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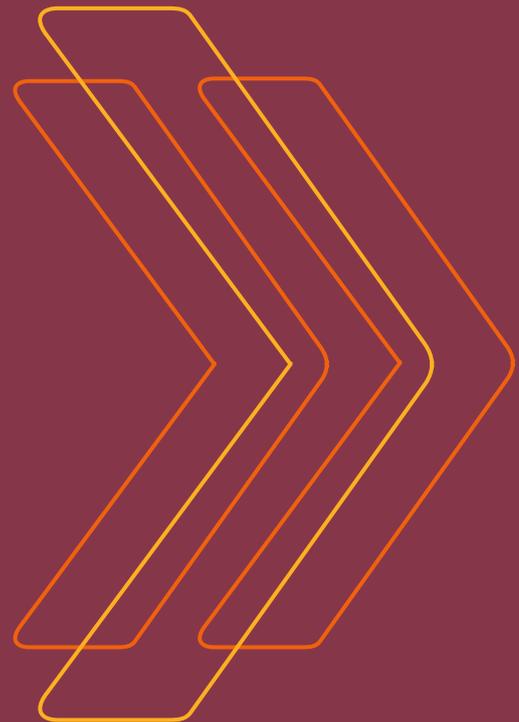
Improving quality in the English NHS

A strategy for action

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1 Introduction

The NHS in England faces the immense challenge of bringing about improvements in patient care at a time of growing financial and workload pressures. It is expected to deliver productivity improvements of £22 billion by 2020/21 as well as implement new commitments such as seven-day working. It is doing so in the context of workforce shortages among key clinical groups and evidence of high levels of work-related stress among staff ([Health and Safety Executive 2015](#)).

The Spending Review has committed additional resources to the NHS yet, even so, health care spending as a share of GDP is forecast to fall by the end of this parliament ([Appleby 2015](#)). The purpose of this paper is not to reopen debate about the adequacy of planned funding, challenging as that is. Rather, its aim is to argue that the English NHS cannot hope to meet the health care needs of the population without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy.

By quality improvement we mean designing and redesigning work processes and systems that deliver health care with better outcomes and lower cost, wherever this can be achieved. This ranges from redesigning how teams deliver care in the clinical microsystems that make up health care organisations to large-scale reconfigurations of specialist services such as stroke care and cancer care. It includes redesign of training, budgeting processes and information systems and requires leadership and cultures that both understand and value quality improvement.

Improvements in the quality of care do not occur by chance. They come from the intentional actions of staff equipped with the skills needed to bring about changes in care, directly and constantly supported by leaders at all levels. They do not come free and will require a substantial and sustained commitment of time and resources.

Numerous reports have outlined the skills and knowledge that equip a workforce and its leaders for success in continual improvement. All emphasise the toxic impact of fear in the workplace. Most draw on systems theory and more recent formulations exploit the power and insights of modern theories of complex adaptive systems.



All reject ‘reliance on inspection for improvement’ as too costly, too weak and inimical to dynamic change, drawing on Deming’s seminal work (*see Orsini 2013*).

The theory and practice of quality improvement is based on a number of principles. They include training staff in the nature of systems, use of statistical and quantitative data over time to understand variation, inclusiveness such that all workers have an opportunity to contribute and act on ideas, and a relentless focus on the needs and experience of the people served by a system (its ‘customers’). They also include employment of many small-scale trials and tests of change as a way to learn in action, the high value attached to teamwork and co-operation, and a belief in the importance of joy at work.

Health care as a sector has been late in recognising the contribution that the theory and practice of quality improvement is able to make to delivering better value care. The experience of the small number of health care organisations that have done so with demonstrable results is a challenge to others to invest in acquiring the necessary skills and capabilities. This paper will have succeeded if it makes a convincing case for quality improvement to be at the heart of how the NHS responds to current pressures and delivers the transformational changes in care that are needed.

Many of the ideas discussed in this paper have been articulated previously in government reports and commentaries by think tanks and researchers, albeit in a more benign climate for the NHS. We therefore begin by reviewing the recent history and fate of policies to improve the quality of care in the NHS. We go on to outline the key features of a quality improvement strategy and the role of organisations at different levels in making it a reality. We seek to express the argument succinctly as an aid to action.



2 A brief history of policies on quality of care in England

Successive governments have pursued policies to improve the quality of care in the NHS. These policies have arisen in part in response to well-publicised failures in patient care in Bristol, Stafford and elsewhere; in part from voters' concerns about particular performance gaps in the NHS (especially waiting times) and evidence that the United Kingdom has fallen behind other countries on some indicators (cancer survival rates being an example); and in part in recognition that the NHS, like other health care systems, could do more to improve quality and patient safety.

Many of the foundations were laid in the early years of the Blair government through the leadership of the then chief medical officer, Liam Donaldson. Key policy documents include *A first class service* (Department of Health 1998), and *An organisation with a memory* which proposed how the NHS should learn from adverse events (Department of Health 2000a). Donaldson also led work to reform the approach to dealing with poor clinical performance after the Shipman Inquiry and to reform medical regulation.

Many of the policy changes that originated at that time might have placed England at the forefront of work to improve the quality of care had they been pursued with constancy of purpose. In the event this did not happen and other priorities and reforms came to receive greater attention under the Blair government. When later governments 'rediscovered' the quality agenda they put forward new policies (or sometimes old policies in new clothes) rather than building on the foundations laid between 1997 and 2000.

These policies included *High quality care for all* which outlined a roadmap to improve quality prepared by Lord Darzi for the Brown government (Department of Health 2008), and *Hard truths: the journey to putting patients first* which set out the coalition



government's response to the report of the Francis Inquiry into Mid Staffordshire (Department of Health 2014a; 2014b). A wide range of institutional and other changes has resulted from these documents. These changes include but are not limited to:

- the establishment of the National Institute for Health and Care Excellence (NICE) to develop guidelines and standards of care and to promote their implementation
- the establishment of a succession of regulators and inspectorates (currently the Care Quality Commission (CQC)) to visit health care providers and report on their performance
- the introduction of systems of clinical governance underpinned by a statutory duty of quality to hold the leaders of NHS organisations to account for the quality of care they deliver
- the use of a performance assessment framework to monitor performance on selected aspects of quality
- the publication of data about performance both to inform the public and to support providers to improve care
- the strengthening of professional regulation including the establishment of the Council for Healthcare Regulatory Excellence
- the use of financial incentives to reward quality of care including the quality and outcomes framework and the commissioning for quality and innovation (CQUIN) framework
- the promulgation of targets to improve quality both in relation to access to care and health care-acquired infections
- the introduction of a duty of candour and protection for whistle-blowers to encourage greater openness when things go wrong
- the establishment and later disbandment of the National Patient Safety Agency to collect and analyse data about adverse events



- the establishment and later disbandment of the NHS Modernisation Agency as a central support system for improvement
- the establishment and later disbandment of the NHS Institute for Innovation and Improvement as a (smaller) successor to the Modernisation Agency
- the establishment and later disbandment of NHS Improving Quality as a successor to the NHS Institute for Innovation and Improvement
- the establishment and later disbandment of strategic health authorities as regionalised resource centres for a range of tasks, including facilitating quality improvement.

As this abbreviated list demonstrates, the NHS has seen no shortage of policy interventions designed to improve the quality of care. Indeed, it could be argued that policy-makers have been over-active in their well-meaning attempts to raise standards and protect patients, and have failed to adopt a coherent, sustained approach to quality improvement. Partly as a consequence, while there have been some improvements in quality and safety since the publication of *A first class service*, progress has been uneven and focus has shifted repeatedly as different areas of care come and go from government's priority list.

This point was made in an independent and expert review published by the Nuffield Trust in 2008, which characterised the quality reforms of the previous decade as 'a bewildering and overwhelming profusion of Government-imposed policies and programmes' (Leatherman and Sutherland 2008). The review went on to argue that the NHS in England needed a national quality programme to provide the integrated quality strategy required in the future. Eight years on, and in the context of the subsequent Darzi review, severe austerity measures and the coalition government's response to the Francis Inquiry report, this argument is even more compelling.



3 Competing beliefs on how to improve quality

Underpinning the many and varied policy initiatives designed to improve the quality of care have been multiple approaches to improving quality, reflecting competing beliefs on how improvements are best achieved. The Nuffield Trust's review in 2008 characterised this as an ideological rift between advocates of central control and supporters of devolution in the NHS. Although the reality was more complex, frequent changes to the policy instruments used and inconsistencies of approach over time – in part a function of changes of government and health secretary – have undoubtedly hampered and confounded efforts to improve quality of care throughout this period.

It is difficult to chart a course when both the destination and the captaincy keep changing.

Subsequent to the Nuffield Trust's review, supporters of devolution found their voice in the Darzi review, which argued that improvements in quality of care were best led by clinicians and should be based on supporting staff within the NHS to bring about change locally. In direct contrast, the coalition government's response to the Francis Inquiry report exemplified the view that central control was the route to quality improvement, particularly through stronger regulation and inspection of providers. Successive governments have also placed faith in the role that patient choice, market forces and 'naming and shaming' can play in improving quality.

A quite different perspective was offered in the Berwick report on patient safety, *A promise to learn – a commitment to act*, which was commissioned by the coalition government to advise on what needed to be done to enable continual reduction in harm in the NHS (**National Advisory Group on the Safety of Patients in England 2013**). In an analysis with loud echoes of the Darzi review, the Berwick report argued that the NHS should become 'more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end' (p 5). The report set out in 10 recommendations how this might be realised, including



simplifying and clarifying supervisory and regulatory systems and fostering a culture more focused on learning and improvement and less on scrutiny, rewards and punishments.

The principal recommendations in the Berwick report were designed to support staff within the NHS to lead improvements in care by providing education and training in quality and patient safety sciences and practices. The report also recommended a renewed emphasis on the transparent reporting of data on quality and safety, and greater attention to the views and voices of patients and carers. Its core argument was that all leaders in the NHS should place quality of care in general, and patient safety in particular, at the top of their priorities, including ensuring that staff were employed in appropriate numbers and were well-supported. One year after the report, a survey found that training and support for staff to improve the processes of care was the area where least progress had been made ([Health Foundation et al 2014](#)).

Much therefore remains to be done to support the ambition that the NHS should become a learning organisation committed to continuous improvement. If anything, in the time that has elapsed since the Berwick report was published, reliance on regulation and inspection as the mainstays to promote safety and quality has increased, and the aim of developing ‘a culture that avoids a predisposition to blame, eschews naïve or mechanistic targets, and appreciates the pressures that can accumulate under resource constraints’ ([National Advisory Group on the Safety of Patients in England 2013](#), p 9) seems more distant. The cycle of fear described in the Berwick report and its toxic effects are stronger than ever and hinder the development of the learning culture it advocated. The NHS staff survey shows that those working in the NHS may be more confident of action being taken following an incident but are also more likely to feel blamed for it.

The adoption of many dissonant means of improving quality is symptomatic of the use of different approaches to reforming the NHS in England, described in a recent analysis by The King’s Fund as ‘hierarchy, inspection and markets’ ([Ham 2014](#)). None of these approaches has had the desired impact on performance either singly or in combination. Echoing the recommendations of the Berwick report, the analysis argued that more emphasis should be placed on reforming the NHS ‘from within’ by appealing to the intrinsic motivation of staff and providing them with the skills, knowledge and support to offer high-quality and continually improving care.



This must include acting on evidence of high levels of stress in the health care workforce and improving the working lives of staff. The well-established relationship between staff experience and patient experience underlines the need to give greater priority to these issues as a matter of urgency. Every provider should aspire to create an environment in which there is joy at work and that avoids the risk of staff burnout in the face of rising demands for care – a phenomenon not unique to the United Kingdom (*see* Bodenheimer and Sinsky 2014 on evidence from the United States).



4 The need for a coherent and integrated strategy

Against this background of hyperactive policy-making and competing beliefs about how to improve quality of care, the rest of this paper outlines what needs to be done to develop capacity and capability for quality improvement in the NHS. It argues that now more than ever the NHS must focus on delivering better value to the public. This means tackling unwarranted variations in clinical care, reducing waste, becoming much more patient- and carer-focused, and redoubling efforts to put quality and safety at the top of the health policy agenda ([Alderwick et al 2015](#)).

As the Darzi review argued persuasively, this is best done by supporting clinical leaders through education and training in quality improvement methods and developing organisational cultures in which leaders and staff focus on better value as a primary goal. There have been, and are, examples of where this is already happening in the NHS in England but they are few and far between. Only by moving from pockets of innovation to system-wide improvement will the NHS deliver the changes that are needed to sustain and transform care at a time of unprecedented financial and service pressures.

We argue that a much more consistent and coherent approach to quality improvement is needed that learns from both the successes and the false starts of the past. This approach needs to provide the resources and expertise that will enable the NHS as a whole to become not only a learning organisation but also a high-performing organisation. Such an approach should draw lessons from organisations and systems around the world that have reformed from within and thereby demonstrated measurable improvements in quality, cost and safety. While each of these organisations and systems has pursued its own path, they have some common features which, taken together, indicate what is now needed and possible in the NHS.

In summary, as the Berwick report and other analyses have argued, these features include but are not limited to the following.



- Cultures in which quality and safety of patient care are valued and leaders work together to bring about improvements in care (as in US-based Mayo Clinic's mantra that 'the needs of the patient come first').
- Continual reduction of fear in the workforce, and total engagement in the design and redesign of work and processes (as at Bellin Health, US).
- Specific and quantified goals for improving care linked to a compelling vision of the future (as in Salford Royal's ambition to be the safest hospital in England).
- Systematic, transparent measurement and reporting of progress in delivering these goals (as in Jonkoping County Council, Sweden).
- The use of an established method of quality improvement, supported by training all staff and all leaders in this method (as in the Virginia Mason Production System and the advanced training programme at Intermountain Healthcare, US).
- Clinical leadership, teamwork and engagement at all levels together with high-quality management support (as in Kaiser Permanente, US).
- Boards and senior leaders who accept personal responsibility for quality and safety and themselves develop deep expertise in quality improvement.
- A commitment to listening to and learning from the experiences of patients and carers and assuring their full participation in design, redesign, assessment and governance (as in the Cleveland Clinic and Cincinnati Children's Hospital Medical Center, US).

The challenges for the NHS in England in acting on these features are how to do so in an organisation that exists in the constant political spotlight, that is accountable to changing governments, and that works on a scale far bigger than any other health care system that has successfully implemented an organisation-wide quality improvement programme. Equally important at the time of writing is the priority being given to restoring financial balance across the NHS and the risk that quality of care will be seen as a lower priority until finances have been stabilised. While



the NHS needs to live within its means, bringing spending into line with available funding needs to be done in a way that promotes quality improvement rather than making it more difficult.

To deliver system-wide improvements, careful thought needs to be given to what is best done nationally and what is best done locally; the role that networks of providers might play in supporting improvement efforts; the role of outside experts and consultants in helping the NHS to take forward these efforts; and how to combine work on leadership development and quality improvement as part of a coherent programme of development and support as these have usually been seen as separate activities in the NHS. By giving careful attention to the design of a quality improvement system for the NHS in England, there is an opportunity to use available resources and expertise to make a real difference.

Of particular importance is the need to be clear about the role of inspection in this system. Our view is that inspection, done well, has a part to play in *quality assurance* but this should not be confused with quality improvement. One of the major missed opportunities in responses to the Francis report has been the failure to understand and act on this distinction, notwithstanding the recommendations of the Berwick report. The result has been relative neglect of quality improvement and unrealistic expectations of what inspection can achieve.

Quality improvement should be taking place within providers, wherever they are on the performance spectrum, and should be based on the internal motivation of providers to deliver the best possible care within available resources rather than their response to external pressures. As Deming argued, quality has to be ‘built into’ production from the outset by focusing on the system of production and designing this to reduce error and waste (Orsini 2013). This requires leaders who understand and value what quality improvement means (literacy in quality improvement, if you will) and cultures in which safety and quality are seen as priorities.

Politicians have seen the CQC as one of the principal means of avoiding a repetition of the tragic failures of patient care that occurred in Mid Staffordshire and its resources have increased commensurately. The CQC’s role is to give assurance that all organisations providing care are doing so to an acceptable level with a particular focus on those not doing so, who are placed into ‘special measures.’ The CQC uses inspection to draw attention to real and potential problems, as well as having powers



to require improvements in care, but its role is not to lead work on continuous quality improvement in the way we argue for in this paper.

Now is the time to correct the imbalance between quality assurance and quality improvement. It means putting much more effort into quality improvement and policy-makers being realistic about what the CQC can and cannot achieve by recalibrating the emphasis placed on each. It also means engaging and supporting staff to serve patients to the best of their abilities by developing cultures within providers based on a commitment to improvement and learning rather than compliance with external standards.

If this can be achieved, and it will not be easy, there is a possibility of harnessing the motivation of staff at all levels to bring about improvements from within. Only in this way is it possible to create the momentum by which continuous quality improvement can occur at scale.



5 Where next?

The rest of this paper sets out to describe the ‘system of support’ needed in the NHS based, as the Berwick report argued, on ‘a considered, resourced and driven agenda of capability building in order to generate the capacity for continuous improvement’ ([National Advisory Group on the Safety of Patients in England 2013](#), p 9). In our view, this means embracing complementary approaches to bringing about improvement that move beyond the oscillations between central control and devolution that have been a feature of the NHS from its inception right up to the current moment.

A coherent and integrated approach to quality improvement should identify the proper role for inspection as well as the support needed by NHS organisations to successfully and continually improve patient care. It should define the roles of organisations at different levels and how, together, they can support improvements in care and how they can co-operate thoroughly with each other, recognising the time and effort needed to build quality improvement capabilities. The NHS quality improvement strategy should also be willing to learn from best practice wherever it may be found both inside and outside the NHS.

The case for a learning health care system has been set out at length with supporting examples in a report by the Institute of Medicine (now the National Academy of Medicine) in the United States and our purpose is not to repeat its arguments here ([Institute of Medicine 2013](#)). Suffice to say that we endorse the case it makes for a system-wide approach that acts on several fronts at the same time. As its report notes, the biggest challenge is how to make a reality of a learning health care system in real-world clinical environments, given the competing pressures they contain.

Addressing this challenge requires real-world clinician leaders to be involved in designing the quality improvement strategy for England alongside the leaders of national bodies and of NHS organisations. It also requires deep personal commitment by the leaders of NHS organisations as exemplified by the involvement of David Dalton in Salford Royal NHS Foundation Trust’s quality improvement work. This in turn depends on the willingness of politicians and leaders of national bodies to reduce the burden of regulation, inspection and performance management



on the NHS to free up clinicians and organisational leaders to give time and attention to the work of improvement.

Work by the Institute for Healthcare Improvement (IHI) on high-impact leadership draws on the experience of those who have led successful improvement efforts and is essential reading for leaders in the NHS committed to this agenda ([Swensen et al 2013](#)). High-impact leaders need to work with a cadre of experienced managers and clinicians trained in improvement methods and supported by technical experts such as system engineers, who can be found in substantial numbers in high-performing health care organisations in other countries. System engineers use their expertise in improvement science to strengthen the operations of health care organisations, for example by reducing delays and improving the flow of patients and information between staff delivering care (for more information see [President's Council of Advisors on Science and Technology 2014](#)).

We now set out 10 design principles to guide the development of a quality improvement strategy. It is for others to determine the level of resources to be committed to this work but, in our view, few higher or more urgent priorities face the NHS today. The gulf between what is needed and what currently exists in the NHS is wide and patience as well as urgency will be needed to bridge this gulf.

Expect NHS organisations to build in-house capacity for quality improvement

High-performing health care organisations build in-house capacity for quality improvement and in so doing learn from others (on which more below).

Building in-house capacity entails adopting a modern, scientifically grounded method for quality improvement, investing in the education and training of all leaders and staff in this method and acquiring skills to support its use 'from the ward to the board'. This requires resources – time and money – and the development of necessary capabilities. Jonkoping County Council in Sweden has done this by establishing a centre of expertise on quality improvement known as Qulturum on the site of one of its hospitals, and every year many staff participate in its training programmes.

Another example is Intermountain Healthcare in the United States, which has pursued its journey of quality improvement for more than 30 years led by



Brent James, its chief quality officer. Thousands of its staff have graduated from the Advanced Training Programme, which provides a grounding in quality improvement theory and practice and requires participants to apply the learning in a project relating to their area of care. Participants come from a wide range of clinical and non-clinical roles with much of the training led by Intermountain's own staff.

A few NHS organisations have made a commitment to building in-house capacity on this scale and some of these efforts have been documented elsewhere ([Jones and Woodhead 2015](#)). Those that come close include:

- East London NHS Foundation Trust
- Northumbria NHS Foundation Trust
- Nottingham Teaching Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Sheffield Teaching Hospital NHS Foundation Trust's microsystems coaching academy
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust.

Beyond these examples, there is previous experience, through the work of the NHS Modernisation Agency, of seeking to strengthen quality improvement capabilities across the NHS in England.

By the time it was disbanded, the Modernisation Agency had developed a network of more than 800 staff and trained 'associates' connecting it to virtually every acute and primary care trust in the nation. We draw out the lessons from this experience below.



Support NHS organisations through shared learning and regional support

Large-scale improvement collaboratives were used in the NHS a decade or so ago to improve care in relation to access, cancer services and primary care. These collaboratives brought together NHS providers from across England and supported them to achieve improvements in care through a combination of expert knowledge, facilitation and shared problem-solving. One example was the work of the primary care development team led by John Oldham (*see box below*).

National Primary Care Collaborative

The NHS Plan in 2000 set objectives for improving access to NHS services ([Department of Health 2000b](#)). A number of initiatives were introduced to try to achieve these aims, including the establishment of the National Primary Care Development Team (NPCDT). The purpose of the NPCDT was to create a National Primary Care Collaborative, with the aim of equipping primary care professionals with the skills needed for quality improvement and to spread best practice methods.

The collaborative focused on improving:

- access to primary care services (using an 'Advanced Access' model)
- care for patients with established coronary heart disease
- access to routine secondary care services.

The programme started in a small number of primary care trusts (PCTs) and was expanded right across the NHS in a series of waves. An Advanced Access model was developed based on the key principles of understanding demand, shaping the handling of demand, matching capacity to demand, and developing contingency plans. Teams used rapid Plan Do Study Act (PDSA) cycles to implement changes, developing generic skills in quality improvement that could also be applied to other areas of patient care (*see Oldham 2005*).

A large-scale evaluation of the programme found that, while implementation of the approach in practice was mixed, those practices implementing the Advanced Access model experienced improved access to services without evidence of disadvantages in terms of workload, ability to contact the practice, continuity of care, or demand on other services ([Salisbury et al 2007](#)).

Alongside these collaboratives, much quality improvement work took shape under the aegis of strategic health authorities (SHAs). Particularly active in the world of



quality improvement were those in the North West, South West, London and East of England, each of which chose specific areas of focus, such as patient safety, stroke care and chronic disease management. The demise of SHAs has removed some of the leadership of quality improvement and opportunities for shared learning on which improvement efforts in the past have been based.

Networks and organisations participating in the new UK Improvement Alliance have partially filled this gap by supporting member NHS organisations to develop their quality improvement capabilities through a shared resource. An example is the Advancing Quality Alliance (AQuA) in the north-west of England which was established in 2010, works with around 72 providers and commissioners in its region and is funded on a subscription basis. It has a small core staff supplemented by the use of national and international quality improvement experts.

AQuA's activities include training for staff drawn from members' organisations in quality improvement methods alongside a small number of programmes focused on specific areas of quality and safety. Examples include programmes on integrated care and system leadership, patient safety, shared decision-making, and patient experience. It seeks to build capability using an improvement skills escalator that provides training ranging from basic skills through to the development of advanced improvement practitioners.

A different example is **UCLPartners** (UCLP), an academic health sciences partnership established in 2009 whose reach now extends beyond its original base in north-east and central London into Bedfordshire, Hertfordshire and Essex. It is unique in England in aligning the work of an academic health science centre, an academic health science network (AHSN), an education lead provider and two National Institute for Health Research research groups. The stated aim of UCLP is 'translating cutting edge research and innovation into measurable health improvements and wealth creation for patients and populations'.

The achievements of UCLP include support for improvements in stroke care across London that has delivered better value for the population (**Hunter RM et al 2013**). It has also established an integrated cancer system known as London Cancer serving 3.2 million people with the aim of improving outcomes for people with 11 different types of tumour. A more recent initiative is the Deteriorating Patient Collaborative designed to reduce avoidable deaths from cardiac arrest by 50 per cent.



Work to design a quality improvement strategy for the NHS in England needs to learn from these and other examples to put in place the expertise needed to support the primary responsibility of NHS organisations to build in-house capabilities for improvement. Much of this support could and should be provided at a regional level, including through academic health sciences networks. In addition, there is a need for a national centre of expertise to offer oversight and co-ordination of quality improvement work at regional and local levels.

Establish a modestly sized national centre of expertise

The experience of the NHS Modernisation Agency contains important lessons about what is needed at a national level to support NHS organisations and encourage the use of improvement networks and collaboratives. From small beginnings in the National Patient Access Team, the agency was created in 2001 and two years later it employed around 800 staff and associates.

The rapid growth of the agency was a testament to its initial success but also contained some of the seeds of its downfall. Many of those working for it were taken away from work in NHS organisations directly providing patient care to work on national programmes. NHS organisations found themselves receiving support from more than one of these national programmes, often with weak co-ordination among them. In 2005 it was decided to replace the agency with a smaller national body and with greater emphasis placed on improvement work being led at regional and local levels by staff with senior improvement experience, including through SHAs.

The agency's successors, the NHS Institute for Innovation and Improvement and subsequently NHS Improving Quality (NHSIQ), have undertaken some important improvement work, for example on 'productive wards.' But they have struggled to establish themselves as valued sources of expertise within the NHS. More focused initiatives such as the Emergency Care Intensive Support Team (ECIST), which provides support to NHS organisations that face challenges in delivering high-quality and accessible urgent and emergency care, have also contributed. Intensive support teams also exist for cancer care and elective care.

It will be important to learn from the experience of the past in developing a quality improvement strategy for the NHS in England. A modestly sized national centre of expertise might comprise leaders with a track record of achievement on quality



improvement and a small number of focused teams like ECIST. These teams would draw on experience from within the NHS in those areas of care where the need for external support is greatest, thereby reducing reliance on expensive and questionably effective management consultants.

The centre would be a repository of intelligence about quality improvement to be called on by the NHS and it would signpost relevant examples and evidence from England and further afield. It would work with regional bodies like AHSNs and improvement networks and collaboratives such as AQuA and UCLP to offer the structured advice and support needed. It would not detract from the primary responsibility of NHS organisations themselves to give priority to quality improvement and invest in building the capabilities required.

Integrate work on quality improvement with work on leadership development

High-performing health care organisations see quality improvement and leadership development as two sides of the same coin – thoroughly connected and synergistic. Put simply, they invest in the development of their staff and their leaders with the specific and direct aim of strengthening their capability to improve patient care. The co-existence of the NHS Leadership Academy and NHSIQ until recently, each with its own staff and priorities and with little connection between the two, signified a gulf in the NHS that needs to be bridged.

Work now under way following the review of the NHS Leadership Academy, NHSIQ and other improvement and leadership development functions ([NHS England et al 2015](#)) needs to act on this insight. A single national centre of expertise in both quality improvement and leadership development is needed – as was once the case when the NHS Modernisation Agency hosted the then NHS Leadership Centre. The work of the national centre needs to be aligned with that of regional bodies and improvement networks and collaboratives with a presumption of support being provided as close to the organisations delivering care as possible.

This would mean bringing together people and resources currently in Health Education England, NHS England and NHS Improvement. These resources would in turn need to be fully aligned with closely related work on NHS productivity following the Carter review ([Carter 2016](#)) and the appointment of senior clinical



leaders to support the implementation of the review's findings by working to identify and reduce variations in clinical care. A logical place to locate the national centre is within NHS Improvement given its role in both regulating and supporting providers to improve their performance.

One of the roles of the national centre would be developing clinical and lay leaders at all levels to deliver the needed improvements in value and productivity. Also important is supporting experienced organisational leaders to become system leaders in the integrated care models that are at the heart of the new care models programme. A sustained effort is required to help leaders at all levels acquire an understanding of the theory and practice of quality improvement. This would occur within the context of highly variable levels of literacy in quality improvement across the NHS.

There is also a need to give more attention to the management of improvement work and the practical skills needed to do this effectively, as in the example of system engineers cited earlier. The curriculum for training staff should draw at a minimum on: relentless focus on the needs of patients, families and carers; proper and sophisticated use of data for learning and improvement; systems thinking; a commitment to engage with the workforce; widespread use of rapid tests of change (PDSA cycles) for continual learning; the removal of waste from processes, products and services; and the pursuit of joy at work. Training should be an expectation of all staff including those in board roles.

One further aim, admittedly difficult to arrange, would be to build understanding of quality improvement among governmental and political leaders, up to and including Whitehall and Westminster. Given the close relationship between the NHS and government, growing the knowledge among governmental and political leaders about the theory and practice of quality improvement might yield wiser decisions and more patience.

Ensure that national bodies provide unified, co-ordinated support to the NHS as full participants in a single strategy

Jim Mackey, the new Chief Executive of NHS Improvement, has spoken of the need to offer more support to challenged NHS organisations alongside regulatory interventions. This is a welcome statement of intent and now needs to be translated



into practice. The experience of NHS organisations that get into difficulty remains one of closer scrutiny of their performance and an ever-present risk that their leaders may be replaced. That looming threat and the fear it induces are severe impediments to the proper pursuit of quality improvement, illustrated by the Health Secretary's recent warning that provider boards will be sacked if they fail to bring budgets back into balance (West 2015).

National bodies should share, and co-operate, in striving for robust, system-wide improvement activities. They should commit to major investments in innovation, such as the new care models programme, and to an evolving, jointly embraced vision of the new NHS care system as a whole. This vision should focus on a modernised, patient-centred service, using telehealth and telemedicine, integrated clinically across time and space, aimed at continual reduction of waste and unwanted variation, and deeply respectful of its own workforce.

This should be done as part of a single quality improvement strategy that is developed and supported by the leaders of all relevant national bodies. There is a precedent for this in the *NHS five year forward view*, which was the product of collaboration among NHS England, Monitor, the NHS Trust Development Authority, the CQC, Health Education England, and Public Health England. It will be particularly important to develop a more explicit understanding of the role and limits of inspection and regulation within the strategy and ensure that the work of the CQC is fully aligned with that of NHS Improvement.

For the avoidance of doubt, a national system of support should extend well beyond challenged organisations to enable all organisations to improve care and innovate at pace and scale. As we argued earlier, the logical place to locate national expertise on quality improvement is NHS Improvement acting in partnership with other national bodies. This will require major changes in approach given the largely financial and technical orientation of NHS Improvement's predecessor bodies, Monitor and the NHS Trust Development Authority.

Involve frontline clinical leaders and the leaders of NHS organisations in developing the strategy

While the involvement and commitment of relevant national bodies in the development of a quality improvement strategy is a necessary condition, it is by no



means sufficient. Equally important is to engage the leaders of NHS organisations with a track record of achievement in quality improvement alongside clinical leaders. The work of the Health Foundation and others in recent years, along with the still-extant legacy personnel of the Modernisation Agency and the Primary Care Development Team, has created a sizeable group of clinical and managerial leaders who have been trained in the theory and practice of quality improvement. Members of these groups should be involved from the outset.

The challenges of bringing about improvement in quality in real-world clinical environments should not be underestimated, as has been reported in work supported by the Health Foundation ([Gabbay *et al* 2014](#); [Health Foundation 2013b](#)). These challenges include finding the time for both managers and clinical staff to review working practices and to test and implement improvements as well as providing these staff with training in methods and measurement. The development of the quality improvement strategy therefore needs to be based on the experience of clinical leaders who have ‘been there and done it’ to ensure that it is designed appropriately.

As we have argued, it also means learning from the experience of improvement collaboratives such as the Primary Care Development Team, whose work contributed to shorter waits and more convenient appointments for tens of millions of people in the 2000s. This work succeeded in part because of leadership by a credible GP leader and the engagement of GPs and others in the participating practices. An evaluation of the booked admissions collaborative similarly found that leadership by senior clinicians was one of the factors that explained why some hospitals made greater progress than others ([Ham *et al* 2003](#)).

Ensure the voice of patients and the public is sought and heard in the design and implementation of the strategy

The purpose of quality improvement as we have described it is to deliver better value for patients, carers and communities, guided by the ‘triple aim’ developed by the IHI ([Berwick *et al* 2008](#)) and understanding deeply and systematically what matters to patients and the public. The transformation of Southcentral Foundation in Alaska, US, exemplifies one approach to doing this ([Collins 2015](#)). Southcentral’s leaders and the population they served redefined the community as ‘customer-owners’ responsible for taking decisions about their own health and care and not simply being invited to participate in these decisions.



The NHS can learn from this experience by involving representatives of patients and the public as equal partners in the design, implementation and governance of the quality improvement strategy. In part this means shaping the goals and in part it means involving patients and the public in the means used to implement these goals. Fundamentally, it means asking whether changes in care will be improvements for patients and the public and, if not, whether they should be pursued at all.

Acting on this principle means developing a cohort of patient leaders able to work in this way. This is beginning to happen through the work of The King's Fund and others, and should be accelerated as part of the more focused approach to quality improvement and leadership development described above. It also means understanding patients' preferences and building these into how care is provided and improved (Mulley *et al* 2012).

Be open to learning from other organisations at home and abroad

The NHS can shorten the time needed to develop and implement a quality improvement strategy by being open to learning from others, which is one of the characteristics of high-performing health care organisations that are already well down this path. The work of the IHI has been influential in a number of cases such as Jonkoping County Council and Salford Royal. Experience in the private sector has been significant in others, for example, the Virginia Mason Medical Center, US (with its learning from Toyota) and Canterbury District Health Board, New Zealand (with its learning from Air New Zealand and New Zealand Post). The writing of quality experts like Deming and Juran are universally acknowledged to be important.

There are, of course, challenges in learning from others. A partnership between the Virginia Mason Medical Center (VMMC), US, and the NHS in the north-east of England, designed to support NHS organisations to learn from and adapt the VMMC's methods of improvement, achieved mixed and often limited results. An independent evaluation found that the reasons for this included the rapid turnover of leaders in some organisations and the distractions of frequent restructuring in the NHS (Hunter DJ *et al* 2014). These findings underline the difficulties of adapting approaches that have borne fruit in one context into an entirely different one.

Closer to home, the NHS in Scotland is pursuing a health care quality strategy supported by Healthcare Improvement Scotland (The Scottish Government 2010).



It seeks to do so through various means including inspection but also by developing evidence-based guidelines and standards, working with frontline clinical staff, empowering patients and the public, and developing and sustaining networks that facilitate the sharing of improvement expertise. An early priority should be for leaders in England to study work going on in Scotland and to learn from it.

Work with organisations and experts outside the formal structures of the NHS

The Health Foundation has invested in the education and training of clinicians and others in the theory and practice of quality improvement. Its UK-wide **Q initiative**, supported by NHS England, builds on this by bringing together a founding cohort of 231 participants to design and test the best ways of connecting people with expertise in improvement to share ideas, enhance their skills and make tangible improvements in health and care. The intent is to widen recruitment in 2016 and establish a community of practice of improvement leaders eventually numbering several thousands.

Other work funded by the Health Foundation has supported NHS organisations to bring about specific improvements in the quality of care. An example is work on patient flow in Warwickshire and Sheffield that is helping to make better use of hospital beds by reducing delays and improving co-ordination both within hospitals and between hospitals and community settings (**Health Foundation 2013a**). Improvements in patient flow in these and other cases have been brought about by the use of established methods of quality improvement that have delivered similar benefits in other areas of care.

The work of The King's Fund is also relevant particularly in relation to the leadership needed to foster a culture of quality improvement. This work emphasises the role of leaders in valuing and engaging staff and supporting them to bring about improvements in care. It also provides a critique of the continued use of targets, inspection and competition as the principal means of reforming the NHS.

The contribution of these foundations is complemented by university-based researchers and by specialist advisory and networking bodies including Haelo in Greater Manchester. A number of the medical royal colleges have also contributed and have the potential to do more given the emphasis we have placed on clinical leadership of quality improvement. This includes making better use of the



understanding that doctors in training have of quality of care and harnessing the resources of the deaneries in this work, for example by including training in quality improvement in undergraduate and postgraduate curriculums.

Reflect, measure and learn rapidly about what is and is not working to help implementation become more successful

This paper outlines 10 design principles in the hope of engaging leaders at all levels of the NHS in debating and agreeing how they should be used in practice. In complex adaptive systems like the NHS and its component health care organisations, learning is dynamic, plans need to be flexible and strategies emergent if they are to be effective. We offer these principles as a basis for action, but we also know that that action should be refined and improved over time, engaging many people with experience to offer.

The key is to get started. Roy Griffiths memorably wrote more than 30 years ago, in his paper on management in the NHS, that the NHS ‘can ill-afford to indulge in any lengthy self-imposed Hamlet-like soliloquy as a precursor or alternative to the required action’ (Griffiths 1983). His words are equally applicable to the arguments of this paper.

The principles we have outlined need to be tested in practice. Not everything will work, but trying, failing, reflecting and learning – ‘Plan Do Study Act’ in the lexicon of modern quality improvement – is far more productive than endless debate and preparation.

Learning requires a commitment to evaluating what works during implementation. A good place to start would be the quality improvement strategy that we have argued for. Evaluation of the strategy and its component activities needs to be pragmatic and as far as possible conducted in real time to enable adjustment and continual improvement in response to feedback on impact.

Evaluation also needs to include a commitment to measure progress towards chosen improvement goals, drawing on routinely available data supplemented by other tools where appropriate. While this paper has consciously focused on the need for a quality *improvement* strategy, it goes without saying that the English NHS also needs a quality strategy that sets out what these improvement goals are. A forthcoming report from the Health Foundation will set out the key elements of a national quality strategy and will make recommendations on how this can be developed.



6 Conclusion

We conclude this paper by reiterating the importance of building capability for quality improvement in each and every NHS organisation. On this foundation support can be provided through networks and collaboratives, supported by regional and national expertise. The work of foundations and others can also contribute, and everyone can draw usefully upon international experience and expertise.

The role of organisations and collaborations at different levels needs to be articulated as part of an integrated and coherent quality improvement strategy. This should avoid unhelpful, ‘either–or’ distinctions between top-down and bottom-up change. Improvement requires both local action and central co-ordination and resources in complementary forms.

Above all, the NHS needs a much greater degree of stability and constancy of purpose, the lack of which confounds far-sighted investments, co-operation, trust and growth of knowledge, all of which are essential for continual improvement.

The challenge of developing and implementing a quality improvement strategy for an organisation serving a population of 53 million, employing 1.4 million staff and spending £116 billion a year should not be underestimated. In fact, this has never been done at this scale anywhere else in the world. In all honesty, it will require a herculean effort to do so but with commitment and persistence it could make a substantial impact.

It will take time to demonstrate progress, as other organisations that have taken this path know very well. As this story unfolds, it will be crucial for leaders at all levels to hold their nerve. As difficult as a quality improvement strategy is, and as long as it may take to harvest the needed changes at full scale, we simply do not see a more promising alternative.

Quality and finance are closely related through the many opportunities that exist to deliver better outcomes at lower cost ([Alderwick et al 2015](#)). Work to achieve



improved financial performance needs to be framed as a mission to deliver better value if staff are to be engaged effectively. The engagement and commitment of staff will not be realised if there is a simplistic focus on cost-cutting and there is a real risk of this happening given the current imperative to eliminate deficits in the NHS.

The NHS remains a great source of hope for nations committed to health and health care as human rights. That promise, and that burden, will not be met through over-reliance on inspection to stimulate improvement, nor through ever-changing rhetoric and ever-migrating goals.

Deming wrote that ‘constancy of purpose for improvement’ is an essential foundation for progress. So it is, and can be, for the NHS, if leaders have the will.



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Chris Ham took up his post as Chief Executive of The King's Fund in April 2010. He was Professor of Health Policy and Management at the University of Birmingham between 1992 and 2014 and Director of the Health Services Management Centre at the university between 1993 and 2000. From 2000 to 2004 he was seconded to the Department of Health, where he was Director of the Strategy Unit, working with ministers on NHS reform.

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A paediatrician by background, Don was for 19 years the founding CEO of the Institute for Healthcare Improvement. In 2010, he was appointed by President Barack Obama as the Administrator of the Centers for Medicare and Medicaid Services (the federal agency overseeing Medicare and Medicaid), a position that he held until December 2011. He has served on the faculties of the Harvard Medical School and Harvard School of Public Health.

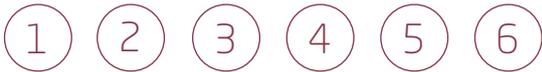
In 2013 he carried out a review of patient safety in the NHS on behalf of Prime Minister David Cameron. Recognised as a leading authority on health care quality and improvement, Don has authored or co-authored more than 160 scientific articles and six books.

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The NHS in England will not be able to meet the health needs of the population it serves without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy. The challenge of developing and implementing such a strategy should not be underestimated given the size and complexity of the system. Yet current financial constraints and the urgency to deliver better value for patients leave the NHS with few alternatives.

Improving quality in the English NHS: a strategy for action makes a practical and persuasive case for developing and embracing a single quality improvement strategy across the health service. It includes:

- a brief history of how incoherent policy initiatives and competing beliefs about how to improve quality have hindered progress to date
- an outline of the key features of a quality improvement strategy, drawing on examples of organisations from the United Kingdom and abroad that have successfully reformed from within
- a plan for creating a 'system of support' for the NHS that defines the roles of organisations at different levels and maps how they can support improvements in care through co-operation and shared learning
- 10 design principles to guide the development of the quality improvement strategy and to build the in-house capability to implement it.

A quality improvement strategy at this scale has not been implemented in any other system, and the paper warns that it will take time to deliver results. With constancy of purpose and greater stability, it argues, the NHS can develop an approach to continuous improvement and become a learning health care system.

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