qualitative set of interviews with 43 senior leaders – from the DH, ALBs, health care providers and commissioners, clinical leaders, patient groups and independent organisations. The specific aim is to construct an experiential-based perspective of the current approach to quality in the English NHS.

3.2 Background

The NHS is an integral and stalwart part of the lives of British citizens. It is the world's fifth largest employer and in England employs over 1.3 million people— and deals with one million patients every 36 hours(18). As such, the NHS in England is a source of national pride and a key issue of public concern (19,20). The quality of care delivered by the NHS is a matter of national importance (21) and political significance: while British citizens are overwhelmingly proud of the NHS (22), a common topic of conversation in households and village pubs is the state of the quality of care in the NHS and how the politicians are perceived to be having an impact (or not).

However, despite its importance in the British psyche, historically there has been very limited data available regarding the quality of care being provided within the NHS. There was data on hospital mortality, renal transplants and in vitro fertilization (23), but little else. Improved data in the early 2000s gave “a very mixed picture of quality of care” though mortality due to major disease groups declined (24). High quality care remains the goal of the NHS in England (25), but there is a strong need for a newly defined national quality strategy in light of recent large-scale challenges and shocks to the system that risk further disrupting the quality narrative of the NHS.

The Lansley reforms, commonly regarded as the most dramatic, impactful, and wide-ranging (26) changes to the NHS since its formation, were laid out in the 2012 Health and Social Care Act, designed to make the NHS “more responsive, efficient, and accountable”(27). The main legislative components were 1) to put clinicians in charge of

shaping services through clinically led commissioning, 2) to put a new focus on public health with the creation of Public Health England, 3) to give patients a greater voice through the creation of Healthwatch, 4) to attempt to limit political micro-management by giving local authorities greater involvement in local health services, and 5) to restructure arms-length bodies to ‘remove unnecessary tiers of management’(28).

Unfortunately, while the logic underpinning these reforms was well-intentioned, they were largely condemned (29). Five years on, the benefits of commissioning have yet to be proven(30), the devolution of health services is an active question(31), and the national-level system architecture remains confused(32).

Two weeks before the large-scale reforms of the 2012 Health and Social Care Act were scheduled to be implemented, news broke about the crises of care at Mid-Staffordshire Hospital, and later, at Morecambe Bay Hospital. In response, the government commissioned six independent reports, each of which made numerous recommendations. The formal government response to these reports resulted in a deluge of initiatives and commitments. A complementary research project to these interviews demonstrated that the government issued 179 separate initiatives within four years. While these have undoubtedly promoted the quality of health care in many aspects, collectively they also represent another shock to the system. (33)

Figure 1: Graphic from “A Clear Road Ahead” demonstrating the plethora of initiatives issued between 2011 and 2015 (33).

Report	Year	Government response	Number of initiatives
<i>Proposed changes to the NHS</i> ¹¹	2011	<i>Government response to the NHS Future Forum</i> ³⁴	33
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry ⁹	2013–15	<i>Patients first and foremost</i> ³⁷ (2013) <i>Hard truths: the journey to putting patients first</i> ³⁵ (2014) <i>Learning not blaming</i> ³⁸ (2015)	68
<i>A promise to learn – a commitment to act</i> ¹²	2014	<i>Hard truths: the journey to putting patients first</i> ³⁵	12
<i>A review of the NHS hospitals complaints system</i> ¹³			21
<i>The Cavendish Review</i> ¹⁴			2
<i>Review into the quality of care and treatment provided by 14 hospital trusts in England</i> ¹⁵			5
<i>The report of the Morecambe Bay investigation</i> ¹⁶	2015	<i>Learning not blaming</i> ³⁸	15
<i>Investigating clinical incidents in the NHS</i> ¹⁷			20
Initiatives that were recommended by multiple reports ^{12,13,14}	2014–15	<i>Hard truths: the journey to putting patients first</i> ³⁵ <i>Learning not blaming</i> ³⁸	3
Total			179

This arguably justified proliferation of quality initiatives against a backdrop of major policy reforms also occurred at the same time as severe financial constraint (34, 35). The 2008 financial crisis means that there is less money to meet increasing demand. The NHS is currently operating with a significant deficit, despite an £8 billion spending increase in 2015/22. However, despite financial constraints posed by this deficit, and spending less GDP on healthcare than the OECD average on healthcare (36), it is still thought that significant efficiency savings can be made (37) whilst quality remains an important stated priority for policy makers, the NHS and the public (38).

In addition to these specific challenges, the NHS in England is simultaneously facing challenges common to most health systems: increasing life expectancy, complexity of healthcare needs, emerging new technologies and treatments, and growing prevalence of long term conditions (39, 40).

3.3 Moving Toward a National Quality Strategy

However, despite this variety of significant challenges, the NHS in England is moving forward. In the Five Year Forward View, the NHS has outlined a continued commitment to improve quality as one of the three identified gaps in ‘health and wellbeing,’ ‘care and quality,’ and ‘funding and efficiency’ (41). The strong leadership around the Five Year Forward View has brought major organisations together, and has already led to collaborative conversations and actions around the financing and service delivery of the NHS.

The currently united national tier of the NHS in England, and the demonstrated momentum, can be utilized by policy makers to evaluate the quality of care in the NHS in England, align priorities, and develop a central strategy to support high quality care. This potential coincides with dramatic need: the extent of the policy and structural changes that have taken place, together with the scale of the challenges the NHS faces going forward, reinforces the need for a coherent and well-understood strategy to improving quality (42).

While the need and timing was clear, it was difficult to find a place to start in the complex quality infrastructure of the English NHS. The NHS doesn’t even have one unified definition of quality throughout (Figure 2)! As such, it was imperative to undertake an extensive mixed methods research program to develop an understanding of the current approach to quality in the NHS in England. To this end, a variety of research methods were used to access traditional evidence bases and published literature, as well as to capture the richness of institutional memory and perspectives.

Figure 2: Definitions of quality currently in use in the NHS, as illustrated in “A Clear Road Ahead” (33)

Quality definition	Source
Safe, Effective, Caring	Lord Darzi ¹³ , Health and Social Care Act 2012 ¹⁶
Clinically effective, safe, positive experience	NHSE ⁸
Safe, Effective, Caring, Responsive, Well lead	Care Quality Commission ³⁴
Safe, Effective, Patient-centred, Timely, Efficient, Equitable	Institute of Medicine ³⁵ used by Institute for Innovation and Improvement (now disbanded) and NHS Improving Quality (now NHS England Sustainable Improvement Team)
1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long-term conditions 3. Helping people to recover from episodes of ill health or following injury 4. Ensuring that people have a positive experience of care 5. Treating and caring for people in a safe environment and protecting them from avoidable harm	NHS Outcomes Framework ³⁶

1. Enhancing quality of life for people with care and support needs 2. Delaying and reducing the need for care and support 3. Ensuring that people have a positive experience of care and support 4. Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	Adult Social Care Outcomes Framework ³⁷
1. Increased healthy life expectancy 2. Reduced differences in life expectancy and healthy life expectancy between communities	Public Health Outcomes Framework ³⁸

As such, the data presented in this thesis is one strand of a five part eight month research programme to review the policy framework for quality in the NHS in England. The programme was undertaken by a small team at the Health Foundation – a non-profit UK health policy think tank – at the bequest of several ALBs and key leaders of the NHS. The project was overseen by Professor Sheila Leatherman – author of *The Quest for Quality: Refining the NHS Reforms* – and sought to identify the strengths and weaknesses as well as duplications and redundancies in the policy framework in the NHS in England, and to set out a set of justified and evidence-based recommendations to re-establish a coherent quality framework in the current context of fiscal austerity and recent changes to the system architecture.

The full programme of research was limited to addressing the approach to quality of healthcare in the NHS in England. We did not examine the approach to quality in the NHS in Scotland, Wales or Northern Ireland, as they already have national quality strategies in place. We also did not examine social care or public health. As examining policies in public health and social care were beyond the scope of our research, we only included them when they directly involved NHS health care. Finally, it is important to note that this report concerns national architecture, initiatives, and levers to promote quality. This is distinct from the concept of quality improvement, which occurs on a local level and is usually developed and implemented by local staff (43).

The full results and recommendations of the eight month research programme can be found in the published Health Foundation report, “A Clear Road Ahead: Creating a coherent quality strategy for the English NHS.” The published report is a preliminary evaluation of multiple sources of evidence that begins to draw conclusions on how quality of healthcare in the NHS in England can be augmented from a national policy level. The five strands of research describe the government’s response to crises in quality, illustrate who is fulfilling what role for quality at a national level, capture the views of the system leaders and players, categorise the policy measures the government uses to improve and assure quality and identify evidence on the impact of policy measures on quality of health care in the NHS in England.

The implications of our findings were used to develop pragmatic and evidence-based recommendations that national-level leaders and organisations can act upon to 1) align the system around quality and therefore reduce unjustified variations in care and costly duplication while 2) rebalancing attention to the trilogy of quality planning, improvement and assurance to thereby 3) create a more supportive environment to empower the workforce as they set local priorities to achieve national standards. These recommendations were used by the National Quality Board and the NHS Improvement body in recent publications.

4. METHODS

4.1 Interviews: participants and format

We conducted a series of 43 qualitative interviews to assess the new system architecture, the cultural context in which it exists, and perspectives on how the health system and supporting structures can best move forward to promote quality in the NHS in England. The interview list was compiled of key individuals from major organisations as well as individual clinical and system leaders who would likely have valuable insights as to the overall system quality (Figure 3).

Figure 3: Example Organizations Represented by Interviewees



To choose which individuals to interview we asked Jennifer Dixon (CEO of the Health Foundation), Sir Bruce Keogh (Medical Director of the NHS) and Mike Richards (Chief Inspector of Hospitals at the Care Quality Commission) to compile an initial list of suitable interview candidates. This list was then further developed and vetted by stakeholders and individuals with long-standing experience with the health system.

Additionally, at the end of each interview we asked whether the participant could think of anybody that we should add to the list. In this way, we felt confident that we had a good representation of key individuals involved in the quality of the NHS in England. Interestingly, very few of the interviewees were female. This could represent a bias in our selection method but it is more likely secondary to the distribution of gender in high-ranking roles in the NHS in England.

It should be noted that a larger number of people were interviewed than is normally seen in qualitative studies. This was done for three reasons. First, given the variety of quality functions existing within the NHS, it was important to make sure that several perspectives on each function were obtained. Second, given the highly political nature of our work, the high number was necessary to give it political significance. And finally, given the tight-knit English policy community, the high number was important to obscure the identity of our interviewees. We stopped at forty-three because we felt that these three objectives had been sufficiently obtained and messages were becoming redundant.

Once an initial list of interview candidates was developed, an invitation to participate in the project was sent to the candidates via email. There was a high response rate, but we did not tally the actual number. Once candidates responded, I answered any questions they had about the project and worked with their personal assistants to schedule the interviews.

Each of the interviews was approximately one-hour long and transcribed by a team-member in real-time. These transcriptions were found to have high accuracy when tested against recordings. As such, the vast majority of interviews were not recorded due to the sensitive and political nature of the interviews. The interviews were mostly done in person at a location of the interviewee's choosing or at the Health Foundation offices.

I attended 40 of the 43 of the interviews, accompanied by either my supervisor Tim Gardner or my colleague Aofie Molloy. Rarely, Jennifer Dixon and/or Sheila Leatherman would do interviews by themselves due to the sensitive nature of the interview or the high rank of the interviewee.

Each of the interviews took place under the Chatham House rule, which is when participants are free to use the information received but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.” (44) A discussion guide (Appendix A) provided context on the project and included questions such as

- What are three to five key policies, approaches, or programs that are currently being used to improve quality?
- Who is accountable for and/or leading these key policies, approaches, or programs?
- What are the major gaps in NHS England's current quality strategy?
- Have there been previous policies, approaches, or programs with a positive impact that have been reduced or eliminated?
- Do you think there's a need for a quality strategy for NHS England?

4.2 Inductive Coding and Thematic Analysis

A process of inductive coding was utilised. This process involves several in-depth readings of the interviews before the reader begins to label the text with 'codes' that capture the core themes of what is being said. The codes emerged from the text, and were not pre-determined. In total, thirty codes (Figure 4) were applied to the interview transcripts. After all the interview text was marked with codes, the coded text was collated, combined, and analysed for common themes and messages. From this, twelve salient messages emerged and are listed in the results section in bullet format. These twelve messages were further grouped and combined to create three themes: Juran Trilogy; A Focus on Quality; and Engage the Workforce.

Figure 4: The thirty codes used to analyse interviews

Regulation/CQC	Top Down	Patient Engagement	Investment	CQC
Definition of quality	Priority Setting	Targets	Financial pressures	Commissioning
Culture Change	NHSI	NQB role	Stability	Facilitated Learning
National Leadership	Data	Other countries	Need for a QS	NICE
What doesn't work for quality	Supporting improvement	NQB leadership/structure	Supporting Improvement	Frameworks
System cohesion/Central Voice	Possible Authors/Leadership on QS	Coordination/Integration	Workforce Professionalism	Workforce Engagement

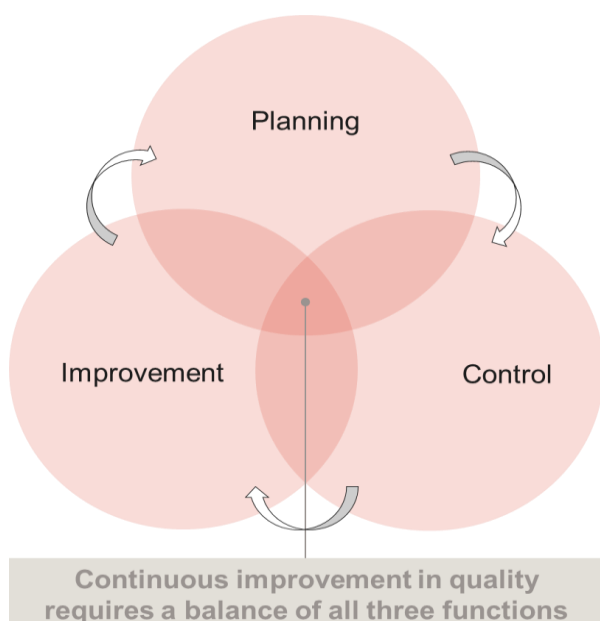
Each bullet point is developed from pages of quotes and reflects the overall sentiment as closely as possible. To this end, the bullet points were often cobbled together from direct quotes from within the transcripts, and as such mirror the language of the transcripts as well as the sentiment. The focus on the rigor of the analysis was critical given the potentially political messages. Finally, to give a sense of the flavour of the transcripts, one or two quotes are included with each bullet point.

4.3 Application of Frameworks

Surprisingly, an assessment of the array of organisations, initiatives and approaches to improve quality in the NHS had not been done in recent years, despite major restructuring designed to address issues of quality. Given the innovative nature of our work, and the knowledge that it was going to be used as the groundwork for the emerging National Quality Strategy, it was important to map the salient messages onto well-known and respected conceptual frameworks.

For this, we used two frameworks, the first of which was the Juran Trilogy which posits the individual and collective importance of three core functions in achieving high quality in any industry: planning; control; and improvement (45).

Figure 5 The Juran Trilogy



Juran framed these concepts as internal planning control and improvement processes within individual organisations. In the context of the National Health Service, the Juran trilogy is helpful to frame the processes needed at national level, external to individual provider organisations: the need for robust national planning to set direction, the provision of meaningful support ('improvement') to the professionals and organisations delivering care and the appropriate use of control mechanisms to ensure risks are minimised and progress is made. Furthermore Juran stressed the inter-relatedness of these functions and the importance of achieving an appropriate balance between them to develop an effective approach to improving quality. How these functions are currently discharged within the NHS, and the extent to which an appropriate balance between them, was a fundamental part of our analysis.

Another concept used in the analysis is that of creating multi-tiered capacity in a nation and is depicted by a pyramid with four levels, allowing for the design of discrete and synergistic activities and interventions at various geopolitical and administrative levels (33). The four levels where activity needs to occur is applicable in almost any country and has been described (25) as:

- **National** – Essential functions are policy formulation, resourcing, infrastructure and accountability to the public
- **Regional/local** – Essential functions include translating national policy into the local context, macro-management and monitoring
- **Institutional** – Essential functions include good governance, competent operational management, and continuous quality improvement
- **Individual** – this is the level of encounter between patients and health professionals where the key attributes of quality must be actualised through individual behaviours

4.4 Ethical Considerations

For this interview section of our research programme, the most important was the issue of confidentiality and anonymity. All participants were invited to participate via email, and could opt to respond at their leisure. Both in the invitation and during the interview, we explained that the content would fall under "Chatham House Rules," which is common parlance in the English policy community. In brief, it means that the "participants are free to use the information received but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed." (44) Once participants verbally agreed to this, we would proceed. To protect their anonymity, the interview transcripts were anonymized and kept on secure computers. Once coded, the transcripts were combined for thematic analysis.

4.5 Limitations of Chosen Methodology

Semi-structured qualitative interviewing has several known and widely-documented limitations, such as the potential for observer bias and tangential digressions. Normally tangential digressions mean that interviews can be difficult to code; however, the vast majority of our interviews had very common themes. This could simply be a positive result of a well-crafted discussion guide, or it could be secondary to the fact that the people interviewed belong to a small community of individuals who talk to each other. As such, in our case a potential limitation is that the population interviewed may be mutually reinforcing and shaping the themes and topics of conversation that were explored in the interviews.

There are multiple layers in the risk of observer bias: that the interviewer asks leading questions or encourages certain answers; that the interviewee is unwilling to be truthful or open; or that the results are interpreted according to a bias. Each of these was mitigated through specific steps. A discussion guide with open-ended questions was used to guide the interviews, and all conversations occurred under Chatham House rules. For the interpretation, all relevant pieces of information were coded and the summary points derived from the most numerically prominent

5 RESULTS

5.1 Major Messages and Themes

In total, we spoke to around a hundred people working at various levels within England, mainly through individual interviews and group meetings; of these we interviewed 43 separate senior leaders, three-quarters from the DH or the main ALBs.

The most striking result of this survey analysis was the unity of the message. The vast majority – at a wide variety of levels and across a variety of organisations – agreed on the initial themes outlined below. While this could be due to an element of ‘group-think’, it also indicates a shared perceived need to develop a more coherent strategy. The twelve themes are as follows.

It is important to note that these bullet points are not the perspective of the authors of this report, but rather have directly come from the system as the result of forty-three individual and group conversations with system leaders.

JURAN TRILOGY: There’s a perceived imbalance between planning, control, and improvement.

- **Regulation currently plays a large role in defining and shaping quality within our system, but there was concern about the risks of an “over focus on inspection” given its limited ability to drive quality improvement.** *“Regulation should be the framework in which professionalism can flourish.”*
- **There is hope in NHS Improvement despite their broad remit. Bringing together two organizations with different regulatory roles is “just enormously complicated,” let alone reconciling that with the mandate implicit in the name ‘NHS Improvement.’** *“It’s going to take a number of years for them to work out what they are supposed to be doing.”*
- **The system is unsure of the NQB’s current impact, but feels strongly that there is a need to “join everyone up” and create a “single point of coordination nationally” to align priorities, challenge the system, and discuss, define, and collaboratively steer the national quality agenda.** *“There needs to be a single voice across the top of the system to ensure quality is kept on the agenda.”*
- **The lack of a clear ‘centre’ and little alignment between national bodies has led to top-down micromanaging and too many national priorities.** *“There are two centers: the government and the ALBs around the 5YFV. They need to agree with each other... and be aligned and then hold firm and allow the system to respond”* *““There’s a lot of people at the center that think it’s a lot clearer than it actually is.”*

A FOCUS ON QUALITY: In an era of unprecedented challenges there must be a sustained and apolitical commitment to quality as an organising principle for the NHS in England.

- **Secondary to numerous challenges – the 2012 Health and Social Care Act, economic pressures, and “policy ADHD” after crises of care – the system has “lost policy coherency” as institutions relearn old processes and develop new ways of working together.** *“Active tinkering can really distract from having a coherent quality framework. You should have a small set of priorities and embed and watch them”*
- **The relationship between money and quality is complex, but overall there was overwhelming support for developing a national quality strategy, to 1) signal that quality is an equal priority to money, and 2) streamline and reduce duplication in an era of austerity.** *“A thousand flowers blooming doesn’t make sense in austerity.”*
- **Quality – not just safety – should be a categorize principle at all levels of the NHS, with a strong focus on delivering care that makes sense for patients and staff, to support “people in a life that is as normal as possible within their condition.”** *“The narrative about safety is very dangerous because there’s a*

thought that there's safe and not-safe, when in reality it's 50 shades of quality."

- **The Department of Health focuses on crises of quality, but for the day-to-day quality of the NHS there needs to be a "sustained approach without political distraction."** *"If it's not in the mandate, it doesn't happen. There's no understanding of the day-to-day work of the NHS."*

ENGAGE THE WORKFORCE: Regional priority-setting and strategic use of data were proposed as ways to empower and engage the professional workforce, strong potential to promote quality but will require collaborative national leadership.

- **National-focused quality is dependent on the quality of national leaders: they must work together and commit to quality.** *"Not a dearth [of leadership] but people are in the wrong places and in check mate."*
- **The professional workforce has the "ability to use skill and judgment" to "make clinical excellence thrive everywhere."** This requires national support for workforce engagement, training of clinical leadership, and amelioration of unnecessary pressures. *"People are intrinsically motivated to do the right things for patients so I think we can reenergize people on that. I think it gets back to the heart of why they do this."*
- **The health system has a lot of measurement and burdensome reporting but not a lot of interpreting and feeding-back; data could be harnessed for learning and quality improvement if there was "routine embedment" and was fed back directly to frontline individuals.** *"The lack of data is absolutely at the heart of the ability to understand the population base quality, organizational quality, individual quality, or whether the patient is getting quality care."*
- **The national government should set standards and be intolerable of variation, but then both allow and support local communities to set their own priorities as to how to deliver those standards since "challenges are local."** *"Outcomes should be the same wherever, but how you deliver is a local operational issue." "The regional approach can reap loads of benefits."*

As highlighted above, there was a perceived imbalance between planning, control, and improvement. On planning, people highlighted the absence of a strategic approach to planning to support the *NHS Five Year Forward View* (41), which was thought to provide a shared vision but not a clear framework for implementation. This was attributed to the lack of a national centre within the reformed system and perceived poor alignment between the national bodies, which has also led to a proliferation of top-down requests for assurance and a surfeit of national priorities.

Most people suggested that, at national level, control had now become the primary driver of choice to improve quality of care. There were mixed views as to whether control has been become over-developed, but there was broad agreement that planning and improvement functions were under-developed. The establishment of NHS Improvement was broadly welcomed to support improvement within the NHS, but there were concerns that the new organisation has a very challenging immediate set of objectives.

The commitment to improving quality as the organising principle of the NHS was thought to be weak. Most people had concerns that the national tier of the system is now fragmented and the coherency of policy and policymaking has diminished. The 2010-2015 parliament – including the reform and organizational restructuring that flowed from *Equity and excellence: Liberating the NHS* in 2010 (46), as well as the need to respond to several high-profile failures of care – was recognised as a turbulent period for the NHS. With national bodies taking on new roles, developing different ways of working and managing a major transition programme, were widely thought to have led to greater divergence in the approaches taken by national bodies as well as increased duplication of effort.

Most people suggested that, in the wake of the Francis Inquiry, there has been a necessary focus on improving safety, but several wanted to see a broader focus on all aspects of quality.

People were mostly clear that health professionals have the ability to use skill and judgment to make clinical excellence thrive everywhere, but this is sometimes crowded out by a lack of national support for workforce engagement, training of clinical leadership and a focus on immediate pressures rather than designing and implementing improvements.

5.2 Minor Messages and Themes

In addition to the 12 themes outlined above, interviewees were quite candid about their personal definitions of quality, despite this not being a prompt in our discussion guide. In line with more comprehensive definitions (1), interviewees were explicit that quality is not just safety – even though 70% of government initiatives have been focused on this one domain of quality in recent years (33). Instead, the definition of quality that seemed to resonate with our interviewees was complex, nuanced, and difficult to summarize in one bullet let alone a pithy definition. What interviewees described as quality, was not scorecards and mortality rates, but rather whether the patient is supported to pursue their health priorities in the least complicated way possible.

In the English NHS, the three areas of the Juran Trilogy – planning, control, and improvement – are perceived by interviewees to be out of balance. Multiple bodies undertake quality planning with relatively weak coordination and considerable scope for duplication. Quality improvement is widely seen as underdeveloped, especially in contrast with the robust system of quality control. Interviewees acknowledged that the government is currently trying to redress through the creation of NHS Improvement, but regularly expressed concerns that it wouldn't be enough, and that NHS Improvement faced an 'impossible task'.

Interestingly, while the interviewees nearly always touched on the challenges that the NHS has faced in recent years, they then turned to solutions – and were often unified in their thoughts about the solutions:

- Nearly everyone said that there was strong need for a national quality strategy, to both align national bodies and to also make explicitly clear that the quality of the NHS in England remains a national priority even as the dialogue increasingly focuses on finances. Quality and finances are not mutually exclusive, but often compatible and always necessary to the other.
- Other solutions regularly focused on by interviewees were improved staff engagement and empowerment, better utilization of existing data, and increased regional prioritisation. For all of these, interviewees made it clear that strong national leadership would be required to implement each, but that it would pay dividends for quality.
- Regarding regional prioritisation, many people said that the system “lost something” with the demise of the Strategic Health Authorities (SHAs). They felt that the regional level should be supported in coming up with solutions unique to their context so long as they managed to meet national standards.

6. DISCUSSION

These qualitative findings suggest that the NHS needs better alignment, leadership and focus on quality, particularly with the current economic pressures on the NHS and the challenges of adapting to the restructuring of the system following the 2012 Act (47). While the challenges of restructuring and increased pressure to make efficiency savings have been a strong theme of the analysis of the interviews with system leaders, the tragic failings of care (9-17) happened prior to the changes brought in by the 2012 Act (47), suggesting long term issues with quality in the NHS in England at all levels of the system. As such, a dedicated national quality strategy will need to address all levels of the system to balance the national Juran Trilogy and achieve a shared definition of quality within the current financial restrictions.

6.1 National Level

The core system functions that support and ensure improvements in quality are distributed between the DH and the ALBs. While the National Quality Board is a forum where ALBs “share intelligence, agree action and monitor overall assurance on quality (48), our qualitative analysis shows the NQB lacks influence and in its new re-energised form, lacks patient participation and engagement of managers and leaders in the system. As such, currently there is no individual or organisation that has the explicit authority to provide leadership on the quality agenda on behalf of the system. Without this central voice, the ability of the national bodies to pursue a shared agenda is highly dependent on personal and institutional relationships.

Furthermore, because there is a number of national bodies separately appear to be central to quality, each setting objectives and standards which may or may not align. This has led to a surfeit of ‘must-do’ priorities for providers, commissioners and healthcare professionals. There is limited clarity as to what is most urgent and/or important, limited resources to implement all these priorities and little scope to cater for local quality priorities. Focus on quality as an apolitical organising principle of the NHS is imperative amidst the current unprecedented pressures.

The result is a chaotic and top-heavy system for quality that lacks coherent vision and places an undue burden on the regional, institutional, and individual levels. Rather than setting clear priorities for the quality of the system, there are metaphorically “too many cooks in the kitchen” with well-intentioned ALBs, the government, and other national level organisations working toward quality in separate – often duplicative, sometimes antagonistic – ways.

As was pointed out in the interviews, the NHS in England has “two centers” with the Department of Health (DH) – the government – setting priorities that the ALBs are responsible for carrying out. The Department of Health is politically accountable to the public, and has demonstrated it’s potential for well-intentioned but knee-jerk responses. More importantly, the DH is responsible for all aspects of the NHS, not just quality. As such, regardless of where the political attention is directed, there needs to be a steady central presence responsible for quality at the national level. What emerged from the interviews is that the capacity for the Juran Trilogy at the national level could be embodied by NHS England (planning), NHS Improvement (improvement), and the Center for Quality Control (CQC, regulation). Together these could combine to provide the direction, support, and control necessary to provide high-level balance and direction to the quality efforts within the NHS.

In this idealized solution, with national ALBs taking responsibility for various corners of the Juran Trilogy, the National Quality Board – which is comprised of representation from the ALBs but is independent from both them and the government – would be able to serve as an independent advisor to the government on the state of quality and make necessary recommendations. In that regard, the Juran Trilogy would become a three-dimensional triangle, or perhaps even a funnel, with the CQC, NHSE, and NHSI forming the three corners and the NQB serving as the point at which they all come together to funnel the information towards the government.

6.2 Regional Level

However, the weakness of this vision of the national level is the overwhelmingly great expectations on the role of NHS Improvement (49) to inspire, align, and support the NHS in England to improve quality. The interviewees

raised concerns about the capacity the newly merged TDA and Monitor to invest in improvement while tending to the mandatory functions of performance management, sector regulation, oversight of NHS payments system and ensuring essential services of providers in difficulty.

At the time of the interviews, we found a lack of regional level alignment, support, evaluation, or data collection. Despite several regional level quality structures identified in the architecture chapter, (AHSNs, Strategic Clinical Networks, Quality Surveillance Groups (50)), no interviewees identified *any* regional level support for quality, suggesting that although the regional level structures are in place they lack recognition, influence and traction. Initial movements of NHS Improvement have been to set up regional teams with a strong system of accountability on the national level. This is a strong move in the direction recommended by the interviewees, although it remains to be seen how effectively this will be executed.

The NHSI opted to use the same regional divisions as NHSE, but these divisions are not universal, with different national organisations having different regional divisions that they use for their purposes. Unsurprisingly, in addition to be very inefficient, it also makes it difficult to have any unified measurements. The national bodies collect, use and publish a wide range of data relating to quality but make little effort to coordinate their efforts. As such, there is considerable duplication of data required which makes measurement and reporting burdensome (51).

However, despite all of this measurement, there is a lack of commissioned research and evaluation of programmes that are implemented. It is not clear what policy levers or initiatives successfully improve and assure the quality of health care. This means there is a lack of system learning.

6.3 Institutional and Individual Level

The aforementioned lack of coordination in measurement has led to voluminous quality initiatives and duplication of data requirements which produce considerable pressures on health care providers. In the context of a lack of national priority-setting, and an imbalance between regulation and improvement, these pressures mean providers feel little scope or independence to evaluate and tend to local quality priorities and feel unsupported to improve quality.

As the fourth largest organisation in the world, engaging, empowering and unleashing the potential of 1.2 million staff is challenging, however there is currently a strong sense of disempowerment amongst NHS staff (52). If this could be reversed, the workforce has the capacity to be the strong force of improvement and maintenance of the quality of care in the NHS in England.

At all levels, The Juran Trilogy defines three management processes, that any system of continuous quality improvement requires – quality planning, quality improvement and quality control. Each process is of equal importance and should complement and reinforce the others. Our research identified a focus on regulation that was often perceived as a burden but was also deemed necessary due to the lack of quality assurance produced by the system itself. We found that regulation was often relied upon as a lever to drive quality improvement. While regulation is essential for quality assurance and may have an indirect role in quality improvement (53), the focus on quality between regulation and improvement is out of balance.

6.4 Conclusion

Quality of healthcare in the NHS in England is an important and central issue for patients, staff, the public and government. Despite the concerns that emerged in the interviews, there is a strong drive to improve quality in the NHS in England with motivated staff and robust infrastructure. There is capacity and potential for policy makers to monitor the quality of care in the NHS in England, align priorities, and develop a central strategy to support high quality care.

Areas of the NHS in England already aim for high quality health care: NICE Quality Standards identify measurable, prioritised areas for quality improvements within a particular area of health or care; CQC's annual State of Care Report provides insights on what it identifies as key elements of high-quality care; NHS Improvement is currently developing the NHSI Leadership, Development and Improvement Board; and the Department of Health is producing a series of roadmaps (54) for the NHS in England that outline areas of priority for quality reflecting the vision Five Year Forward View.

However, as indicated in the interviews, these efforts remain largely uncoordinated. As a result, they can feel burdensome and duplicative; the latter poses an especially acute problem in the context of England's current fiscal austerity. My thematic analysis of the interviews both individually and as a whole, demonstrates a need to balance the improvement, regulatory, and leadership of quality efforts in the NHS in England. The Juran Trilogy is a good fit for the NHS in England given the strong role of the CQC as a regulatory body and the recently formed NHS Improvement which is still searching for its role.

The third leg of the Juran Trilogy - the leadership - will be the hardest part to develop and maintain. There are currently too many cooks in the proverbial kitchen, with, as said by an interviewee, "two centers of the NHS:" the DH and NHS England. With two organizations in charge, it often seems as though no organization is in charge, and each of the seven ALBs are left to work on their corner of quality. This will need to change if future crises of care are going to be successfully avoided.

In the past, the government and national bodies have had great successes in improving and assuring quality of health care in certain areas in the NHS in England nationally. Some examples include the dramatic decrease in HCAs (55), the successful reduction of venous thromboembolism disease in hospitalised patients (56), and the world class care of stroke patients (57). This indicates that the pieces are present to develop a unified National Quality Strategy. It is possible to turn these spot successes to a comprehensive approach to quality that would fulfil the dream of Aneurin Bevan, founder of the NHS, to "place this country in the forefront of all the countries of the world" in its healthcare services (58)

And now is the time to do so. The Five-Year Forward View has led to meaningful conversations and actions by the DH and the ALBs, but they have mostly been focused on closing the fiscal gap. This same momentum could be tapped to develop a balanced and comprehensive National Quality Strategy that could close the quality gap for many years, not just five.

Currently, there is promising progress being made as various national agencies work together to take advantage of this momentum. Specifically, they are using the research presented in this thesis to develop a National Quality Strategy. This spring, the National Quality Board published their "Shared Commitment to Quality," (59) which utilized a model – the modified seven steps on page 8 of their publication – that was directly developed from this research. This publication publically declared an intent to work together to streamline quality in the NHS in England. This report was then followed on by another from NHS Improvement (60) that echoed similar messages. At this point, it is too early to say what the results will be of these reports, but they represent concrete steps toward the NHS in England developing a dynamic and unified National Quality Strategy that can guide the NHS through the challenges ahead.

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Appendix A

Introduction - Background

- Thanks again for giving up your time to talk to us.
- In May 2008, the Nuffield Trust published *The Quest for Quality: Refining the NHS Reforms*: the fourth and final report in a series by Professor Sheila Leatherman and Dr Kim Sutherland that provided a definitive picture of changes in quality of care since 1997.
- The report also made the case for a national quality programme to provide a comprehensive and coherent national strategy to improve quality, which directly informed the national quality framework subsequently set out in the final report of Lord Darzi's next stage review.
- Since then there has been a proliferation of quality initiatives against a backdrop of major policy reform, large-scale organizational change and financial constraint.
- The purpose of this project is to review the policy framework in England for improving quality to identify any duplication, inconsistencies and gaps, and set out key actions required to re-establish a coherent framework in the context of the reforms.
- We're aiming to produce practical recommendations that use existing resources and work within the current system architecture. We hope to conclude the project by April 2016.

Introduction – Framing the Interview

- If you're happy, we'd like to record and transcribe this interview – this is purely in order to inform and support our analysis, we have no intention of publishing our interviews and would obviously seek your permission if those plans should change.
- All interviews are being conducted under the Chatham House rule and no direct comments would be attributed in the final document without your consent.
- Are you happy to proceed on that basis?
- Do you have any questions before we begin?

Questions about Quality Specific to Organisation

- We are particularly interested in talking to you today given your role in _____. What role does this organization currently play in promoting quality?
- Is this different at all, from what role you think this organization is supposed to be playing in strategy?

Current Quality Strategy (or Lack Thereof)

- What are three to five key policies, approaches, or programs that are currently being used to improve quality?
- Of these, which are having a positive impact on quality? How do you know?
- Who is accountable for and/or leading these key policies, approaches, or programs?
- Have there been previous policies, approaches, or programs with a positive impact that have been reduced or eliminated?
- What are the major gaps in NHS England's current quality strategy?
- Similarly, are there any major inconsistencies or duplications in NHS's England's current quality strategy?
- Which parts of the current NHS quality system function best and should be strengthened or protected?

Developing and Implementing a National Quality Strategy

- Do you think there's a need for a quality strategy for NHS England?
 - If no, why not?
 - If yes, do you think there is the will to implement it?
 - How could your organization contribute to the implementation?
 - Do you have any thoughts on the best ways to facilitate collaboration and engagement with this process?
 - What concerns do you have about the process?
- What should NHS Improvement's role be within a national quality strategy?
- What should the NQB's role be within the national quality strategy?