Quality and Safety in the NHS: Evaluating Progress, Problems and Promise

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Executive Summary

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Executive Summary

1. The NHS in England is facing challenges and changes as great as any in its history. These include increasing demand, population demographics, changes in disease type and frequency, technological changes, and a major structural and culture change programme, all in a context of national economic austerity. In such circumstances, ensuring that organisational cultures remain focused on improving high quality and safe patient care is all the more important. The research programme reported here was initiated by the Department of Health Policy Research Programme to assess the extent to which NHS organisations in England have cultures in which the most important values are those of providing and improving high quality and safe patient care. The programme used a combination of methods, including interviews, surveys and ethnographic case studies, to assess the extent to which organisational cultures and values support high-quality care and patient safety. It aimed to determine how to secure a sustainable focus on quality and safety, how quality improvement happens, how change in the right direction can be accelerated, and how innovation can be encouraged.

2. Virtually all those we interviewed were firmly committed to the ideal of a safe, high-quality health service for patients and to good patient experience. Many identified the values of compassion and care as at the heart of the mission for their organisations, and as their most deeply felt personal professional commitment. Our interviews, observations, surveys and documentary analysis were united in suggesting for organisations to succeed in delivering high-quality, safe care, they needed to have a clearly articulated vision, including explicit goals for quality and safety and a strategy for achieving them. But converting laudable aspirations for high-quality, safe and compassionate care into clear goals appeared challenging. Clarity about goals, how they could be achieved, and leadership for delivery were highly variable, and will be a focus for improvement in the future.

3. There were many examples of outstanding care throughout our research. But we found considerable variability in how far organisations succeeded in making their aspirations for high-quality care real: what we termed ‘bright spots’ and ‘dark spots’ were both evident, even within the same organisations. Bright spots included teams and individuals who demonstrated caring, compassion, cooperation and civility, and a commitment to learning and innovation. Direct observations found that in many settings patients were often treated with kindness and respect, systems functioned well, and staff were busy but knew what they were doing and why. Compliance with many standards of good practice, such as hygiene and equipment counting, was observed to be very good in many cases.

4. Though much care was of such high-quality as to be inspiring, sub-standard care or dark spots were also evident. Dark spots were found where staff were challenged to provide quality care, were harried or distracted or were preoccupied with bureaucracy. Interviews and surveys with patient and carer groups suggested that patients and their carers were often concerned about quality and safety. Observations in clinical areas and our interviews confirmed that inconsistency was a feature of many settings. For example, though most staff spoke to patients politely and with kindness, some others were
brusque, impatient or discourteous. Concerns were expressed at tendency towards task-focused rather than person-centred care. We found evidence of problematic handovers and interfaces between shifts, teams, departments, and organisations, as well as a tendency in some settings towards team conflict and a diffusion of responsibility relating to particular patients. Patient and carer groups reported discontinuities in care between institutional boundaries and even within single organisations. These ‘responsibility cordons’ left patients variously ill-informed, distressed, and disappointed.

5. Confusion about leadership of quality and safety and overlapping responsibilities among a number of national-level organisations for leading, monitoring, and improving quality and safety have created difficulties for NHS organisations. Multiple lines of accountability have produced misaligned performance measures for monitoring and reporting on quality and safety.

6. Few trust boards reported clear, agreed upon, challenging, and measurable quality and safety-related objectives. Clarity of aims relating to quality and safety was not assisted by ‘priority thickets’: targets, standards, incentives, initiatives, drives, and measures that crowd in from multiple external sources, and are ill-coordinated and misaligned. In trusts whose boards prioritised productivity and targets over safety, staff were less engaged, less satisfied, more stressed, and less likely to report being able to contribute to improvements in the workplace. Where safety was prioritised, staff experience on all these dimensions was more positive. However, there was a low level of board innovation and a significant decline in the amount of innovation over the study period. Relatively few innovations by boards related to quality and safety; most related to efficiency and productivity. We found that high levels of competition between trusts were associated with lower staff satisfaction, poorer implementation of human resource management practices, and lower levels of staff satisfaction with the quality of care they were able to deliver.

7. Using the NHS National Staff Survey data, we found that one of the strongest predictors of patient mortality in acute trusts was the percentage of staff working in well-structured teams. Although 91% of NHS staff report working in teams, only 40% worked in well-structured teams. Working in poorly structured teams was associated with higher patient mortality, more errors that could harm staff or patients, and higher levels of injuries to staff. Staff working in well-structured teams had better health and well-being and took less time off work. The best indicator of a variety of outcomes including staff health and well-being, absenteeism, intention to quit, quality of patient care, patient mortality, and use of resources was the level of staff engagement. The research demonstrates a strong relationship between quality of staff management and the quality of patient care. It was thus disappointing that a number of key scores in the National Staff Survey and Acute Inpatient Survey, indicative of quality and safety issues, which had improved steadily in the years up to 2009, have since stagnated or deteriorated.

8. Although they were committed and innovative in their approaches, some staff reported often being unable to achieve their goals for patients because of organisational factors outside their control. Changes within organisations, uncertainty about priorities, poor systems, and increased workload and staff shortages created serious challenges. These frustrations were compounded by staff feeling they lacked support and appropriate intervention from management, further reducing their motivation and morale. However, when they had the right support, either from within their teams or as a consequence of enlightened management, front-line teams felt able to deliver high quality care,
reinforcing their high levels of motivation and morale in a virtuous circle. Having appropriate resources and adequate staffing levels allowed staff to do their jobs effectively and this seemed to promote resilience by also enabling staff to explore new ways of working and develop reflective practice. Staff at the sharp end were very often aware of systems problems but could feel powerless to bring about change. Organisational change, uncertainty about priorities, poor systems, heavy workloads, and staff shortages were all blamed for staff feeling they lacked support, further reducing their motivation and morale. Disagreements between senior, ‘blunt-end’ managerial staff, and clinical staff working at the ‘sharp end’ of care, on the causes and solutions of quality and safety problems led to wasted effort and loss of trust. But strong focus by executive and board teams on their own role in identifying and addressing systems problems was powerful in supporting positive cultural change; our observations and interviews identified many examples of where impressive gains had been made by the sharp and blunt ends working together around unifying goals.

9. There was evidence of wide variation in the ability of NHS organisations to gather, identify sort, understand, monitor, and appropriately act upon information about their performance in relation to quality and safety. In many trusts, an inability to interpret quality and safety-related data at board level was compounded by the use of ill-coordinated and sometimes poorly designed measurement processes at the front line. Data collection was sometimes used as a means of reassurance rather than as a way of detecting and acting upon problems. More constructive behaviours involved using data to go beyond merely ensuring compliance; data was used to challenge and reveal areas requiring action.

The findings suggest a need for a renewed but more coordinated emphasis on quality and safety to ensure that recent progress is not lost and that a focus on quality remains permanent amid other pressures. The research also suggests how best to secure quality and patient safety in the NHS:

- Direction for quality and safety must be set from the top. Clear national-level direction setting is crucial. It must avoid dispersing responsibility and accountability, and avert confusion and misalignments for service providers.
- Within NHS organisations, leaders must work with staff to agree clear, measurable, and challenging objectives. Trust boards must make safety and quality their overriding focus, shaping organisational environments that promote continuous improvement in patient care quality and safety.
- Change programmes must embrace multifaceted and complementary strategies to effect deep and sustainable improvements. Some quality improvement techniques show promise and have been used with some success. But they need a supporting culture change if they are to succeed, and to avoid being treated as magic bullets.
- To secure improvement, the focus must be on both systems and individuals. This means enforcing personal accountability, ensuring that staff at all levels share an understanding of quality and safety problems and agree on solutions, and investing management time in addressing systems problems that require senior-level intervention.
- Supportive management that secures staff engagement is needed. Staff need to feel valued, respected, and supported, and successes should be rewarded.
There is a need to increase the percentage of staff working in well-structured teams and reduce the percentage working in poorly structured teams by ensuring clear, challenging, and measurable team objectives; better communication and coordination within and between teams; and encouraging teams to regularly take time out to review their performance and how it can be improved.

A key objective of every team in the NHS must be to continuously improve the effectiveness with which they work with other teams (within and outside their organisation as necessary) to ensure effectiveness and efficiency in the delivery of high quality patient care.

The patient perspective should be valued at all levels, from national to local. Patients’ views should be the key source of intelligence for organisations about the quality and safety of their services.

Organisations must get smarter with their use of intelligence. Burdensome and inefficient systems for data collection should be avoided; so too should a culture of using data as a form of comfort-seeking behaviour. The right information needs to be gathered, interpreted correctly, and fed back to staff at the front line so that they can sustain and improve their performance.

Innovation at the sharp end of clinical practice must be positively reinforced and supported by senior staff. And they should nurture environments in which front line innovation can flourish. Cultures of innovation at the sharp end of care need to be encouraged by ensuring work pressures do not crowd out space for the development of new ways of providing high quality care.

Overall, there is a need for the issues identified in this report to be discussed at all levels of all NHS organisations and for shared strategies and solutions to be developed in the interests of high quality and safe patient care for all. That requires cultures of involvement, good communication and consultation, constructive critique, exploration of opinions, and ideas for innovation from the board through to the front line.