Keywords: Quality/Quality agenda/ Productivity/Patient engagement

This article has been double-blind peer reviewed

The quality agenda in the NHS is often discussed, but research found there is confusion over what quality means and several barriers to achieving it

Barriers to managing and improving quality

In this article...

- How quality initiatives are being implemented in the NHS
- Barriers to achieving these objectives
- How trusts can improve their standards

Author Simon Feary is chief executive officer, Chartered Quality Institute, London.

Abstract Feary S (2012) Barriers to managing and improving quality. *Nursing Times;* 108: 10, 12-14.

Although the term "quality" is frequently used in healthcare, there is confusion over what it means and how to improve it. The Chartered Quality Institute commissioned a survey to investigate staff views on quality and its implementation. This article reports on the results and makes recommendations.

Quality and improvement are purported to be at the centre of NHS restructuring plans (Dorrell, 2011). Yet the term quality is difficult to define and little understood.

As the body that represents 10,000 quality professionals, including many in the health sector, the Chartered Quality Institute understands the improvements that can be made through quality management, from greater efficiency, productivity and customer satisfaction to more sustainable, desirable outcomes. However, there is a great deal of confusion, among healthcare staff and the public over what is meant by quality and how to improve it.

Survey and interviews

The CQI commissioned an online survey to better understand how the rhetoric of quality and quality improvement relates to reality for those working in the NHS. The survey of NHS staff (n=93) was complemented by more than 30 in-depth interviews with health professionals acting as quality leads in NHS organisations.

The structured web-based survey, comprising 17 questions, was posted on the *Health Service Journal* website (*Nursing Times*' sister publication), inviting health professionals to take part. A cross-section of staff completed it, from clinicians to managers; approximately 60% were managers and chief executives. Respondents covered all organisation types, from hospital trusts to GP practices; around 40% were from trusts (provider organisations). Fig 1 shows the breakdown of respondents by role.

The in-depth telephone and face-to-face interviews were carried out by Atos, an IT services company, which selected interviewees to provide a cross-section of levels and organisations. The interviews were a combination of structured questions based on the survey findings and semi-structured questions to uncover themes that might challenge those findings.

The survey and interviews found high levels of incoherence and misunderstanding surrounding the definition of quality. They also found numerous barriers that prevented the management of quality from being implemented, including a lack of leadership, different priorities and failure to prioritise quality objectives throughout NHS careers.

How are we implementing quality?

In the health sector, the use of international quality standards and documented standard operating procedures is limited.

The survey found that only 15% of NHS bodies are working to an International Organisation for Standardisation (ISO) standard and 24% are working to other quality standards, including those from the National Institute for Health and Clinical Excellence, the Care Quality Commission, the NHS Litigation Authority and the Royal College of General Practitioners.

However, one secondary/tertiary care

5 key points

1. **There is considerable confusion over the definition of quality**
2. **Only 15% of NHS bodies are working to an international quality standard**
3. **Time available and lack of leadership are the main barriers to achieving quality**
4. **To improve quality, a clear direction, strategy and definition must be established**
5. **One body should serve as quality expert and leader to ensure consistency**

Being too busy can detract from quality

"Make sure you get support for the emotional labour you undertake every working day"

Yvonne Sawbridge › 36

FIG 1. **RESPONDENTS BY ROLE**

- Manager 51%
- CEO/director 9%
- Other 19%
- Doctor 6%
- Nurse 2%
- Clinician with management responsibilities 13%

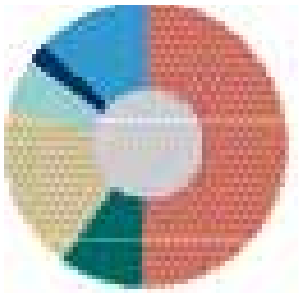


FIG 2. **QUALITY STANDARDS USED IN NHS**

- ISO 9001 Quality Management standard 15%
- None 32%
- Don't know 29%
- Other 24%

organisation interviewed was registered to three ISO standards (quality, security and environmental) and had adopted the European Foundation for Quality Management excellence model. This shows quality standards can be achieved by provider organisations. Fig 2 shows the use of quality standards in NHS organisations.

Documentation of standard operating procedures provide a baseline understanding of the activities required to deliver consistent quality. Respondents were asked whether their organisation had a set of documented operating procedures; 48% said they did, 35% had some and 17% had none.

While clinicians use many codes of practice, they are not referred to on a daily basis and are not monitored consistently.

Barriers to achieving quality

The low adoption of quality standards and lack of robust implementation of documented procedures suggest there are a number of barriers to improving quality.

Survey respondents were asked to identify the relative impact of a range of potential barriers. The biggest constraint appeared to be the time available to focus on improving the quality of services, followed by a lack of leadership (Table 1).

Time available

Since staff numbers are not cited as a significant barrier to delivering quality, it is reasonable to infer that the time constraint affects a few influential staff rather than whole organisations. These people need to be identified, trained and supported to provide leadership and commitment.

Leadership

Lack of leadership in delivering quality was identified as the second-largest barrier. The Quality, Innovation, Productivity and Prevention initiative aims to improve the quality of care while saving up to £20bn by 2014-15 (Department of Health, 2011). However, health professionals are critical of its effectiveness in improving quality.

Respondents were asked to rate the effectiveness of QIPP in improving quality. On a scale of one (bad) to nine (good), 27% were positive, scoring six and above, while 42% were negative, scoring four and below, with 12% selecting one or two. Just under one third (31%) selected five, showing no strong view. Overall, there were more negative responses than positive, with a bias towards the very negative end of the scale.

The research also showed the approach to quality is fragmented, with the four facets in healthcare identified as:

- Clinical quality;
- Patient experience;
- Operational effectiveness;
- Financial outcomes.

TABLE 1. **BARRIERS TO ACHIEVING QUALITY**

Percentage of respondents who scored each potential barrier as a constraint

	Does not represent a constraint (%)	Represents a constraint (%)
Time available	27	73
Leadership	34	66
Training	37	63
Morale	39	61
Targets	39	61
Cross-sector relationships	41	59
Finance	42	58
Staff numbers	45	55

When asked which aspect of quality took precedence through QIPP, around one third of respondents said financial outcomes, closely followed by operational effectiveness, adding up to 61%. The in-depth interviews supported this bias. Interviewees felt QIPP prioritises operational effectiveness as a result of financial constraints. A similar mismatch between aspiration and reality was reflected in views on the Health and Social Care Bill, with almost half (49%) saying it would not improve quality.

When asked to rate the relative importance of the facets of quality, the most important element that respondents identified was operational effectiveness. However, this data was reviewed by respondent category, it became clear that it was skewed by the high number of managers and chief executives responding (accounting for 60% of all respondents). Managers saw operational effectiveness as more important than clinical outcomes and patient experience, whereas the other staff groups viewed the latter two as more important.

The differences in priorities between managers and other staff groups, although slight, show the lack of a clear strategy for delivering quality improvement.

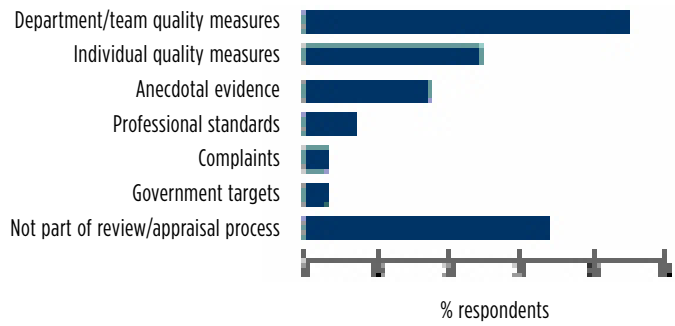
Training

In terms of training in quality, 28% of respondents had received none at all, rising to 34% among managers. Among other staff groups, over 75% had received training in quality. Respondents fell broadly into four categories – a quarter had received no training, a quarter was trained in all the identified areas of quality, a quarter had been trained in only one area (predominantly clinical governance and audit) and the remainder received an inconsistent mix of training in different areas. A consistent package of core training in all facets of quality is needed for all NHS staff.

Quality training is mainly delivered through employers and the NHS Institute for Innovation and Improvement; and 50% of respondents received training via one of these. A much smaller percentage received it from a university or professional body.

Respondents were asked about their usual sources of information on quality. From publications, the primary route overwhelmingly seemed to be professional bodies, with 80% citing this as their primary or most common source of information. This was followed by external quality organisations and talking to colleagues (56% gave these as their primary or most common source). The remaining three routes were the NHS III, the DH and local

FIG 3. **QUALITY IN APPRAISALS**



Quality is not prioritised sufficiently in performance assessment or career development

quality initiatives, which scored 43%, 39% and 32% respectively.

These results can be interpreted in three ways; staff use a provider because it is easy to access, its information is trusted or because of its independence. It is therefore not surprising that professional bodies are the most frequently used source of information, closely followed by external quality organisations and talking to colleagues. What is surprising, though, is that the least mentioned sources – the NHSIII, DH and local initiatives – are most likely to deliver quality training for NHS staff.

Morale and appraisals

For quality to be sufficiently prioritised and consistently applied, it needs to be recognised and staff rewarded through the appraisal process.

This limited focus on quality in staff development was mirrored in its infrequent inclusion in appraisals, with 34% of respondents indicating that quality did not form part of their appraisal (Fig 3). Of the remaining respondents, 42% were assessed on one facet of quality, usually individual quality metrics. The second largest group was assessed in three areas of quality (16%), which commonly included individual metrics, team/department metrics and professional standards. Several of those interviewed said quality did not feature strongly in appraisals.

This demonstrates that quality is not sufficiently prioritised in performance assessment or career development.

How can we improve quality?

A clearly articulated, defined strategy is needed to encourage staff to adopt high-quality practices and remove barriers.

In terms of defining quality, the survey asked respondents to identify who would be best placed to develop the definition. Around one third said patients (Table 2); the second highest response was "other". When suggestions were analysed, over 85% indicated that all or a combination of the suggested stakeholders should be involved in defining quality.

As patient perception is important, respondents were asked about their own or their organisation's engagement with patients. Responses indicated that NHS organisations are becoming more active in engaging patients in several ways, although some are at the early stages. The data shows that 49% of respondents engage patients using only one method, predominantly standard surveys, although 47% use two or more ways. Surveys and complaints monitoring account for nearly 70% of all patient engagement, with the remaining 30% being more active routes, such as focus groups.

More than once, interviewees said their organisations often spent more time justifying why the responses to the surveys were wrong than they did taking corrective action in response to the findings.

A number of respondents identified advanced techniques, including co-design activities for services where patients/service users and clinicians work together to design services and patient forums.

TABLE 2. **VIEWS ON GROUPS BEST PLACED TO DEFINE QUALITY**

Group best placed to define quality	% respondents
Patients	32
Other, please specify	22
Clinical staff or their representative bodies	19
Care Quality Commission	10
Patient representative groups	8
Managers	5
Commissioners	2
Department of Health	1
Government/parliament	1
Strategic health authority	0

Conclusion

To improve quality in the health sector, a clear direction, strategy and definition must be established at national level. The current policy mismatch and different priorities among managers, clinicians and government has resulted in an incoherent and unstructured approach.

One of the reasons why the definition of quality is so unclear is that health professionals believe patients should define it. Yet, the major forms of engagement with the public seem to be surveys (assessing the delivery of the current state as defined by the organisation) or complaints (useful for identifying failure), neither of which engage the public in defining or assessing quality in services.

There is clearly a lack of leadership in quality in healthcare, with initiatives such as QIPP deemed to be focusing mainly on financial factors to the detriment of other aspects of quality. The CQI recommends that this imbalance is rectified by giving equal importance to all facets of quality.

The lack of leadership is compounded by the problem that no single body appears to be responsible for quality. Most staff receive training from the NHS III yet rely on other organisations, most notably professional bodies, for information on quality. To promote consistency, one body should serve as quality expert and leader.

A further barrier to quality implementation is lack of training in this area and its absence in appraisals. This suggests quality is not prioritised in performance assessment, which sends a message that it is not as important as other assessment criteria.

Nevertheless, the fact 48% of organisations have a full set of documented standard operating procedures is positive and means around half those surveyed could start the process of ISO accreditation. A concerted effort to move to an internationally recognised quality standard, to include organisations with only partial documentation, could create a culture of quality improvement in 83% of organisations across the NHS. **NT**

For more information on the CQI, go to www.thecqi.org, contact Ruth Chrystie on 020 7245 8510 or email rchrystie@thecqi.org

References

Department of Health (2011) *Quality, Innovation, Productivity and Prevention (QIPP).* London: DH. tinyurl.com/qipp-dh

Dorrell S (2011) *Dorrell Tells FTN Conference That Real Reform Will Spring From the Efficiency Challenge.* London: NHS Confederation and Foundation Trust Network. tinyurl.com/NHSconfed-Dorrell