Developing whole-organisation Quality Management Systems in health care: learning from practice and recommendations for progress

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The Health Foundation

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Foreword

I am delighted to support the publication of this insight report from the Health Foundation. The last decade has seen tremendous growth in the application and belief in quality improvement, driven largely by the results and impact seen through rigorous adoption. It has become increasingly evident that the organisations and systems that have truly sustained their approach to continuous improvement have integrated improvement within a broader management system. This has been recognised within England's NHS IMPACT framework, published in 2023, which included Quality Management Systems (QMS) as one of five pillars essential for the embedding and adoption of continuous quality improvement. A well developed, yet simple and practical management system helps us all – whether we are a clinician, administrator, support service or senior leader – understand and make sense of our work. Ultimately, the management system informs the way we lead and behave on a daily basis – through clarity of function and purpose. This insight report helps deepen our understanding of the development of quality management systems, through exploring seven case studies, and I highly commend it as a resource to all who are looking to support their organisations and systems to develop a single, integrated way to lead and manage the delivery of health care.

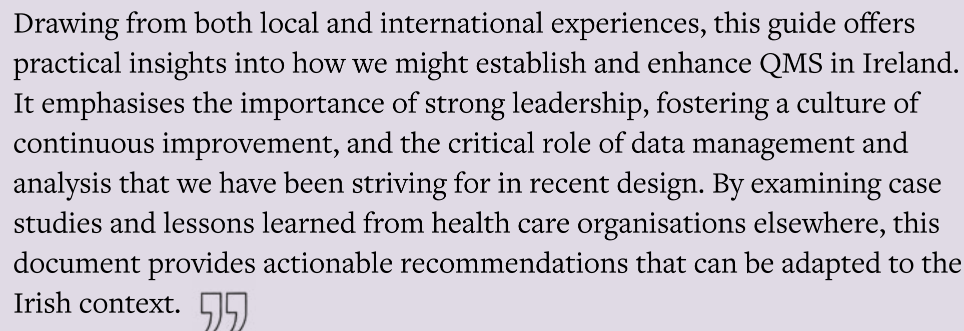
Amar Shah, National Clinical Director for Improvement (NHS England) and Chief Quality Officer (East London NHS Foundation Trust)

The shift in focus from Quality Improvement to the broader Quality system as a whole is crucial in the context of the growing demands on our health services, increasing expectations from our populations and the broader financial context we are facing in the UK and more broadly. We have strong foundations in place within many organisations and theories are beginning to develop; but to embed and sustain Quality Management Systems we need to first begin with the need for the focus on a QMS, evidence of their impact, examples of their application and a common language that simplifies and resonates with the system; and this insight report is a significant contribution to enable the shift that is required. As nations within the UK and Ireland, we need to continue to learn together. Whilst our systems and policy contexts may differ, we have the common ambition of improving how our organisations operate – so that we are creating the conditions that support and enable our workforce to provide the best quality care that meets the needs of our populations.

Felicity Hamer, Head of Strategic Quality and Safety, Improvement Cymru, Quality, Safety and Improvement, NHS Wales Executive

In Ireland, the health care sector stands at a pivotal point in its redesign. The development of Quality Management Systems is central to improving the way in which we design and deliver integrated person-centred health care. While this concept is still in its embryonic stages within our system, the potential for significant improvement in patient care and operational efficiency is immense. This document, 'Developing whole-organisation Quality Management Systems in health care: learning from practice and recommendations for progress', as crafted will guide Irish health care providers through this transformative process.

Drawing from both local and international experiences, this guide offers practical insights into how we might establish and enhance QMS in Ireland. It emphasises the importance of strong leadership, fostering a culture of continuous improvement, and the critical role of data management and analysis that we have been striving for in recent design. By examining case studies and lessons learned from health care organisations elsewhere, this document provides actionable recommendations that can be adapted to the Irish context.

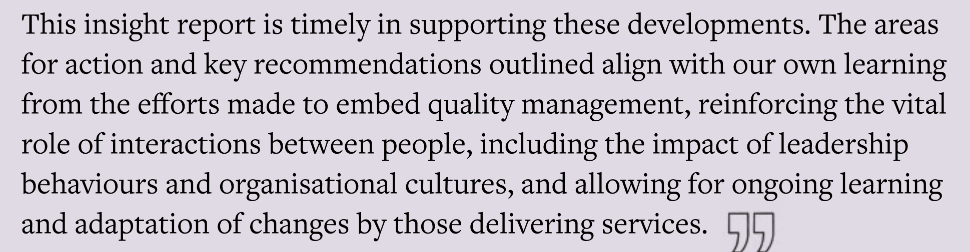


Orla Healy, National Clinical Director of Quality and Patient Safety, Health Service Executive

Much has been written on the benefits of health and care organisations taking a systematic approach to quality improvement. NHS Scotland has taken a national approach to this for over a decade with impact demonstrated across many settings. However, our learning over this time has identified the reliable delivery of high-quality care requires an approach that goes beyond quality improvement to one which is inclusive of all the key components of quality management.

Healthcare Improvement Scotland's strategy Leading quality health and care for Scotland describes the role Quality Management Systems play in bringing together the activities that drive improvement in health and wellbeing outcomes and has committed to this approach through the Scottish Approach to Change. Much of our health and care system is developing its approaches locally.

This insight report is timely in supporting these developments. The areas for action and key recommendations outlined align with our own learning from the efforts made to embed quality management, reinforcing the vital role of interactions between people, including the impact of leadership behaviours and organisational cultures, and allowing for ongoing learning and adaptation of changes by those delivering services.



Jo Matthews, Associate Director Improvement and Safety, Healthcare Improvement Scotland

Acknowledgements

This report was made possible through the contributions of numerous individuals and organisations. We are grateful to the interviewees who shared their learning and reflections with us, and especially to the organisational leads who allowed us to present their Quality Management System journeys. We also want to thank the advisory group, who provided constructive feedback and strategic guidance for this work. Finally, we extend our gratitude to everyone who generously gave their time to share with us their thoughts and ambitions for QMS in the UK and Ireland, including members from across the vibrant Q Community.

Executive summary

Why are organisations developing QMS?

Health care organisations around the world recognise the need for a more integrated, proactive and systemic approach to managing quality and performance. Nationally and locally, Quality Management Systems (QMS) are seen as an important way to drive this evolution. QMS has the potential to align key services and lead to better coordination and consistency in how quality is planned, improved and maintained in an organisation.

What is QMS and its components?

At Q, we define a whole-organisation Quality Management System as **a coordinated and dynamically interconnected approach to planning, improving, controlling and assuring high-quality care. A QMS is applied across all levels of an organisation – from team to board. It is aligned to strategy, underpinned by documented processes, procedures and responsibilities, and embedded in organisational culture.** Part 1 provides more detail on the definition, potential benefits and other frameworks related to QMS.

There are three core internal components of QMS: Quality Planning, Quality Improvement, and Quality Control. There is one surrounding, predominantly external component: Quality Assurance. Table 1 (page 13) describes the components of quality management and gives examples of activities and tools from a health care context.

Organisational case studies

As well as reviewing existing literature on QMS, we approached seven organisations at different stages of the QMS journey. Part 2 shares their learning and talks about the challenges and successes they have experienced so far.

Case studies	Their QMS journey so far
Sheffield Health and Social Care NHS Foundation Trust, England	Using a QMS approach to get 'Back to Good', following an 'inadequate' rating from the Care Quality Commission (CQC).
Great Ormond Street Hospital for Children NHS Foundation Trust, England	Developing a 'Quality Governance Framework' to meet a single set of quality standards, consolidating external quality standards – including ISO 9001, 7101 and 31000, CQC standards, and the NHS IMPACT self-assessment principles.
Aneurin Bevan University Health Board, Wales	Taking an integrated approach to quality management at a system level, aligned with the Wales Duty of Quality, with links between finance, performance and quality.
The Leeds Teaching Hospitals NHS Trust, England	One of five organisations in England to partner with NHS Improvement and the Virginia Mason Institute, developing a 'Leeds Improvement Method' management system grounded in Lean.
NHS Lanarkshire, Scotland	Embedding 'Whole System Quality' from corporate communications to QI training, with 'True North' statements informing quality activities.
East London NHS Foundation Trust, England	Developing a 'management system' around a culture of continuous improvement, building on strengths in quality improvement and quality assurance, with work taking place within clinical directorates to further develop quality planning and quality control.
Northern Health and Social Care Trust, Northern Ireland	Beginning the quality management journey, through extensive staff engagement, to develop guiding questions to use for service planning and delivery.

Recommendations for progressing QMS

Drawing on insights from the case studies, our stakeholder interviews and the advisory group, and findings from the wider literature on QMS we developed nine key recommendations to progress QMS for senior leaders of health care organisations. Part 3 details each recommendation which includes practical actions for people operationalising QMS in organisations and those supporting quality at a national level.

Recommendations for progressing Quality Management Systems

1. Leaders must set the vision, direction and culture for QMS, connecting your strategy to everyday work. This will involve ensuring resource and skills for delivery.

2. Co-develop meaningful shared language and understanding of QMS at all levels of your organisation, including staff, patients and leaders.

3. Position QMS as an evolution of your quality work. Start by mapping existing strengths and build on these.

4. Ensure the four components of QMS are well connected and function dynamically – planning, improvement, control and assurance.

5. Commit for the long term while celebrating short-term success. Connect QMS to staff and patient priorities.

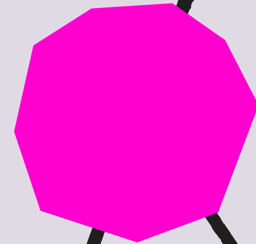
6. Actively involve patients and service users in QMS, setting clear expectations for their involvement and providing appropriate support.

7. Invest in good data infrastructure (both technical and human) to drive learning and connection between QMS components.

8. Pursue ongoing learning about QMS internally and externally bringing in specialist support providers if required.

9. Contribute to the evidence base through systematic evaluation. Start by assessing your QMS but move focus towards patient outcomes as your work develops.

Part 1:
Why QMS and what are they?



Why are organisations developing QMS?

Health care organisations around the world recognise the need for a more integrated, proactive and systemic approach to managing quality and performance. Nationally and locally, Quality Management Systems (QMS) are seen as an important way to drive this evolution. QMS has the potential to help align key services and lead to better coordination and consistency in how quality is planned, improved and maintained in an organisation.

There is evidence for the link between QMS and organisational performance in other sectors.[1,2] In health care, the evidence for whole-organisation QMS is less well developed.[3,4] A paper from Healthcare Improvement Scotland argues that the delivery of high-quality care **requires** organisations to have a consistent and coordinated approach to managing quality.[5] National organisations and the literature note the potential benefits of well-developed whole-organisation QMS. They include:

- Putting the needs of citizens at an organisation's core[4] and improving outcomes.[5]
- Building shared purpose and a common vision.[4] Every member of staff understands what is important.[5]
- Better supporting needs, reliably eliminating quality and safety defects and building resilience in the organisation.[6]
- Helping organisations to understand their improvement priorities and design interventions to achieve them.[5]
- Staff having clearly defined work and processes,[4] with access to relevant data to maintain high quality.[5]
- Boards using QMS to manage the everyday running of their organisation with data to track progress.[7]
- A strong culture of quality and safety that values learning, with ownership at every level.[4]
- Allowing organisations to more easily respond to system and national priorities.[7]

As well as an emergent evidence base, interest in QMS is growing due to several policy developments across the UK and Ireland. For example:

- In England, QMS is part of NHS IMPACT (Improving Patient Care Together). It is one of its five components – 'embedding improvement into management systems and approaches'.[8]
- In Wales, a Duty of Quality[9] is a legal obligation that applies to all NHS organisations and Ministers in Wales. It requires them to establish effective QMS that focus on learning and ensuring that planning, control, improvement, and assurance function collectively.
- In Scotland, QMS has provided the basis for national-level programmes. In partnership with the Scottish Government, Healthcare Improvement Scotland (HIS) has developed a high-level QMS framework.[10] Their five-year strategy[11] commits to its development.

Finally, individual provider organisations are driving interest in QMS. This includes several of the case studies in this report. At Q, we see a considerable appetite from our members, across a range of roles and settings, to learn more about QMS. We have had high engagement on the topic in groups, webinars[12] and with our resources.

Our work

Yet, our work has found that the development of whole-organisation QMS in health care in the UK and Ireland is in its infancy. The theories are well-developed, but the mix of definitions and concepts can be confusing for those who are new to the approach. There is little understanding of how different organisations have developed QMS. This has left many unclear on where to start and what is needed to make progress. More provider organisations are sharing their progress and learning. But there is little published work to draw on, apart from a few notable exceptions.[4,5,13,14]

In this context, Q set out to better understand QMS as part of a long-term quality journey. We aimed to learn from the different paths that organisations have taken to develop them, to consolidate good practice and recommend ways to support their development. This work included a literature review; 15 semi-structured interviews with national leaders, topic experts and organisational leads; and seven case studies of provider organisations who have made progress on QMS (four from England and one each from Northern Ireland, Scotland and Wales).

A workshop with stakeholders from the UK and Ireland refined the recommendations in November 2024.

The key questions that guided this work were:

- How is whole-organisation QMS currently framed and understood?
- What can we learn from QMS examples of different maturity levels and journeys?
- What are the conditions and enablers that support the development of QMS?
- What is needed to progress more systemic approaches to managing quality in UK and Ireland health care organisations?

The insights and learning in this report will underpin Q's work to support the development of QMS.

Part 1 draws on existing external evidence and Q's insights to outline the different definitions and components of QMS. Part 2 presents the case studies. All offer insight and learning on how QMS is being developed in current organisational contexts. Part 3 presents nine key recommendations to progress QMS. It includes practical actions for three distinct groups:

- people operationalising QMS in organisations
- senior leaders of organisations
- those supporting quality at a national level.

What is a whole-organisation Quality Management System (QMS)?

QMS is well-defined and well-established in some sectors. They include aviation and engineering, and in some aspects of health care such as medical devices and radiology. However, there are many, sometimes contested, definitions of QMS at the organisational level in health care. At Q, we define a whole-organisation Quality Management System as **a coordinated and dynamically interconnected approach to planning, improving, controlling and assuring high-quality care. A QMS is applied across all levels of an organisation – from team to board. It is aligned to strategy, underpinned by documented processes, procedures and responsibilities, and embedded in organisational culture.*** We take a broad, holistic approach to quality – well beyond clinical quality and safety. We include areas like operations, workforce, finance, governance, environmental sustainability and patient involvement. This definition deliberately aims to include many of the different and contested definitions used by other contributors.

As with our definition, many frameworks in health care draw directly on the Juran Trilogy.[15] It comprises **quality planning, quality control** and **quality improvement. Quality assurance** is usually added in some form due to its importance in health care.

There is also a set of approaches in health care that are variously described as QMS, as very similar to QMS, or as part of a QMS approach. These don't explicitly draw on the Juran trilogy and usually use their own terms and definitions. These include Six Sigma and Lean, which underpinned the NHS-Virginia Mason Institute partnership (see the Leeds case study).

In other industries, the most common framework is the ISO 9001:2015 – Quality Management Systems[16] standard. This approach has been applied to health care organisation management through ISO 7101:2023.[17] It draws on standards from other sectors to outline the principles for delivering sustainable, high-quality health care systems. We see our definition as inclusive of this standard. Some providers in the UK are beginning to use this standard, and its application should be followed with interest. However, at the time of writing this report, no organisation in the UK or Ireland has obtained ISO 7101:2023 certification.

* This is adapted from Healthcare Improvement Scotland – Quality Management System

What should we call QMS?

Language around QMS matters. Our work on this topic highlights that the term ‘Quality Management System’, or ‘QMS’, can alienate those who are less familiar with it. Some people prefer the term ‘management system’. They argue that this shows a successful shift towards embedding QMS in the organisation’s wider management approach – not only in a quality domain. Others opt for ‘managing quality’, dropping ‘system’, due to its perceived technicality. The literature has other terms that align with our view of QMS. One example is the Institute for Healthcare Improvement’s Whole System Quality.[6]

At Q, we recognise some of the limitations of the term, but we will continue to use ‘Quality Management System’ when describing this work. It is still the best-recognised term, and it is important to distinguish QMS from other wider or less specific work. However, we encourage anyone using the term to define and explain what they mean by it. This includes when speaking to those familiar with it, as definitions vary. We also recommend that people developing QMS in organisations should work with their colleagues and service users to develop meaningful shared language around QMS. Many organisations have already done this well (see Parts 2 and 3 for good examples).

What are the components of QMS?

Table 1 (page 13) describes the components of quality management. It gives examples of activities and tools from a health care context. These are taken from the wider literature[4,6,10,13,18,19] and include insights from our interviews and case studies. The descriptions are not meant to be definitive but rather to provide an overview of the components. There are three core internal components: Quality Planning, Quality Improvement and Quality Control. There is one surrounding, predominantly external component: Quality Assurance.

Table 1: Components of QMS

QMS components	Description	How case study sites translated QMS components	Examples of activities and tools
Quality planning	Identifying and understanding patient and users' needs to develop the services necessary to support them. Defining quality goals, and designing, documenting and deploying a clear plan and processes to meet these needs. Typically done once a year.	'What do we need?' (Lanarkshire case study) 'What do we need to do well?' (Northern case study)	Service user feedback surveys Designing and deploying a quality strategy Commissioning process Team structures and job roles
Quality improvement	A systematic and coordinated approach to solving problems using specific improvement methods and tools, to achieve a measurable gain. Typically done when needed.	'What could be better?' (Lanarkshire case study) 'How do we do it better?' (Northern case study)	Process mapping Plan, Do, Study, Act (PDSA) cycles Driver diagram Divergent and convergent thinking tools Problem identification, iterative testing and learning, and measuring
Quality control	Measuring and evaluating quality and performance, comparing them to agreed goals, and acting on any gaps. Organisations must maintain vigilance to sustain improvements. Typically done every day.	'What is our performance?' (Lanarkshire case study) 'How do we know we are doing it well?' (Northern case study)	Standard work Performance monitoring Visual display of key service-level metrics (eg quality dashboards) Huddles around data to discuss and take action
Quality assurance	Regularly checking whether a service is meeting needs based on outside requirements. Typically done retrospectively.	NA	External review and benchmarking Audit Inspection Gap analysis Service User-Led Accreditation programme[20]

Crucially, QMS is more than a sum of its components. The key feature that makes the four components a QMS is their interconnectivity. As is discussed in Part 3, it is the dynamic and cyclical functioning that gives QMS its systemic nature. There are several ways to enable interconnection. They include data infrastructure, a learning culture, and leadership support for linking up teams and functions.

The outline of QMS and its components (Table 1) fit with the best-established frameworks in health care. These include:

- Healthcare Improvement Scotland (Figure 1)
- NHS Wales Executive (Figure 2)
- Institute for Healthcare Improvement
- NHS IMPACT
- Other organisations' frameworks covered in this report (see Part 2).

Some of the frameworks include additional elements positioned as essential to QMS. These include:

- vision and purpose
- co-design and co-production
- leadership and culture
- learning (sometimes framed as a learning system).

These elements are important. But we frame these as crucial **enablers** of a successful QMS rather than defining components (see more on enablers in Part 3).

Figure 1: Quality Management System framework from Healthcare Improvement Scotland

Figure 2: Quality Management System framework from NHS Wales

Which other frameworks relate to Quality Management Systems?

There are several frameworks that are distinct from, but related to, QMS. Some of these are well established in health and care. They include:

- Clinical Governance
- Organisational approaches to improvement
- Learning Health Systems
- Quality as an organisational (or business) strategy
- Continuous Quality Improvement
- Safety Management Systems.

These frameworks contain elements that overlap with QMS. For example, they seek to integrate quality-related functions and develop infrastructure, such as data use and improvement capability. They aim to adopt a philosophy of continuous quality improvement (see Table 2 on page 16 for details).

There are other frameworks that have not taken root in health care. These include Strategic Quality Management, and Total Quality Management (TQM). These have distinct historical roots and focus. However, they share a focus on customers, effective leadership, continuous improvement and strategic quality planning.

It is important to be clear and precise about the different related frameworks (see Table 2). Each has its strengths and weaknesses, but we should not get bogged down in the purity of different approaches. Developing a QMS in today's complex health care context requires flexibility and skill. It must blend different approaches to ensure high-quality care at all levels.

The four components of QMS made sense to and resonated with participants of this insight project. All interviewees leading QMS in their organisations could discuss their 'quality management' work. They found the four components helpful for framing discussions with staff. However, they used different methods and terms when embedding QMS in their organisations.

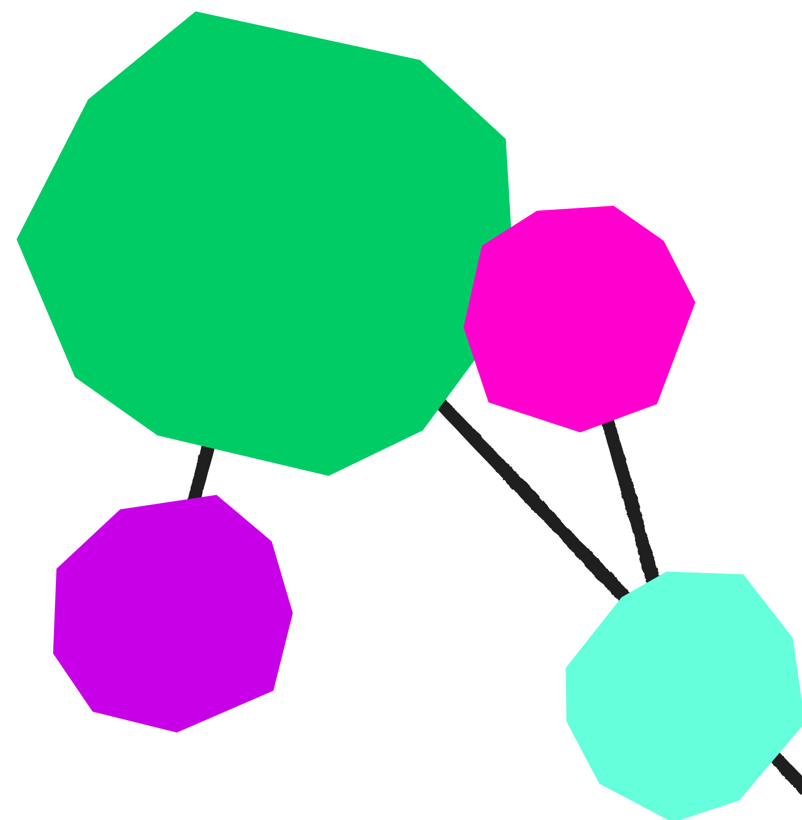


Table 2: Frameworks related to QMS

Clinical Governance. A system that holds NHS organisations accountable for continuously improving their service quality. It includes quality assurance and quality improvement. It is supported by approaches such as clinical audit and risk assessment.[21]

Organisational approaches to improvement. Seeks to embed a culture of continuous improvement and learning to deliver lasting improvements in care. These approaches are based on a clear vision for improvement. This vision is understood and supported at every level of the organisation.[22]

Learning Health Systems (LHS). Aim to develop, learn and improve from the delivery of routine care as part of business as usual.[23] LHS help organisations to use data and evidence to make quick decisions. They monitor the impact of those decisions and adjust their approach as needed.[24]

Quality as an organisational (or business) strategy. Sets out a leadership framework and set of activities to help organisations participate in system transformation and continuous quality improvement. It includes work by leaders to articulate the organisation's purpose, and develop processes to inform, plan for and manage improvement.[25,26]

Continuous Quality Improvement (CQI). A progressive incremental improvement of processes, safety, and patient care. Process improvement may be gradual or 'breakthrough'. It includes defining the problem, benchmarking and setting a goal. This is followed by iterative quality improvement projects. Improvement methodologies include Lean, Six Sigma, Plan-Do-Study-Act (PDSA) cycles, and Baldrige Criteria.[27]

Safety Management Systems (SMS). A proactive approach to managing safety. It integrates and organises all safety-relevant functions, activities, priorities and accountabilities. SMS incorporate elements in common with QMS. This includes monitoring processes and controls, evaluating safety improvements, and building a culture of learning and improvement.[28] Many consider safety to be an inherent part of quality.[29] Others argue that safety requires its own particular considerations.[30]

Part 2:

Learning from practice – organisational case studies

Now that the definition of QMS and related frameworks is clear, Part 2 of the report presents the seven organisational case studies.

We used the initial scoping review and input from the project advisory group and stakeholders to select case studies. Our aim was to gather learning from organisations in different contexts that had made some progress on their QMS journey and were willing to share their learning. We have included organisations from across the UK that offer a range of services, but they are mainly large organisations. The case study search was not exhaustive, and there are other organisations making notable progress on their QMS.

Once selected, we approached the person responsible for leading QMS in the organisation. Where specific individuals were not available for interview, we identified other interviewees. Suggestions were also made by research participants (snowball sampling). As well as interviews, participants shared documents (published and unpublished).

Case studies	Their QMS journey so far
Sheffield Health and Social Care NHS Foundation Trust, England	Using a QMS approach to get 'Back to Good', following an 'inadequate' rating from the Care Quality Commission (CQC).
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Sheffield Health and Social Care NHS Foundation Trust

Using a Quality Management System approach to get 'Back to Good'. Interview with Sue Barnitt, previous Head of Clinical Quality Standards.

Sheffield Health and Social Care NHS Foundation Trust (referred to hereafter as Sheffield) provides a range of mental health and learning disability services to the people of Sheffield. It employs around 2,500 staff, providing services to around 55,000 people a year.

Key elements

- Sheffield's journey began following an 'inadequate' rating and a warning notice from the Care Quality Commission (CQC), and was grounded in the strengths of their quality assurance work.
- The four components of quality management were used at the beginning of their work to map areas of strength and areas in need of strengthening.
- Board-level leadership, project management support and learning from others have been important enablers to progress, in the face of challenges in developing their data dashboard, and over-optimism in how quickly the QMS could be implemented.

What is your approach to managing quality?

> '... it's taken me a long time to develop my understanding of what a quality management system is and put it in a simple way for other people. So, for me, it's a framework for quality. And it's a cyclical process for improvement.'

The four components of quality management form the basis for the trust's newly designed approach to managing and monitoring quality. It is based on the idea of a data dashboard, consisting of a set of quality metrics that perform a quality control function. Selected metrics include standard quality indicators, such as complaints and incident data, and bespoke intelligence on what is important to service users and staff.

Data can then be used to inform their quality assurance activities and help to triangulate what is known. This approach was used in their 'Fundamental Standards of Care' programme, involving annual service visits to inpatient areas. The data is used to help target their 'lines of enquiry' and ensure they focus on the right areas and monitor performance against a defined set of quality standards. Insights from this inform the quality planning process, determining each service's quality objectives, and the necessary quality improvement activities involved in achieving those objectives.

Where did you begin?

> 'When we first started on the QMS journey, if I'm honest, I think the board had heard about it from somewhere and said,"we need one of these", without really appreciating the complexity of what that might look like.'

In April 2021, the trust received an 'inadequate' rating and a warning notice from the Care Quality Commission (CQC). In response, the trust developed a 'Back to Good' programme to implement and embed the 75 requirements and 250 actions arising from the CQC assessment.

Sue joined the trust later the same year, and was tasked with leading the programme, in addition to overseeing quality assurance reporting and development and oversight of a new Quality Strategy. One of the first things she was asked to do was to establish a Quality Management System (QMS).

How did you go about it?

> 'We needed to sell an idea and get people on board, but actually it was really difficult to articulate what a QMS looked like as there was no blueprint of how to do it ... it took quite a long time to get the right people around the table ... [so] that we had the right expertise, knowledge and organisational reach to deliver the ask.'

Sue sought to involve key individuals from an early stage, including the Quality Improvement Lead, the Business and Performance Manager within the Quality Directorate, and members of the Digital team. One of their first activities was to map all of their current quality activities to the four QMS components (see Figure 3), to assess their strengths and gaps – 'this is the point where it clicked'.

Figure 3: Mapping existing activities to the QMS domains in Sheffield

They had to pivot away from their original data dashboard concept, due to the delayed implementation of an Electronic Patient Record system. The dashboard was replaced with physical quality whiteboards situated within units. The whiteboards displayed information such as 'what are the top three things we need to do this month?', and 'how are we doing against our top three metrics?' They provided a talking point, and transparency for service users and staff who were closely involved in their design.

Unlike some organisations, there has been no dedicated project team to develop the QMS, and it was done 'on top of everything else people had to do'. However, once the Project Management Office was involved, 'it made a massive difference'. The trust found it invaluable to learn from the experience of other organisations also on their QMS journey, who were willing to share what they had done.

What have you learned?

Sue made a conscious effort to socialise the QMS and make it relevant to the nine individual clinical strategies that sat beneath the trust's overarching strategy. When they launch the data dashboards, their intention is for them to be useable, have a clear purpose, and to not be over-complicated:

> 'I think using the words Quality Management System made it sound really technical. Yes, there are some technical elements of it, but I think referring to it as a framework for quality… articulates that it is something that literally touches on every single element of the work that happens.'

The team acknowledged that they would take the same phased approach again to scale it, but recognised they were far too ambitious in terms of the amount of time it would take to fully embed it. The revised plan involved testing it with 12 teams in the first year, rather than trying to implement it across all 52 services within 18 months.

What difference has it made?

As an organisation on an improvement journey, their QMS work has had to compete with other priorities, which has had an impact on the resources available to support it. This is particularly true for an organisation of the trust's size, around 2,500 staff. Despite this, there has been a significant increase in board and director-level understanding of what doing it well looks like, and the resources required to do it, even if tangible benefits are difficult to quantify at this early stage:

> '… if you were to measure [impact] on strategic ambition… absolutely it's impacted on them [the board and directors] and they know and believe it's the right thing to do that will benefit our organisation and benefit our services. The problem we've got is that, because we've not been able to roll it out into the services as we'd planned to, the teams aren't [yet] getting the benefit.'

Great Ormond Street Hospital for Children NHS Foundation Trust

Developing a Quality Governance Framework to meet a single set of quality standards. Interview with Jit Olk, Head of Quality.

Great Ormond Street Hospital for Children NHS Foundation Trust (referred to hereafter as GOSH) is a world-famous children's hospital, employing more than 4,000 staff. Established in 1852, it sees around 76,000 children each year. GOSH provides 67 specialist services, including supporting children with a range of complex conditions, such as rare cancers and genetic disorders.

Key elements

- GOSH took a novel approach to consolidating the external quality standards they are subject to, turning them into a set of seven domains to describe to services what good looks like from a quality perspective.
- They have sought to strike a balance between ensuring a level of standardisation across teams, and empowering teams to lead on the assurance process and their resulting improvement plans.
- Feedback from teams piloting the framework suggests it can provide a unified approach to meeting regulatory requirements, as well as functioning, first and foremost, as a learning and improvement tool.

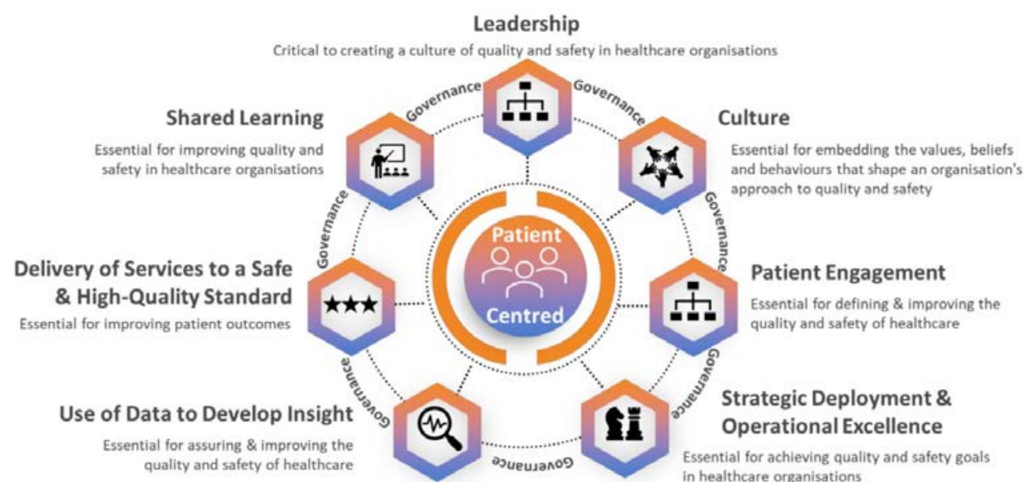
What is your approach to managing quality?

> 'I see it as a dynamic, responsive system that not only ensures compliance but also fosters a culture of ongoing enhancement in patient care and organisational performance. This is exactly what this Quality Governance Framework aims to achieve.'

As part of a new quality management initiative at the trust, Jit has led the development of a 'Quality Governance Blueprint'. The blueprint is the result of a nine-month project to consolidate the array of external standards that the organisation is required to comply with relating to quality governance.

The blueprint includes a framework which identifies 55 standards centred around 7 domains 'to clearly articulate what is expected [of each service] from a quality perspective' (Figure 4). Each standard includes the anticipated outputs, behaviours and outcomes when each standard is being met.

Figure 4: Seven domains of the GOSH Quality Governance framework



The framework aims to develop a clear vision of what good quality looks like, with active governance at the heart of it. Good governance for the trust means knowing where the blind spots are and putting in appropriate mitigation. They have established clear accountability structures by aligning roles and behaviours, with a strong emphasis on data-driven decision making to ensure resource deployment is most effective.

The framework enables a level of consistency in how quality is measured from service to service and acts to 'support synchronisation' between them. This is particularly important given the complexity and multi-specialty nature of the care required for many of GOSH's patients. However, the framework is designed to recognise that the patient remains at the centre, and it is not about telling clinicians what to do but to support them to deliver excellent patient outcomes:

> '…the patient interaction is the bit that remains bespoke, every individual patient has different needs. But for a large proportion of the work that happens in the system, we can apply some level of consistency.'

Where did you begin?

Jit joined the trust in 2022 as Head of Quality. With several years' experience in quality assurance, and developing quality improvement programmes, he wanted to develop a more systematic approach to quality.

Senior leaders at the trust were receptive to taking a new approach. Jit was tasked with putting in place an operational QMS 'by the end of 2025'. The QMS was intended to bring together a range of quality activities – including clinical audit, improvement and assurance – to reduce existing duplication:

> '…we probably don't acknowledge that we have all the facets of a QMS in place. The only issue that we have is that we don't effectively bring that together in a way that gives us valuable insight.'

How did you go about it?

The work to create the framework began with a detailed review of all of the existing standards that the trust was required to comply with from a quality perspective. They included ISO 9001, 7101 and 31000, Care Quality Commission standards, and the NHS IMPACT self-assessment principles.

From an initial list of 183 standards, this was eventually consolidated into a single list of 55, noting the high degree of duplication between them. The standards are weighted, and each assigned a risk rating based on the impact severity and frequency. This is then pulled into an improvement tracker for services to work on.

A period of consultation took place with key internal stakeholders, including board members, and clinical and non-clinical staff, followed by an initial pilot with a single directorate in June 2024. There was positive feedback from the service team, citing how easy it was to understand and to work through.

What have you learned?

At the beginning of the process, they had considered applying the Quality Governance Blueprint at directorate level, rather than at service level. However, they realised that it was important for teams to be empowered, and for services to take ownership of the resulting improvement plans:

> '…because that's the real win, that cultural piece. This is definitely not about performance management. Because what we want is a level of psychological safety that sits around this, so that services can be open to sharing good practice and feel comfortable about areas for improvement. This a platform, first and foremost, for learning, so that we're not creating multiple solutions for the same type of thing. But more importantly, it shows us actually where we're at, not where we want people to think we're at.'

They haven't used the traditional language of the four components of quality management, to try and 'remove a lot of that corporate-type language' and make it more user-friendly – 'they [the components] are in there, we just don't talk about them that way'. Alongside the key components, such as leadership and patient engagement, it was important to add in what Jit describes as 'the doing bit'. This is referred to in the framework as 'strategic deployment and operational excellence'.

What difference has it made?

The process, when fully implemented, will form a self-assessment exercise. Services will upload evidence (such as service feedback or performance data) to an online portal, which is then pulled into a central repository to feed into a system-wide dashboard.

Although it can support activities from a regulatory information perspective, it has been designed primarily as a shared learning platform. From an organisation perspective, 'we can see where the gaps are… and use that to set our priorities strategically'. Despite it being early days, feedback suggests that teams in future could stop carrying out the 'existing uncoordinated activities', such as CQC readiness assessments, and instead work with the framework as a 'single version of the truth'.

Aneurin Bevan University Health Board

Taking an integrated approach to quality management at a system level. Interview with Jennifer Winslade, Executive Director of Nursing.

Aneurin Bevan University Health Board (referred to hereafter as Aneurin Bevan) is one of the largest health boards in Wales, covering Gwent, a population of around 570,000. It provides acute, community, primary and mental health services, employing around 14,000 people.

Key elements

- Aneurin Bevan's approach has been led by the executive team, placing a strong emphasis on patient engagement and ensuring the 'softer intelligence' from staff and service users is captured routinely.
- They have taken an integrated approach, which aligns the principles of the Wales Duty of Quality with the components of quality management, makes the link between finance, performance and quality, and applies equally to the commissioning and provision of care.
- They have worked hard to engage staff in developing their approach and have brought together staff in quality-related roles into a single directorate.

What is your approach to managing quality?

> '...those four [components] of the quality management system should be at the background of your thinking and way of operating, and you need to make sure your quality strategy meets that.'

Quality management at Aneurin Bevan means managing 'the total quality system', extending to both the provision and commissioning of health and care. Their Quality Strategy is structured around the six STEEEP pillars (care that is Safe, Timely, Effective, Efficient, Equitable, and Person-centred, see Figure 5) as set out in the Wales Duty of Quality.[9]

In practice, however, they 'wrap the quality management system around' the work they do within each of those pillars, using the four components of quality management as their guiding framework:

Figure 5: Aneurin Bevan's approach to quality (as set out in the Wales Duty of Quality)

Where did it begin?

> 'The first thing I noticed when I came into the organisation was that I couldn't put my finger on learning. I really couldn't see it. We had lots of stuff going on in quality, but it wasn't coherently brought together.'

Jennifer has been a Director of Nursing for 15 years, moving to Aneurin Bevan two years ago as Executive Director of Nursing. One of her first tasks was to update the Quality Strategy. This was done 'rapidly', within six months, before the national Duty of Quality came out 'because we needed something strategic to hang our hat on'. This was followed by a number of other strategic actions.

They were the first organisation in Wales to develop a quality outcomes framework, focused on the data and metrics needed to judge their performance. They developed a Listening and Learning Framework to draw in the 'softer intelligence' from the perspective of staff and service users. They developed a Patient Experience and Involvement Strategy around the same time, 'to be really clear about how we triangulate our data with the experience of service users and our staff'. Most recently, they have developed a commissioning quality framework:

> 'It's early days. It's bare bones. But we're at least setting out our stall… [and] we're ambitious around starting to draw that into our Quality Management System.'

How did you go about it?

A lot of work went on behind the scenes, with staff and with the board, to operationalise the strategies and 'to work out exactly how to deliver an effective quality management system'. This included, for example, thinking more systematically about quality planning and redesign as an important first principle, asking themselves, 'What is it we want to change? What is it we want to do? What are we ambitious about for quality?'.

To better understand quality control, they explored what their systems and processes should look like, what the data flows and standards should be, who needs to be involved, and what this should look like within each divisional care group. For quality assurance, they provided clarity on reporting arrangements to the Board, the Executive Committee and the Quality Committee. A particularly strong emphasis was then put on the quality improvement component:

> '...being really clear that we can't do any of this if we don't actually focus on the quality improvement element, because that is really, really important in terms of that systematic change and learning.'

What have you learned?

> 'I think it's necessary [that] the Quality Management Systems differ for each organisation. I don't think what's right for my organisation would be right for every organisation, and I think too much prescription is going to be unhelpful. But to keep the principles and the guardrails of what a quality management system is, is really important.'

This work has been done alongside an Organisational Change Programme. This brought together around 40 people, who were already undertaking quality-related activities, into Jennifer's directorate. While acknowledging that this work doesn't necessitate structural change, 'in order for me to get the quality control and the planning right, I've needed to bring that resource in-house in my directorate'.

It hasn't all been straight forward. There have been challenges, for example, with engaging operational colleagues, given the pressures they are facing. It has been helpful in conversations to illustrate how the approach can support them in their role. Working closely with the Director of Planning and Director of Workforce has been an important part of this.

What difference has it made?

Taking a Quality Management System approach has helped to make the link between finance, performance and quality. For example, they now specifically examine the costs associated with harm when making assessments about whether services are effective. The Finance Director routinely asks for quality impact assessments associated with service changes, and the Director of Planning uses information on the impact of performance issues to better target resources. In future, board reports will change from being a separate quality report to an integrated report 'which will be important to join the dots':

> 'I think it's okay to have a Quality Management System, as long as, at executive level, that includes finance and workforce, so you've got that integrated approach.'

The Leeds Teaching Hospitals NHS Trust

Developing a management system grounded in improvement thinking. Interview with Jimmy Parvin, previously Professional Lead for Leeds Improvement Method.

The Leeds Teaching Hospitals NHS Trust (referred to hereafter as Leeds) is one of the largest and busiest NHS acute health providers in Europe. It treats around 1.5 million patients each year across seven hospital locations. The trust provides local and specialist services to its immediate population of around 770,000, employing more than 20,000 staff.

- Leeds' philosophy is marked by an overall shift in the balance of activity, from quality assurance to quality improvement work, and moving from tackling discrete quality problems to adopting a pan-organisation approach.
- Adopting Lean as a management system ensures quality and value is seen from the patient's perspective and enables improvement work to include consideration of issues that impact quality, including cost, efficiency and sustainability.
- Improvement is led by those closest to the front line, and they have therefore worked hard with staff to demystify the original improvement concepts while retaining fidelity to their principles.

What is your approach to managing quality?

> 'The Leeds Improvement Method makes it sound quite formulaic, and I don't think it is. It's more of a system, and systems have to adapt… it's a management system, grounded in improvement thinking.'

The Leeds Improvement Method (LIM) is the trust's philosophy of continuous improvement (Figure 6). It combines quality improvement and daily management methods with respectful behaviours and Lean processes. It aims to 'put people at the heart of improvement', sharing improvement tools with people closest to the front line to develop long-term, sustainable solutions to quality problems.

The approach supports the organisation to evolve how it manages quality. Part of this has involved a shift away from having a strong focus on quality assurance, and the temptation to 'add yet another layer of checks', to one that shifts the balance much more towards quality improvement.

Figure 6: The Leeds Improvement Method

Where did it begin?

Jimmy was previously the Professional Lead for the Leeds Improvement Method. A physiotherapist by background, he joined the trust in 2009. At the time, the trust had a track record in quality improvement, using the Institute for Healthcare Improvement Model for Improvement. Their focus was on tackling discrete quality problems, such as reducing the incidence of falls and pressure ulcers:

> '...but we didn't have a pan-organisational improvement approach, of "this is how we do things around here".'

Jimmy joined three other staff in the newly formed Kaizen Promotion Office in 2016, when the trust became one of five organisations in England to partner with NHS Improvement and the Virginia Mason Institute (VMI). The partnership sought to test the application of the Virginia Mason Production System. Since then:

> 'We began using the VMI model very directly, and as we've learned through practice, we've been able to evolve and adapt our approach to shape the system that we now own as the Leeds Improvement Method.'

Jimmy acknowledges that there remains some variation in understanding of the approach across the different layers of the organisation, and they are trying to narrow the gap on that understanding.

How did you go about it?

As a partner within the VMI programme, the trust adopted Lean as a management system, which involves an organisation-wide approach to improve quality and safety and enhance value from the patient's perspective. It included a monthly Chief Executive meeting across the partners, structured learning and teaching of the method across the organisation, and support for staff to apply the methods in their daily work.

Although the language of a Quality Management System would not be routinely recognised across the trust, 'we do run a version of a QMS'. For example, their quality planning includes the setting of annual commitments that are agreed by the board. These commitments, alongside the principles of their Improvement Strategy, then 'permeate the way we do things'. For each of the trust's 19 clinical service units:

> 'We'll say to them, "you know your services, what are the things that you need to focus on? Here are the trust's annual commitments, which might help you".'

Jimmy describes a level of 'connectivity' across the different elements of their system. For example, the governance structures include steering groups to routinely capture the learning from data, incidents and other sources, triangulating it to determine where to focus improvement efforts.

What have you learned?

The VMI approach defines quality 'in its broadest sense', resulting from good outcomes, appropriate care and positive patient experience, minus any waste in the process. This has meant that, while quality of care remains the primary aim, 'we now have a degree of maturity where we can bring [into conversations] cost, efficiency and sustainability'. For example, delays in care become part of discussions about quality, and any work on waste reduction has quality impact assessments against it.

The trust has retained fidelity to the core principles of Lean – 'it's important to choose a system and stick with that system'. But they now have the confidence to test and experiment with different methods and have worked hard to demystify some of the language associated with the original concepts. This has resulted in a management system that people are using, day in and day out, to solve their problems themselves.

What difference has it made?

Jimmy acknowledges that it's very difficult to prove what difference their approach has made. However, improvement is evident in their staff survey scores on questions around people's ability to improve work and being listened to by managers.

Their Quality Account cites how the LIM approach was applied in a range of clinical value streams in the past year, demonstrating improvement in quality while reducing waste in the process. This included a 28% reduction in children's cardiac surgery cancellations, and a 51% improvement in the correct recycling of medicines. Their focus in future is on scaling up localised improvements and on addressing quality challenges at the care pathway and organisational level.

NHS Lanarkshire

Building a structure and setting a long-term strategy for Whole System Quality. Interview with Karon Cormack, Director of Quality.

NHS Lanarkshire (referred to hereafter as Lanarkshire) is the third biggest health board in Scotland, serving a population of 655,000 bordering Glasgow, Ayrshire and Lothian. It employs around 12,000 staff working in three district general hospitals, 12 community hospitals and across their communities of north and south Lanarkshire.

Key elements

- The quality management components have been translated into four simple questions, under the banner of 'Whole System Quality', to help engage frontline staff.
- Lanarkshire has a dedicated Quality Directorate, bringing together evidence, improvement and assurance teams which support services with their quality work.
- The principles of Whole System Quality are embedded at every opportunity, from corporate communications to QI training, with 'True North' statements informing quality activities across the system.

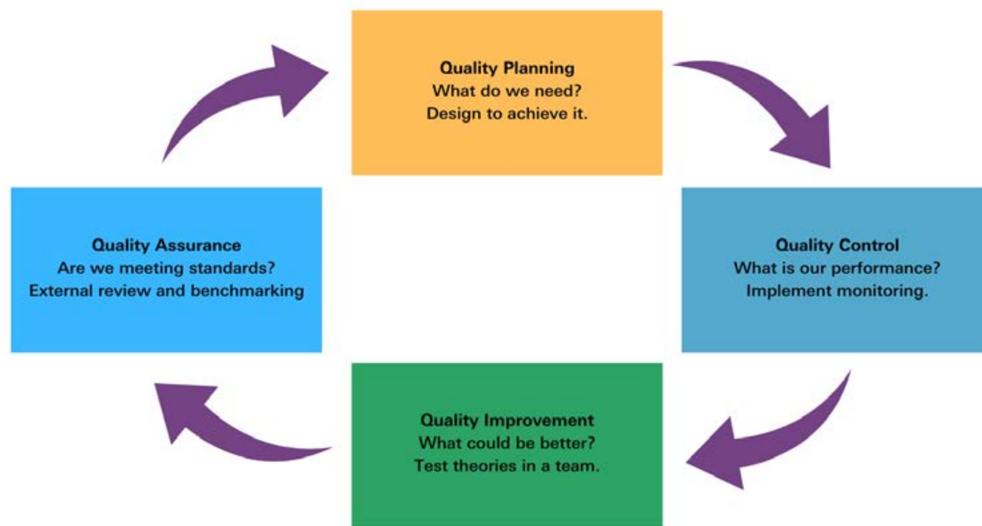
What is your approach to managing quality?

> 'We decided to go for Whole System Quality because there are a lot of language barriers with clinical staff... as soon as you see 'management system', people think about the quality of management. So, we wanted to make sure it was quite clear what this is, it's about whole system quality.'

Whole System Quality at NHS Lanarkshire describes the pursuit of quality through an agreed set of values and practices, structured around the four components of quality management. Their Quality Strategy 2023-29 sets out what each of these components mean, and when staff should consider using them.

The four components of quality management have been simplified into four questions: 1) What do we need? 2) What is our performance? 3) What could be better? 4) Are we meeting standards? (see Figure 7). A core part of their approach is a commitment to listening to service users and staff to inform each of the four areas, which is set out in a separate Learning Strategy.

Figure 7: NHS Lanarkshire's Whole System Quality approach



Where did you begin?

> 'I really like the structure, it's one of the reasons I took the job… having that all under one roof just makes it so much easier.'

The organisation had an original Quality Strategy for 2018-2023. It described their approach to achieving quality as being structured into three elements: evidence, assurance and improvement. These elements now form the structure of the Quality Directorate that Karon leads:

- **Evidence Team** supports staff to have access to the best evidence to inform and improve patient care. Functions include librarian services, patient information, evidence service, clinical audit, and standards and guidelines.
- **Assurance Team** supports the organisation to monitor and use performance and quality data to compare actual performance against quality goals. Functions include managing adverse events and complaints, data and measurement, and system development.
- **Improvement Team** provides guidance and expertise in quality improvement (QI) methods to frontline teams to turn learning into action. Its functions include supporting local and national improvement initiatives, delivering QI training, and supporting patient engagement.

How did you go about it?

The IHI model on Whole System Quality helped them to think through what their approach should look like, and it formed the basis for conversations with staff. They break down discussions into simple ideas based around the four components (see Figure 7) to build understanding and address areas of misunderstanding.

> 'It's helped with asking people, "so how do you know your care's okay? What quality controls do you have to make sure? What are you doing about that?" And they're thinking, "Oh, actually, how do we know that"… So, anything you can do to make this as easy as possible for people to get is, I think helpful.'

They found that staff were often confused about the difference between quality control and quality assurance. Staff found it helpful to distinguish between them as developing locally-important measures compared to compliance with external requirements, respectively. The principles of Whole System Quality have been embedded into their QI training programme (aEQUIP) and their quality improvement portal (LanQip), and formed the basis for their COMPASS newsletter to provide more detail on what it means for staff.

During discussions, they realised that quality planning – which they describe as understanding the needs of their service users and population – was the area most in need of extra attention. They developed their 'True North' statements, which set out how they will achieve their quality vision and should 'guide every decision relating to quality of care'. The statements have an annual action plan to determine what needs improving, and how, co-developed with the service. By working with staff on this, and focusing discussions on it:

> '[It] gave us the opportunity to talk about health system quality that maybe we hadn't had before in that way, and maybe hadn't thought about as a cycle.'

What have you learned?

Having people in Karon's team who can operate at a senior level, has been an important enabler. In relation to the improvement advisors:

> 'I'm quite lucky with the number of staff that I've got. They are all at a senior level … [which makes] a difference because they'll take the initiative, they'll move things forward. They don't feel the need to ask for permission all the time, they can speak to senior management. We found that makes a big difference.'

They also found that having conversations using the language of 'Quality Management Systems' has not been helpful. Staff found it too vague, and needed to discuss the practical applications of it to be helpful:

> 'You can see people glaze over when you say, "how are you getting with your Quality Management System…" we need to drill down to the nuts and bolts of [it] for people to engage with it… [otherwise] it's like the emperor's new clothes, this thing that nobody really can pin something to it.'

What difference has it made?

The organisation's quality activities are felt to be making a tangible difference. The team has worked hand-in-hand with services to address significant challenges, ranging from the set-up of Covid-19 vaccination centres to relieving pressure at the front door of their hospital emergency departments. This can be attributed to the systematic use of improvement methods, and the organisational commitment to investing in quality.

There remains a longer-term ambition to recognise how their Whole System Quality approach is contributing to this, but they consider that the impact is already being 'felt':

> '… we could evaluate it, so survey [staff] to see what their understanding of it is, now and in three years' time, but at the moment I can tell you… we're doing it, dripping it into conversation, doing the education and training… You might not be able to measure it, but I think you feel it. So we're not there yet. But I think we're moving in the right direction.'

East London NHS Foundation Trust

Developing a management system around a culture of continuous improvement. Interview with Duncan Gilbert, Associate Director for Quality Management.

East London NHS Foundation Trust (referred to hereafter as ELFT) provides mental health, community and primary care services to a population of approximately 1.7 million people across the City of London, Hackney, Newham, Tower Hamlets, Bedfordshire and Luton. It operates from more than 135 sites employing more than 7,500 staff.

Key elements

- ELFT's management system represents an evolution of its long-term, organisational commitment to improvement, led by the board and senior leadership team.
- Strengths in quality improvement and quality assurance provided the foundation for their management system, with work taking place with clinical directorates to develop their quality planning and quality control approaches.
- They have socialised the approach with staff based around work already taking place across the organisation, and how that can be further improved, to avoid it being seen as a new system to be implemented.

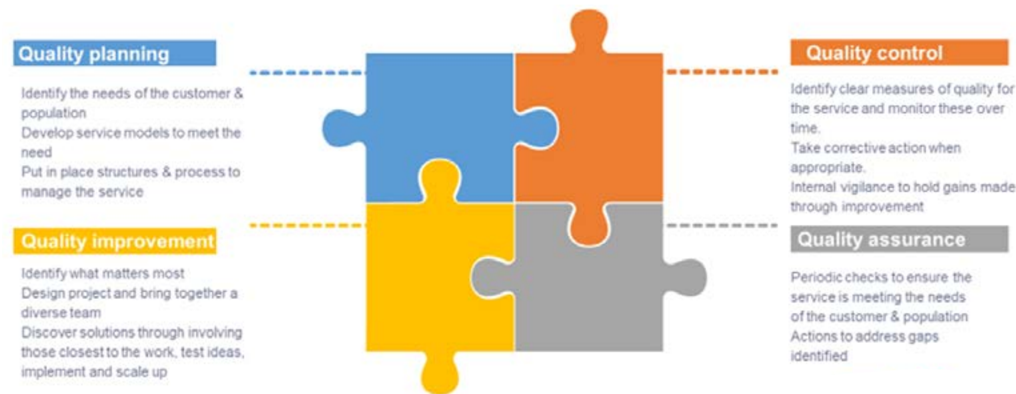
What is your approach to managing quality?

The trust takes a systematic approach to quality that supports staff and service users to identify and address quality issues. This has been enabled by several factors:

- a board that is focused on improvement
- development of an organisation-wide QI system
- QI department structure and function
- development and roll-out of improvement capability training
- meaningful engagement of people in QI
- use of data for learning and improvement.

Building on these foundations, the trust is developing an integrated Quality Management System (Figure 8). A range of activities and methods are used as appropriate under the four components of quality management.

Figure 8: ELFT's Quality Management System



These include, for example, use of the annual planning and commissioning process (for quality planning); use of visual management boards and regular huddles (for quality control); and use of audit, inspection and accreditation (for quality assurance).

Duncan Gilbert described an important part of their approach as recognising the dynamic nature of the management system – 'it's not a constant' – balancing attention and activities across the four components at any one time.

The trust emphasises the need for work under the four components to be interconnected, and conducted sequentially, not in isolation. For example, once improvement efforts have achieved new levels of performance, the system moves back into quality control to maintain the new level of performance.

Where did it begin?

East London NHS Foundation Trust's improvement journey began in 2010. They formally introduced a quality improvement programme in 2014, as part of an intentional effort to embed a culture of improvement across the organisation. Since then, the trust has achieved significant improvements in the quality and safety of its services, earning recognition nationally and internationally for its approach and outcomes.

The development of a management system represents a more organic evolution of this work, to bring together the relevant quality activities. In this sense, they consider themselves to be relatively early on in their quality management journey. In 2020, Dr Amar Shah published a paper[13] articulating the next stage of their quality journey, building on the solid foundations they had established through their work on quality improvement and quality assurance.

How did you go about it?

The trust has tried to be more intentional about its work on quality planning and quality control, and to enhance understanding about how the different components connect to each other at the service level. Duncan has some specific objectives as part of the continued development of the management system, focusing on:

- **Socialisation** – including working with colleagues to articulate what the management system looks like, how it benefits teams, and what it is for. This includes developing website content and resources, and a new internal online platform for action tracking (and sharing) progress on quality activities.
- **Strengthening** – working with clinical directorates to assess and strengthen quality control activities, enhance their team's quality assurance offer, and provide greater support to the non-clinical and corporate functions on their quality journey. Further work is being provided to help teams with their planning and strategy work, including how teams conduct stakeholder engagement.

A key part of their work has involved meaningful engagement of people in quality activities. One example is the development of a Service User-Led Accreditation programme, which forms an integral part of its quality assurance work. The programme invites teams to undergo a self-assessment process against 24 standards that are most important to service users. Around 70 services have gone through this process, with service users being involved in assessor teams and accreditation panels.

What have you learned?

> '…the main enabler has been the prevailing culture of the organisation, the embedded nature of the quality improvement methodology and the kind of culture that that's engendered.'

The existing culture of continuous improvement, and the senior leadership support and advocacy it has received since 2010, has provided fertile ground for this work. The trust has existing and well-established Quality Improvement and Quality Assurance teams, which remain vital to its work. Duncan has been supported by, and has worked in concert with, key colleagues at a similar level – such as the Associate Director for Performance and Planning.

There was a risk involved in calling their work the development of a Quality Management System, 'as it would imply it was a whole new thing'. Instead, conversations have been framed around 'here's a conceptualisation of what you're already doing, and here are some ideas about how you can do even better.' They find that, as a term, quality control (understanding quality and performance in real time) can be quite alienating when they are talking to colleagues, but in reality they are often already doing activities within it.

What difference has it made?

The impact of their improvement journey has been evident in gains across many areas of organisational performance, from reductions in instances of physical violence to increased levels of staff satisfaction. Although it is too early to assess the impact of their work to bring together the components of their management system, Duncan could imagine how they could, for example, understand how effective their work on quality control had been in due course:

> '…they'd have a much more robust process for quality control, where they're visualising data more smartly, and have a better understanding of the quality of their services. They're finding it easier to make better decisions based on that.'

Beginning the quality management journey. Interview with Sarah Williamson, Assistant Director of Performance, Reform and Quality Improvement.

The Northern Trust (referred to hereafter as Northern) is one of five health and social care trusts in Northern Ireland, providing a wide range of services to a population of around 479,000. It covers the largest geographical area of any trust in Northern Ireland and employs around 15,000 staff.

Key elements

- Extensive discussions with staff found the original language of quality management to be ‘too theoretical’, leading to the development of four questions to use for service planning and delivery.
- The recent publication of their quality strategy, which articulates their quality management approach, represents a significant milestone, with work to operationalise the strategy to follow.
- Discussions have illuminated challenges in understanding where best to apply their approach, from the micro (service or problem) level to the macro (organisational) level.

What is your approach to managing quality?

In September 2024, the trust published its first ever Quality Strategy, setting out its ambition and priorities for delivering high quality care for 2024-2027. The strategy states that the principles of Quality Management Systems can ‘help us continually improve as an organisation’.

Derived from the four components of quality management, they have developed the following four questions that act as 'guiding principles' that they intend to use when planning and delivering services (see Figure 9).

- What do we need to do well?
- How do we know we are doing it well?
- How do we do it better?
- How do we know it has made a difference?

Figure 9: Northern's Quality Management System approach

Where did it begin?

Sarah's role covers performance oversight, service redesign, and quality improvement, and she has been leading on developing their quality management approach – 'I've read a lot, studied the existing material on Quality Management System as they've been applied to health care and looked at other organisations'. Despite describing themselves as being at the beginning of their journey, conversations about developing their approach began around three years ago. The development of the Quality Strategy has taken place over the past 12 months, involving conversations with hundreds of staff and service users.

There is a strong foundation of enthusiasm for quality improvement to build their work around within the trust. Discussions are ongoing about whether their quality management approach will build on this to operate at the micro (service or problem) level, or at the macro (organisational) level:

> 'How do we as an organisation identify patient and population needs, measure (control) the metrics to show that we're delivering well, and if we're deviating? How do we improve those? How are we assured externally? And how do we take things back into a planning cycle?... or [do we] use a QMS cycle more specifically for instance, to improve falls prevention or pressure ulcers? In all the discussions that I hear... it isn't clear to me exactly where's best to apply the Quality Management System methodology.'

How did you go about it?

They held a series of top leaders forums with visiting speakers from other countries, discussing different aspects of Quality Management Systems. That led to some 'iterative conversations', followed by the establishment of a Quality Management System (QMS) Design Group and a QMS pilot workstream.

One of their biggest challenges has been to understand, 'how do you pick out what to improve first, how to improve it, and how to scale that up?' Their early work focused on identifying 'the big five' issues within the organisation. They began by looking at the key metrics, triangulating these with a range of different sources.

However, it has been a challenge, with ongoing discussions to try to gain consensus on their priority areas. When engaging hundreds of staff about the need for a quality strategy and asking 'what do we need to do well?' staff overwhelmingly want to focus on areas like care and compassion. 'We thought they would present strategic safety or quality issues, but rather than specific safety and quality concerns, we heard much more about how care should be delivered – with compassion, and with patient experience at the fore.'

What have you learned?

> '...as we were talking about quality management, we'd find people began to switch off, because we're not in a factory setting, we are about people.'

Following feedback from colleagues, they changed the formal descriptions of the quality management components into the four questions (see Figure 9). As a result, 'people feel much less threatened by them', with some senior colleagues finding the original model and concepts 'too theoretical'. The new questions aren't rigid interpretations of the components but instead reflect the importance that the model for improvement has within the organisation.

Despite actively engaging with other Q community members with an interest in QMS, and organisations involved in developing their own approach, Sarah and her colleagues are still working through how to 'nail down' the core principles and apply them in a way that will provide an evidence-based outcome for improved service delivery.

What difference has it made?

The next phase of work is focused on putting the ambitions around a QMS into practice. They are creating an operational plan and hope to use a QMS approach across all of their divisions primarily to identify risks and issues using a 'Heat Map' approach, and demonstrate actions are being taken to address them.

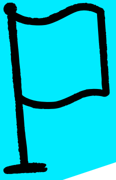
They will also implement a structure for reporting this information from the ward to the board, and envision it will be used at accountability meetings – '... more like a first, second line of defence approach' – with a view to discussing how it can be incorporated into their planning process going forward.

Part 3:
Discussion and recommendations for progress

This part of the report builds on earlier sections. It includes insights from our stakeholder interviews, case studies and the advisory group, and integrates findings from the wider literature on QMS.

Part 3 presents nine key recommendations to progress QMS for senior leaders of organisations. It also includes practical actions for people operationalising QMS in organisations and those supporting quality at a national level throughout the discussion.

There is a summary of the recommendations for senior leaders at the end of Part 3.



1. Leaders must set the vision, direction and culture for QMS, connecting your strategy to everyday work. This will involve ensuring resource and skills for delivery.

This insight project strongly supports wider evidence[4,31,32] of the need for proactive leadership. It is vital for embedding and sustaining QMS at whole-organisation level. This is our first recommendation due to its importance. But also, because leadership will need to drive the other eight recommendations. One organisational lead framed such leadership as a prerequisite:

> '… none of it is possible without leadership. That's where we [organisational leadership] are focusing most of our effort. Towards an executive team saying, "what is the point of this, and what role do we have to play, and how do we do it in an authentic way?"'
>
> Organisational lead

Case study interviews highlighted the importance of QMS being owned and driven by senior leaders within their organisations. For example, the maturity of ELFT's approach stems from a focus on organisation-wide improvement enabled by senior leadership support and advocacy. Similarly, the Leeds Improvement Method was driven by organisational leaders. But it was developed and owned by the whole organisation. Wider evidence from the evaluation of the five NHS-VMI partnership sites – of which Leeds was one[33] – highlighted the importance of leadership. Particularly in embedding and developing a positive organisational culture.

We found that senior organisational leadership must set the vision for and direction of QMS. They should connect QMS to organisational, staff and patient priorities and ensure that everyday work aligns with purpose and strategy. The case studies show how board and executive-level leadership could manifest as dedicated resources for work on QMS. This helps allow time for in-depth exploration on the approach taken, an openness to ideas from outside and a commitment to staying the course amid competing priorities and pressures. Leadership plays an instrumental role in supporting connectivity and coherence across the different QMS components. Some interviewees stressed the need for ongoing attention to leadership. They felt senior leaders must build credible expertise in improvement. They said 'sub-board-level' leaders must engage with the QMS work.

National bodies must set out how QMS can work at different levels of the system. In Wales and Scotland there is already a clear commitment from national government around QMS. In England, this connects to some of the Darzi review[34] findings on the over-emphasis on external accountability within the NHS. Similarly, the recent Dash review recommended that the CQC should focus more on how organisations are delivering improvement. This could encompass more holistic approaches to managing quality at an organisational level.

> 'A greater focus on how organisations are approaching and delivering improvement, rather than looking at input metrics, could enable more significant improvements in quality of care.'[35]

Prioritising QMS may feel like it requires leadership commitment against the expectations of funders and policymakers. However, this will hopefully evolve as QMS is seen as good practice for leading and managing quality and is increasingly recognised and required by regulators.

2. Co-develop meaningful shared language and understanding of QMS at all levels of your organisation, including staff, patients and leaders.

We have seen in the case studies that the term QMS can obscure its real meaning and make it hard for those who are less familiar with the term to connect to it. For some, the language of 'Quality Management Systems' is associated with 'corporate jargon'. It can be misconstrued as technical processes, such as writing planning documents or developing IT systems.[36] Similarly, the terms for the four components of quality management (quality planning, control, improvement and assurance) alienated some staff. This complicated picture is confounded by the various terms and definitions used in different frameworks – as we discussed in Part 1.

When confronted with this type of challenge, the correct path forward is not always clear. There is a need to maintain precision and clarity, but this should not be at the expense of accessibility and engagement. We recommend two interconnected actions. Firstly, using the terms for 'Quality Management System' and its components makes sense in some situations. The terms let those leading this work share learning and build recognition of QMS and the skills and support needed to develop it successfully. Although, QMS and its components were not commonly referred to in case study organisations, interviewees who were leading this work all spoke confidently about it in these ways. However, anyone using the term in any context should explain what they mean to avoid confusion and misinterpretation.

Secondly, if people are unfamiliar with the term, it is essential to develop and use language that is meaningful to them. Several interviewees used feedback from staff and service users to co-develop more 'user friendly' language. It helped to demystify the original concepts while retaining fidelity to their principles. For instance, some organisations have developed their own place-based names (for example, The Leeds Improvement Method). Several organisations made the language for QMS components more accessible or reframed them as simple questions (see Table 3). This process was key to successful staff engagement. As one interviewee mentioned, it helped 'people feel much less threatened'. The process and context of co-development were often felt to be important in building understanding.

Table 3: Examples of how organisations translated QMS components

	Quality Planning	Quality Improvement	Quality Control
NHS Lanarkshire	What do we need?	What could be better?	What is our performance?
Northern Health and Social Care Trust	What do we need to do well?	How do we do it better?	How do we know we are doing it well?

Beyond language, we also heard the importance of connecting QMS to organisational activity. This can help staff at all levels understand their own role in QMS and how they can benefit. Several interviewees spoke about helping teams to understand how they were already using quality management approaches. This included mapping existing services and tools under the four components. The IHI White Paper on whole system quality presents examples of activities that would typically be included in each QMS component (see Table 1). Other sources give further examples, including some broken down by specific roles.[6,18]

Several interviewees highlighted the importance of relating the quality management components to existing organisational priorities. Aneurin Bevan, for instance, described wrapping the quality management principles around their core work on the six STEEEP pillars (Safe, timely, effective, efficient, equitable, person-centred).

Other activities were mentioned as helpful for building understanding of the fundamentals of QMS and bringing its components to life. These included:

- providing training to staff
- using the terms in everyday conversations
- including terms in internal quality improvement training programmes
- putting posters up to increase familiarity
- developing website content to promote their use
- building internal software platforms to record and track activity across the four components.

Despite issues with terminology, some interviewees saw their QMS work as a chance to develop 'a common language' for quality work. This helped align different functions in their organisation.

As discussed in Part 1, different national bodies across the UK and Ireland have a slightly different framing of QMS – all designed to appeal to their particular context. Those responsible for quality at a national level need to use clear and consistent language on QMS in each country. This should be standardised across different guidance, policies and strategies. As much as possible it should be used by different agencies operating within the same system.

This also applies to support providers such as Q. In this report, we have attempted to describe QMS and its components in ways that balance the need for simplicity, precision and inclusivity of different perspectives. Our language on QMS will remain consistent. Q's future work will focus more on how to frame and promote QMS so it connects to all those who have a role in managing quality – leaders, staff and patients.

3. Position QMS as an evolution of your quality work. Start by mapping existing strengths and build on these.

Insights from interviews suggest that QMS is best framed as an evolution of an organisation's work on quality. It involves an incremental approach that builds on the assets already in place in an organisation. It is not about implementing from new. Several interviewees spoke about positioning QMS as a continuation of the work they are already doing well. It is a way to identify how they can do it even better – avoiding portraying it as a 'whole new thing' [organisational lead].

> 'I don't think QMS is a different way of doing it. I think it's a maturation of existing ways. So, not positioning it as a substitute is important. Otherwise, it's another shiny thing that [will] become layered on top of other things.'
>
> National stakeholder

Embedding QMS takes different paths in different contexts. The journey for each case study in this report varied depending on their starting point. It was affected by the existing strengths, and the capacity, capability and resources available. Some case study sites began their journey with an explicit and intentional effort to establish a QMS. A few used quality assurance activities, such as inspection report outcomes or compliance with external standards, as the basis for their QMS. In Sheffield, for example, the creation of their QMS formed a core part of operationalising its 'Back to Good' programme. It was initially conceived as a new system to be implemented. However, the work evolved to build on organisational strengths in quality assurance. It was later given extra resource and a timetable for scaling it up that built on the experience of the services using it.

Most organisations included in this report started from a solid foundation of quality assurance activity or quality improvement (for example, Leeds and ELFT). Overall work on quality planning and quality control were areas of comparative weakness and sources of potential confusion. Quality planning was a particular area that some sites struggled to visualise and put into practice. Some organisations had well-established methods for setting commitments or improvement priorities as part of annual planning processes. Others were still trying to understand what this work would look like, and at what level of their organisation it should be carried out.

To support this evolutionary framing, organisations need to understand their strengths, challenges and infrastructure. Many sites found it helpful to map and self-assess their current quality activities against the four components of quality management. Self-assessment tools,[6,37] can support organisations on their QMS journey. However, further work is needed to develop more sophisticated self-assessment tools. In particular those that encourage specific action and provide a framework for measuring progress.

As part of the development of QMS, organisations need to understand the cultural underpinnings for it. The case studies stressed the inseparability of the cultural and technical aspects of QMS. For example, the maturity of ELFT's approach is largely a by-product of its foundations in organisation-wide improvement, a journey that began in 2010. Their existing culture of continuous improvement, and the senior leadership support and advocacy for it, were cited as the main enablers for their quality management approach. Relatedly, some noted that a certain level of 'cultural readiness' is needed before embarking on QMS. As one national stakeholder highlighted, many organisations 'won't be ready for it [QMS] yet'. Existing models of organisational readiness for capability development may help those at the start of their journey.[38] Findings from the evaluation of the NHS-VMI partnership[14] back this up. They identified culture as a precursor to successfully adopting a systemic, organisation-wide approach to improvement.

4. Ensure the four components of QMS are well connected and function dynamically – planning, improvement, control and assurance.

A feature of more mature case studies was the ability to connect components of quality management and their associated activities and ambitions. Indeed, this is what ultimately gives QMS its systemic character. The four components need to interconnect and operate cyclically and dynamically. For example, attention may shift between improvement and control activities. Once performance improves, the system moves into quality control to maintain that performance.

> 'It's thinking about that connectivity. You've got your planning directorates within organisations, you've got your improvement hubs. How are they connected, and how are they aligning on what matters most?'
>
> National stakeholder

It takes considerable effort to ensure connectivity between the different components of quality management. Some organisations, for instance, are collecting and reporting too much assurance data internally. It would be wise to 're-balance' some of their activity to other areas. GOSH to some extent designed its quality governance framework to help bridge the gap between its assurance and control activities.

Bringing people in quality-related roles into a single team was cited as a useful approach to coordinating work and deploying resources. Aneurin Bevan brought around 40 staff carrying out quality activities into a single function to streamline and build momentum for their work. In Lanarkshire, the Quality Directorate included evidence, assurance and improvement teams. They support service teams with improvement initiatives, quality improvement training, and patient engagement. At ELFT, who have long-established assurance and improvement teams; emphasis was given to relational working with colleagues across the organisation, in areas such as data and performance. Structure clearly matters. We need further research on the implications and efficacy of different setups. However, such evidence rarely prescribes one form to the exclusion of all others.

A well-functioning QMS, with interconnected components, has the potential to reduce duplication. It may allow organisations to focus on patients and communities rather than overly 'looking upwards' for external assurance. Several interviewees spoke about opportunities for QMS to better align and potentially reduce existing activities. For instance, by bringing together separate quality and safety functions. Or by consolidating multiple external requirements into a single assurance process. Staff piloting GOSH's framework suggested it could provide the single framework through which all assurance activities are undertaken. This is echoed in wider evidence that suggests that as QMS becomes more established, the 'highest performing teams reduce assurance activity'.[39]

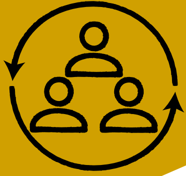
5. Commit for the long term while celebrating short-term success. Connect QMS to staff and patient priorities.

Consistent with what has been found elsewhere,[4] analysis from this project shows that embedding a QMS requires a long-term commitment. It needs to be framed as part of an ongoing quality journey. QMS requires a different way of leading and a different way of doing things. So, it needs a shift not only in terms of infrastructure and technical elements but also, crucially, culture. And this takes time.

This long-term commitment can be at odds with the pressures of demonstrating more immediate benefits. Several interviewees spoke about challenges of having to manage unrealistic leadership expectations around how quickly QMS can be embedded and show benefits. Sheffield, for instance, noted that there was an initial over-ambition about the speed at which they could implement QMS. It led them to develop a revised plan with a phased approach that felt more realistic. For example, starting with 12 teams rather than all 52 services they had initially planned.

Several interviewees raised the challenge of the extreme pressures facing the health and care system. It impacts on the momentum of their work and the ability to take a long-term view. This can mean QMS having to compete with other issues that are considered more pressing. As well as the long-term commitment, case studies highlight that QMS should be used to address current priorities and crises, ensuring that the focus on QMS is not crowded out. This is not easy, but it is crucial.

Across the case studies, the commitment of senior leaders to the development of QMS in the face of competing priorities was seen as key to success. Strategic versatility is needed to balance short-term objectives with long-term goals. It can be particularly valuable in managing the long-term commitment to QMS. Furthermore, while embedding QMS is a long-term journey, organisations can capture incremental progress along the way. We suggest that this could be done using self-assessment tools, collecting and sharing data, setting up ‘model teams’ to demonstrate rapid success and using evaluation on key areas (see also Recommendation 9).



6. Actively involve patients and service users in QMS, setting clear expectations for their involvement and providing appropriate support.

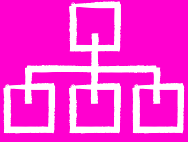
This project identified several examples of effective engagement of patients and the public. For example, Aneurin Bevan's work on their listening and learning and patient engagement strategies; ELFT's service-user led accreditation programme, which forms an integral part of their quality assurance work; and Sheffield's learning about providing clarity for people with lived experience when involving them in co-producing their QMS. Several case studies also involved patients and service users in developing accessible language around QMS.

However, further work is needed to effectively and comprehensively engage patients and the public in QMS. Instructive here is Shah's 2020 paper[13] that outlines the roles that different team members can play in QMS (see Table 4). Healthcare Improvement Scotland's framework also explicitly identifies co-design and co-production as part of a QMS. It links to more detailed resources on what role service users and carers can play.[40]

As with patient and public involvement across health care, senior leaders should set clear expectations for the role this should take across the four components of QMS. Enablers of good co-production from the wider literature include providing people with enough time and resources for it and developing their capacity and confidence to engage in it.[41]

Table 4: Roles of service users within each aspect of the Quality Management System (from Shah, 2020).

	Quality planning	Quality improvement	Quality control	Quality assurance
Service user	Be able to contribute to identifying the needs within the population and what types of service might best meet them.	Help the team determine the big issues that need improving. Be able to help inform how the service improves. Be able to contribute to the improvement work as much as desired. Be able to feedback whether changes have made a difference.	Be able to feedback experience of the service through a variety of ways.	Help set standards against which services are measured. Be involved in auditing or inspecting services.



7. Invest in good data infrastructure (both technical and human) to drive learning and connection between QMS components.

The effective use of data proved to be an obstacle, enabler, and focus for case studies. The literature identifies the need for a data-driven system. It should create evidence for decision making, monitor the impact of decisions, and adjust the approach as needed. This is key to developing organisational or system-level approaches to improvement, as outlined in the Health Foundation's learning health systems research.[23] When done well, data dashboards can be invaluable in QMS. They can help align and connect the different components by serving as a shared platform.

ELFT and Lanarkshire, for example, have well-established and integrated data, evidence and informatics teams to support quality activities. Several case studies spoke about the potential implementation of data systems at the time of the interview. For example, GOSH's new quality governance framework will use data to triangulate self-assessment submissions by service teams. However, despite its importance and potential, the case studies show there is still a need to improve the collection, access to, and use of data to support QMS. An important aspect of QMS maturity is developing data infrastructure. It should help organisations better capture, connect, and use data within and across components.

We can use the well-established evidence on data issues in health care to help us make more specific recommendations from the case study findings. Firstly, there is a need to tackle many of the enduring technical issues with data itself. This includes missing data, inaccurate data, fragmentation[42] and restrictive governance arrangements.[43] In organisations this will likely require investing in data infrastructure. It will also mean standardising data collection (or at least making data compatible). It will need better data visualisation and analytic capabilities and better connections between them. At national level, this will require longer-term support – especially for organisations earlier in their QMS journey. We need to spread best practice on procuring data tools and promote more open-source data and data tools for analysts to use.[23] Overall, there needs to be 'much closer alignment between efforts to improve the use of data and other efforts aimed at transforming health and care'.[42] QMS provide a potential engine for doing this.

Secondly, alongside technical aspects, organisations must develop the culture and 'human infrastructure' to effectively use, learn from and act on the data. The importance of which is oft repeated in the literature.[6,23] This requires building networks of people and a collaborative culture. It must prioritise using data for learning and improvement rather than judgement or external assurance. This importance is sometimes emphasised by explicitly referencing a 'learning system' at the very heart of QMS as in Healthcare Improvement Scotland's framework[10] (Figure 1).

Thirdly, a key learning from the case studies is that progress on QMS can be made despite significant data challenges. We recommend a dual track approach where efforts are devoted to improving data and data use while not letting data issues stifle progress. This can take many forms in organisations. Such as valuing different types of data to inform the different components of QMS – including qualitative data, staff and patient surveys and participative co-design at the strategic and service levels.[4,43]

8. Pursue ongoing learning about QMS internally and externally bringing in specialist support providers if required.

Most case studies highlighted the important role of ongoing learning in supporting the development of QMS. Broadly, this could take three forms:

- learning within the organisation about how to successfully develop the QMS (this is distinct from data-led learning that is part of the Quality Management System itself)
- bringing in external expert support, such as a strategic or technical partner
- peer learning with other organisations.

Firstly, within the organisation, a range of activities can support learning. This could be ongoing training and capability building on different elements of QMS. It could be actively sharing good practice or examples of failure, for example, through newsletters or posters. Or it could be actively supporting peer learning and networked approaches to share insights between those developing QMS.

The case studies show a range of these approaches. Leeds, for example, embedded a structured learning and teaching of the method across the organisation. It included support for staff to apply the methods in their daily work. Most case study sites had internal learning structures. These supported shared understanding of QMS and helped build capability for teams to make progress on the QMS journey. Notably, senior leaders may need support to develop a strong understanding of QMS, such as through board development with a specific QMS focus.

Secondly, some sites found an external partner to be critical to their progress. Leeds, for instance, received support from such a strategic partner. For some organisations, a strategic partner could provide the vital expertise, capacity and credibility needed at the start. Many aspects of QMS are highly specialised, requiring specific skills that are not always available within the NHS. However, external expert support may not be an option for every organisation. A national stakeholder we interviewed emphasised that there were 'lots of examples' of organisations that have made good progress without such external support.

> ‘It [a strategic partner] definitely brings something that you might not be able to do yourself. It brings credibility. It brings a bit of a mirror, particularly for an executive team, which can be so helpful. It brings some experience that you definitely might not have yourself, that you can harness, and it opens networks up which you might not be privy to otherwise…. but not everybody either has the money, or could invest in it, or necessarily needs to invest in it. There are lots of good examples across the country of places that are making great progress without a strategic partner.’
>
> National stakeholder

A formal external strategic partner may not be essential. But many believe that exposure to quality work, including international work and experience from other sectors, is invaluable. Indeed, openness to outside ideas is an essential part of this process. QMS has developed over many years in other sectors, which could provide useful learning for organisations. The debate surrounding exactly how much of this is transferable to QMS at the whole health care organisation level will continue. But there is little doubt that there is considerable expertise and experience to draw on.

Thirdly, some found great value in learning from peers in other organisations. Peer learning can take several forms. Documented evidence of good practice and detailed case studies are important. But, given the evolutionary, flexible and long-term nature of QMS development – they are unlikely to be enough. Additional opportunities include visiting other organisations implementing a QMS approach. The ability to exchange learning, provide peer support and share challenges is vital. In particular when it is still a relatively new way of working for a lot of organisations and people want to avoid reinventing the wheel. Some case study sites, like Northern, have invited input from other national and international organisations to learn from their experiences of QMS.

At the national level, there needs to be a more clearly defined support offer for those leading and delivering QMS. The exact form that this takes will need developing with those in receipt of it. But it is likely to include a combination of strategic support and peer learning elements. It will also need to distinguish between those at different levels, in different settings and at different stages of their QMS journey.

9. Contribute to the evidence base through systematic evaluation. Start by assessing your QMS but move focus towards patient outcomes as your work develops.

As discussed in Part 1, there is evidence for the benefits of QMS in other sectors[1,2] and there is clear affinity between QMS and the evidence base on the characteristics of high performing organisations. However, the evidence base for QMS in health care specifically is underdeveloped, though it is growing and showing promise.[3,4,5,6] Through our case studies, we heard about perceived potential benefits of QMS. These include improvements in staff engagement, better consistency of measurement, waste reduction and fewer uncoordinated activities and functions. All of which adds to this emergent evidence base.

However, it is important not to overstate the current evidence base for QMS in health care. Although several case studies cited the quality, safety and workforce benefits of discrete, service-level improvement interventions, few could be specifically connected to their quality management approach. Capturing the benefits and impact of whole-organisation quality management approaches is a significant challenge. Factors include the early stage of implementation in health care, the variation of approaches within and between organisations, and the complexity of attributing benefits.

Capturing the learning and benefits of QMS systematically and developing mature evidence on their development and impact more widely will be crucial to their progress. This is especially true when organisations are facing difficult choices on what work to prioritise in the face of multiple strategic demands and resource constraints.

We recommend that organisations apply a similarly strategic approach to building their evidence base as they do to developing their QMS. Initially it is likely that they will need some measures to determine whether they have the processes and systems in place for a good QMS. This could be based on tracking self-assessment results or stakeholder feedback. Early on, organisations will also want to capture and share some evidence of success. Quick wins, such as showing positive benefits on a smaller scale (or by 'model teams'[6]), can be especially useful. They help to inspire ongoing commitment to QMS from senior leadership and the wider organisation. As QMS work advances and matures, organisations may want to invest in a higher standard of impact evaluation connected to their QMS. At this stage, evidence should focus as much as possible on what the QMS has allowed the organisation to achieve. Demonstrating any impact on staff and patients is key, rather than appreciation of the QMS itself.

Those responsible for quality at the national level should take the lead in building the evidence base for the development and impact of QMS in health care. There are many questions that need to be answered. We need more empirical research on exactly how whole-organisation QMS can be effectively developed, with evidence that helps distinguish between different frameworks and approaches. Research should explore what, if any, prerequisites are necessary for QMS, and what national policies and structures support providers in developing QMS. Furthermore, we need greater focus on QMS in relatively new areas such as primary care and other non-acute settings as well as exploring new opportunities for QMS such as more advanced data systems and artificial intelligence. As part of this, there are also opportunities to develop standardised tools that support organisations to assess and measure their approach to QMS.

Key recommendations for senior leaders

1. Leaders must set the vision, direction and culture for QMS, connecting your strategy to everyday work. This will involve ensuring resource and skills for delivery.

2. Co-develop meaningful shared language and understanding of QMS at all levels of your organisation, including staff, patients and leaders.

3. Position QMS as an evolution of your quality work. Start by mapping existing strengths and build on these.

4. Ensure the four components of QMS are well connected and function dynamically – planning, improvement, control and assurance.

5. Commit for the long term while celebrating short-term success. Connect QMS to staff and patient priorities.

6. Actively involve patients and service users in QMS, setting clear expectations for their involvement and providing appropriate support.

7. Invest in good data infrastructure (both technical and human) to drive learning and connection between QMS components.

8. Pursue ongoing learning about QMS internally and externally bringing in specialist support providers if required.

9. Contribute to the evidence base through systematic evaluation. Start by assessing your QMS but move focus towards patient outcomes as your work develops.

Conclusions

Whole-organisation QMS provide the opportunity for a more integrated and systemic approach to managing and improving quality and performance– ultimately supporting high-quality care for all. Yet, despite growing interest and although well-established in other sectors, whole-organisation QMS are currently underdeveloped in UK and Ireland health care.

Based on a review of the literature, stakeholder interviews and seven case studies, we have outlined the differing terms and concepts associated with QMS (Part 1), presented detailed learning from seven organisations (Part 2) and identified key recommendations (Part 3). These recommendations build on the insights from our data collection. They were refined through a workshop with stakeholders and research participants.

The report adds to the growing research in this area. It makes a particular contribution to how QMS is being developed in the reality of current organisational contexts. The case studies do not necessarily all showcase 'best practice' to be emulated. But they undoubtedly provide valuable insights into the variety of ways QMS work is being framed, driven and progressed. Based on these insights, we developed nine overarching recommendations for actions needed to progress the development of QMS. They stress the importance of leadership, shared language, building on existing strengths, connecting the different components of QMS and committing for the long term. They also recommend paying particular attention to patient involvement, data infrastructure, ongoing learning and contributing to the evidence base.

Appendix

List of interviewees

- Sue Barnitt, previously Head of Clinical Quality Standards, Sheffield Health and Social Care NHS Foundation Trust.
- Nicola Burgess, Professor of Operations Management, University of York.
- Karon Cormack, Director of Quality, NHS Lanarkshire.
- Joy Furnival, Head of Strategic Insight, Care Quality Commission.
- Duncan Gilbert, Associate Director for Quality Management, East London NHS Foundation Trust.
- Ann Gow, Director of System Improvement, Healthcare Improvement Scotland.
- Felicity Hamer, Head of Strategic Quality and Safety, Improvement Cymru, Quality, Safety and Improvement, NHS Wales Executive.
- Jennifer Martin, Director of National Health Service Improvement, Health Service Executive Ireland.
- Jit Olk, Head of Quality, Great Ormond Street Hospital for Children NHS Foundation Trust.
- Jimmy Parvin, previously Professional Lead for Improvement Method, Leeds Teaching Hospitals NHS Trust.
- Amar Shah, National Clinical Director for Improvement (NHS England) and Chief Quality Officer (East London NHS Foundation Trust).
- Iain Smith, Associate Director of Planning, Business Development and Improvement, South Tyneside and Sunderland NHS Trust.
- Sarah Williamson, Assistant Director of Performance, Reform and Quality Improvement, Northern Health and Social Care Trust.
- Jennifer Winslade, Executive Director of Nursing, Aneurin Bevan University Health Board.
- Frances Wiseman, Director of Improvement and Insight, Hampshire and Isle of Wight Integrated Care Board.

List of advisory group members

- Emma Adams, Associate Director of Quality and Effectiveness at Cheshire and Wirral Partnership NHS Foundation Trust.
- Nicola Burgess, Professor of Operations Management, University of York.
- Felicity Hamer, Head of Strategic Quality and Safety, Improvement Cymru, Quality, Safety and Improvement, NHS Wales Executive.
- Bryan Jones, Senior Improvement Fellow, the Health Foundation.
- Levette Lamb, Senior Improvement Advisor, HSCQI, Regulation and Quality Improvement Authority.
- Jennifer Martin, Director of National Health Service Improvement, Public Health, Health Service Executive, Ireland.
- Penny Pereira, Q Initiative Director, the Health Foundation.
- Amar Shah, National Clinical Director for Improvement (NHS England) and Chief Quality Officer (East London NHS Foundation Trust).
- Mirek Skypark, Director of Quality Improvement, North East London NHS Foundation Trust.

Methods

We conducted a rapid scan of the literature to examine how QMS is conceptualised in health and care in the UK and Ireland. This surfaced examples of QMS applied in practice at an organisational level, for further exploration in the interview phase. The search strategy incorporated grey literature, including trust and health board strategy documents and board papers, which provided the richest source of information on organisations applying QMS.

Potential interviewees and case studies surfaced from the literature, alongside suggestions from the Advisory Group. Interviewees were divided into a) national leaders and topic experts and b) organisational leads for QMS. Where individuals were not available for interview, alternative interviewees were identified. Suggestions were also provided from research participants (snowball sampling).

Between May and August 2024, total of 15 semi-structured interviews were conducted by John Illingworth and Carl Macrae. Interview topic guides were developed in consultation with the Advisory Group. The topic guides covered the core areas below:

- Conceptualisation of QMS, including its component parts.
- Objectives of QMS, including their distinctiveness from other approaches.
- Practical steps and resources involved with implementation, including foundations of work.
- Necessary innovation, adaptation or evolution of work during implementation.
- Core conditions, activities and capacities (including patient and public involvement) for successful implementation and sustainability.
- Experience of implementation challenges, and advice for overcoming them.
- Evidence of, or consideration of, realised or intended benefits, or evidence of impact.
- Other resources, case examples, or bodies of work for consideration.

Interviews were recorded and automatically transcribed, then manually reviewed for accuracy. Key insights were grouped thematically around the core areas of the interview topic guide, with additional themes added as required. The research report prepared by John Illingworth and Carl Macrae was examined by two peer reviewers and forms the basis for the final report.

Recommendations were refined through a Q-led workshop with stakeholders from across the UK and Ireland held in November 2024.

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