

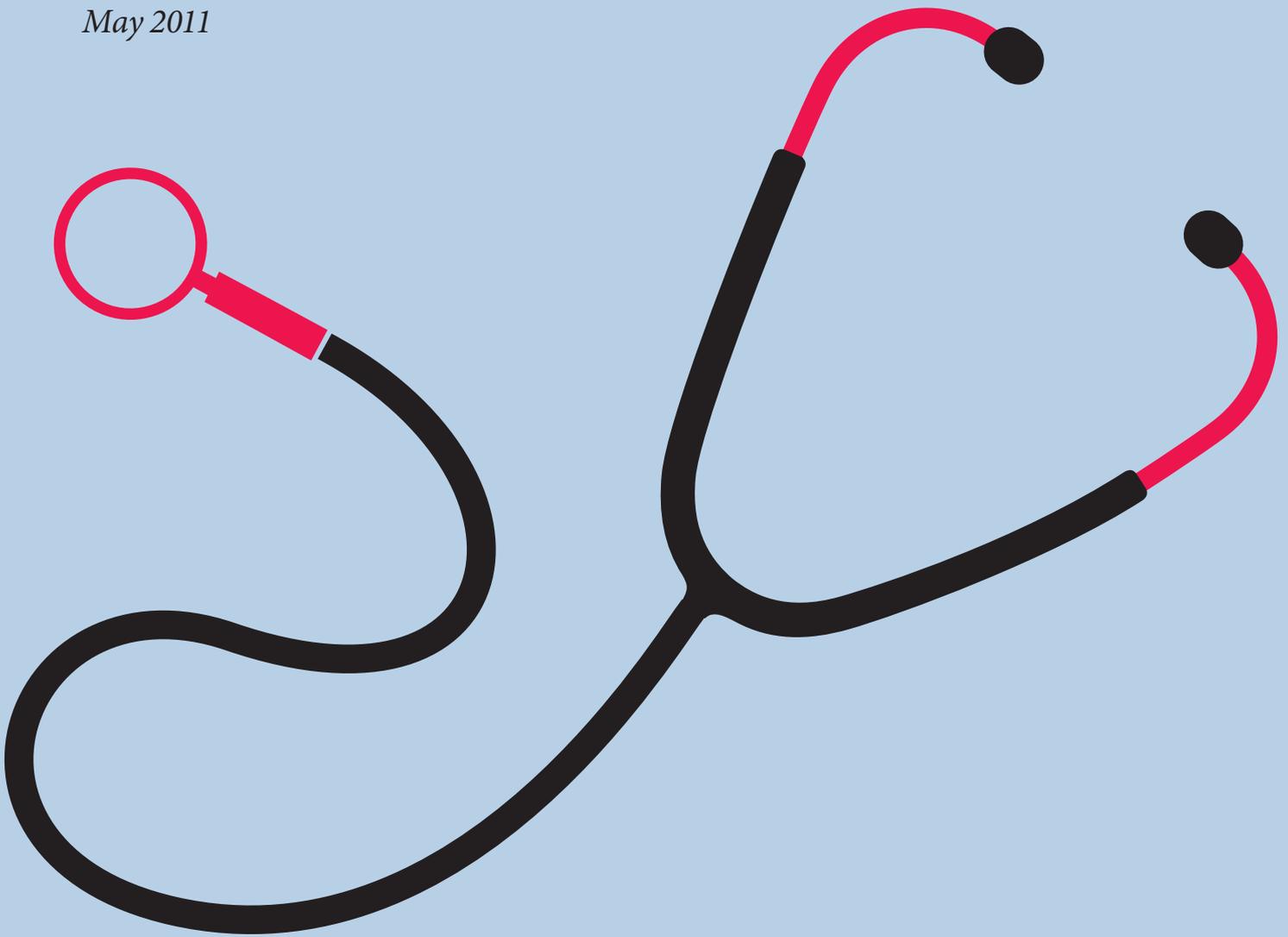
Evidence:

Are clinicians engaged in quality improvement?

 The
Health
Foundation
Inspiring
Improvement

A review of the literature on healthcare professionals' views on quality improvement initiatives

May 2011



Identify Innovate Demonstrate Encourage

This research was commissioned and funded by the Health Foundation to help identify where and how improvements in healthcare quality can be made. The views expressed in this report do not necessarily represent the views of the Health Foundation.

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Evidence: Are clinicians engaged in quality improvement? is published by the Health Foundation, 90 Long Acre, London, United Kingdom, WC2E 9RA

ISBN 978-1-906461-27-0

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Foreword

The Health Foundation is an independent charity that aims to improve the quality of healthcare across the UK. We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services. Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change that are essential for real and lasting improvement. Our programmes which aim to inspire improvement through healthcare professionals represent an important part of this work.

The active involvement of clinical staff is an essential component of quality improvement, yet systematic improvement initiatives in the NHS have not generally secured the full engagement of clinicians. In 2006, the Health Foundation commissioned a review seeking to clarify what is already known about the views of UK healthcare professionals in this area. This updated review builds on the findings of this earlier review and highlights how clinical engagement in improvement remains a complex, challenging issue.

Although healthcare professionals are committed to providing high quality care for their patients within the constraints of the environment they work in, there still remains little evidence that they engage in systematic quality improvement initiatives.

The reasons for this include ‘change fatigue’. This can be created by sustained organisational change and policy overload, the challenge of collaborative working across professional boundaries, and wariness to engage caused by perceived negativity from the media and politicians. The findings further enhance our understanding of how best to involve clinicians in quality improvement.

The Health Foundation wants to inspire and build the will, enthusiasm and commitment among clinical communities to acknowledge and adopt system-wide quality improvement methods to enhance the patient experience and the quality of clinical care. The evidence from this review suggests that this goal will need a collaborative dialogue with healthcare professionals to explore what this means for the established model of professionalism.

We believe that an enhanced model of professionalism is required and one that has a number of components. It places a stronger emphasis on accountability, recognises the benefits of creating a different dynamic between patients and professionals, assumes a stronger sense of responsibility for how the wider health system works and for all dimensions of quality.

It promotes a constant drive to improve what clinicians do and accepts change as a virtue rather than a threat. It commits to using a range of different approaches to develop and mobilise knowledge about how to improve care and build the formal evidence base underpinning improvement.

Finally, it emphasises the importance of clinicians working in multidisciplinary teams and across professional and organisational boundaries.

We hope that this review builds on our understanding of how clinicians engage in improvement and contributes to the debate about how clinicians can be best supported to improve the quality of care for patients.

Martin Marshall

Clinical Director and Director of
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Executive summary

Introduction

It is widely accepted that the active involvement of staff is an essential requirement for quality improvement in any organisational setting. Yet quality improvement initiatives in the NHS have not generally secured the full engagement of clinicians. Recent changes to UK policy and the introduction of new initiatives relating to quality improvement have highlighted the importance of understanding clinician engagement.

This is an updated review on an earlier report (Davies et al. 2006) in the light of the recent policy and quality improvement focus and the following should be noted.

This narrative literature review examines six areas:

- Healthcare professionals' understanding of, and attitudes towards, quality and quality improvement.
- What activities healthcare professionals are involved in that they would describe as quality improvement.
- Where healthcare professionals think responsibility should lie for quality and quality improvement.
- What activities healthcare professionals would like to do to improve quality and what would enable them to do so.
- What we currently know about any relationships between clinician engagement (or not) with quality issues and other clinician attributes (for example, attitudes and beliefs).

- To what extent (if any and if discernible from the available data) there are trends in clinician engagement, activities related to engagement, or in underlying attitudes and beliefs that may be precursors to engagement.

The review examines relevant published and grey literature on UK healthcare (primary, secondary and tertiary care; employees and contracted staff; NHS and the independent sector) published in the period 1990-2009.

For the purpose of this review the term 'healthcare professionals' includes doctors and non-medical health professionals (for example, nurses, midwives, allied health professionals, pharmacists and others) and managers (both clinically-qualified and 'lay' managers) from all different grades and levels.

The following definition of quality proposed by the Health Foundation is used: 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'. *

Our reading of the wide literature documenting how healthcare professionals have responded to various quality initiatives in the UK since 1990 prompted the following 10 interrelated questions which are used to structure this summary and the main report.

* Institute of Medicine. Medicare: a strategy for quality assurance. Lohr KN, ed. Volumes I and II. Washington DC: National Academy Press, 1990.

10 key questions that emerge from the literature

1. Do different healthcare professional groups define quality in the same way?

Different health professional groups largely inhabit separate hierarchies and networks with often surprisingly little inter-communication. Thus different professional groups often do not define quality in the same way. Moreover, the processes of determining what constitutes good or quality practice within an individual profession are complex, sometimes divergent and often contested between different professional groups.

2. Do healthcare professionals think that the quality of care needs to be improved?

In general, there is widespread agreement that care quality needs to be improved, but this may reflect more the current policy focus, rather than the committed views of individuals. Many believe that high quality care is already being provided through the inclusion of quality as a central tenet of professional codes of practice. Paradoxically, however, clinical staff are often well able to identify important deficits in care - usually care provided by others - that they believe need to be addressed.

3. What are healthcare professionals' attitudes towards initiatives aimed at quality improvement?

Although some studies show that healthcare professionals may respond positively to involvement in certain national quality initiatives, overall, healthcare professionals are reluctant to engage. In part this is because they believe the initiatives are driven by management to reduce costs or that they will be ineffective or increase workload for little gain. Healthcare professionals may also be concerned about harmful effects for staff and patients that may result from quality initiatives.

4. Do healthcare professionals have a clear understanding of the concepts and methods of quality improvement?

Overall, clinicians and managers seem to have a limited understanding of the latest concepts and methods underlying quality improvement. Clinical governance, although not new, is still poorly understood by clinicians and managers. The introduction of patient safety initiatives may have further complicated an already crowded healthcare context, replete with concepts, methods and programmes aimed at improving care quality, which healthcare professionals struggle to understand.

5. Where do healthcare professionals think that responsibility for quality improvement should lie?

Quality improvement often causes conflict between doctors, healthcare professionals and managers, with doctors taking a dominant position. Doctors think that responsibility for defining and assessing healthcare quality should rest with the medical profession, seeing the role of managers as providing adequate resources to enable this. Managers may struggle to implement quality improvement initiatives against entrenched attitudes, and they may have to devise strategies to circumvent considerable opposition. There is an increasing recognition by clinicians of organisational or systems approaches to quality improvement, rather than a focus on individuals. The engagement of patients as active participants in healthcare has increased their role in highlighting quality gaps.

6. What do healthcare professionals think about clinical guidelines and ‘evidence-based practice’ (EBP) as routes to quality?

Despite some positive orientations, many clinicians do not regard clinical guidelines and related initiatives as useful tools in providing quality care, and may resist them because they are perceived as hampering clinical freedom and impeding local practice. EBP is a controversial issue, with enthusiastic supporters and equally vociferous detractors. For many clinicians, it is seen at best as only one tool in a range of approaches to providing quality care and, at worst, as an impediment to providing individualised and holistic patient care. While many clinicians’ beliefs about guidelines and EBP are entrenched, there is a declining focus on these in the literature, which may indicate an acceptance of these at least as concepts, if not in day-to-day practice.

7. What are healthcare professionals’ attitudes to the measurement of healthcare quality for quality improvement purposes?

Clinicians have strong and diverse concerns about the measurement of healthcare quality. There are concerns that: the indicators are flawed and do not reflect the care provided; they are based on inaccurate data; and they are difficult to understand and interpret. There are fears that the measurable will take precedence over the important. In addition, there are ongoing concerns that the data will be used for managerial and cost-cutting purposes that may impose significant constraints and control on healthcare professionals. The inclusion of patient survey data as a measure of quality causes concern that they may not focus on aspects of care that clinicians regard as important.

8. What are healthcare professionals’ attitudes to measures of quality being made public and used for external judgement and accountability?

Managers and clinicians remain wary about the adverse effects of certain data, on clinicians, on public understanding and confidence, and on healthcare organisations, based on concerns that certain data provides an incomplete or skewed picture of quality. Changes to the law regarding public access to data has shifted the focus of clinicians from whether data should be made public, to concerns about what should comprise data and who should decide; and what should be made public and in what format.

9. What do healthcare professionals see as the barriers and enablers to quality improvement?

Healthcare professionals describe a wide range of barriers to quality improvement, and a more limited list of enablers. Lack of time and resources are most commonly cited by all healthcare professionals, however, competing priorities and policy overload are also significant barriers to local implementation of quality improvements. In addition, many of the identified barriers arise from the well-documented problems of working effectively between and across health professions. This means that more time and more resources, while they may be necessary or helpful, are unlikely to be sufficient in overcoming the substantial barriers to clinicians’ active engagement in successful quality improvement.

10. What trends are discernible from the literature that may or may not relate to clinicians’ views of engagement with quality improvement?

The following four trends emerge from the literature that raise questions for further consideration, debate or research:

- The possibility of involvement or compliance which stops short of full engagement.
- The increasing separation of quality and safety in the literature and its impact on active engagement.

-
- The increased involvement of patients in care delivery and quality assurance.
 - A greater focus on systems approaches to quality improvement, rather than a previous focus on individual clinicians.

Conclusions

- This review is necessarily broad, encompassing 100 or so empirical studies to broader literatures. Many of the areas touched on have their own substantial bodies of research (for example, evidence-based practice, management of change or professional identity).
- The review draws predominantly on studies that rely on self-reported attitudes; inevitably there is a risk in such studies of social desirability bias. Nevertheless, studies like this provide a rich picture of perceptions. Such perceptions arise from, and contribute to, the shared meanings which are part of local organisational cultures.
- Studies of healthcare professionals' perceptions cannot show the extent to which these perceptions accord with actual circumstances and so they need to be used with care in identifying what may be needed to promote engagement with quality improvement. Nevertheless, such perceptions are an important part of setting the context for change and in constraining what may be achieved.
- Attitudes towards specific quality initiatives are influenced by the political and local contexts and by other events occurring at the same time. Contextual features that have been particularly influential in shaping healthcare professionals' attitudes to quality and quality improvement in the period covered by the review are: the substantial and sustained organisational turbulence in the NHS; the sustained and largely critical attention the NHS receives from politicians and the media; and the increasing patient involvement focus.
- We were unable to find any references in the literature relating to possible relationships between clinician attributes (such as attitudes and beliefs about other aspects of care) and the extent of clinician engagement. This leaves an important area for further study.

- Increasing clinician engagement is likely to remain difficult: non-engagement of clinicians is a long-standing, multifactorial and international problem. Nevertheless, a detailed understanding of the diverse perceptions of healthcare professionals in relation to quality and quality improvement, as contributed by this literature review, is a vital part of planning and implementing such change.

Joyce Wilkinson, Alison Powell, Huw Davies
(January 2010).

Chapter 1

Introduction

My patients seem to be reasonably happy, and I don't know what I could personally do to make it better.

Consultant anaesthetist, quoted in Powell 2006: 245

There's definitely a culture against doing this kind of thing. There's a definite culture where you shouldn't implicate other doctors when things go wrong because it's not in their interests, despite being in the interest of safety and improvement.

Consultant anaesthetist quoted in Currie et al. 2008: 377

Patient safety is just integral to things out in practice...I don't think you can separate it from doing the rest of your job, it's just part of it.

Newly qualified nurse quoted in Smith et al. 2009: 233

Unfortunately, recent surveys have shown that there is widespread disenchantment and disengagement among doctors and clinicians in all healthcare professions, particularly from what are perceived to be political or managerial initiatives.

Teasdale 2008: 5

1.1 Engaging clinicians with quality

In terms of top down strategy, the UK NHS probably has the most ambitious quality improvement strategy in the developed world.

Roland 2001: 66

In all public services we are making a radical shift from top-down, target driven performance management to a more bottom-up, self-improving system built around the individual needs of service users and will be influenced by effective engagement with the public.

DH 2006: 4

In tracking the historical roots of quality improvement, from Hippocrates right up to the contemporary healthcare context, Neale et al. (2007) provide a comprehensive account of the number of different international and UK initiatives that have been introduced to improve care quality as a background to the National Reporting and Learning System in England and Wales. They recognise many of these have attempted to secure greater engagement with doctors. What becomes clear from this account is that, in recent years, more initiatives have appeared than ever before, and the majority of these have come from the top-down mechanism of policy which is recognised as a barrier to clinician engagement.

The medical profession does not yet perceive itself as having a trusting relationship with politicians. The perception that the NHS has been reorganised on a near continuous basis without adequate clinical engagement has done little to address scepticism among doctors about whether their views, or those of other health professionals (and the public), have been properly heeded.

Levenson et al. 2008: 13

An important component of the substantial and often controversial NHS policy agenda since 1997 has been the implementation of the 'quality agenda' (Ferlie and Shortell 2001). This has led to what has been described as a 'massive overhaul' of the NHS, with the establishment of new organisations and processes in such areas as external inspection and oversight; performance evaluation and public reporting; payment reform; and public engagement (Leatherman and Sutherland 2003).

It is widely accepted that an essential requirement for quality improvement in any organisational setting is the active involvement of staff. For organisational change to be successful, all key players have to recognise and acknowledge that the proposed changes have a clear advantage over current practice in terms of effectiveness or cost-effectiveness (so-called 'relative advantage'; Rogers 1995; Gustafson et al. 2003; Greenhalgh et al. 2004).

Staff members also need to perceive that they, as well as patients, will benefit (Ham et al. 2003). The specific benefits for staff will vary depending on the change, but perceived benefits will always be needed to compensate for the effort required to change. Relative advantage is also important as a prerequisite for successful organisational change, that of 'ownership' of the change by participants (Flood 1994; Harvey and Kitson 1996; Locock 2003).

Quality improvement initiatives in the NHS have not yet secured this vital ingredient of the full engagement of clinicians (Ovretveit 1996; Shekelle 2002; Leatherman and Sutherland 2003; Degeling et al. 2004; Jorm and Kam 2004; Leatherman and Sutherland 2004). This is having a marked impact on the success of initiatives:

The widespread engagement of staff has not yet occurred and is slowing the potential impact of modernisation...the opinions and behaviour of doctors are particularly important, and their support is vital.

Gollop et al. 2004: 113

Unsurprisingly, healthcare professionals express strong support for the principle of quality patient care:

Quality has traditionally represented a relatively risk free and widely popular articulation of policy. It is, after all, extremely rare to find someone who is opposed to the notion of quality.

Leatherman and Sutherland 1998: S54

Quality patient care is emphasised as the overriding objective in all professional documents and in both public and private statements made by individual healthcare professionals. For example, consultants and managers closest to service delivery have ranked quality as their primary goal over volume of care (for example, number of patients treated) or financial break-even (Crilly and Le Grand 2004). Nurses and midwives have cited their inability to deliver quality care according to their own standards and professional training as a major reason for leaving a particular post or leaving the NHS altogether (for example, Meadows et al. 2000; Newman and Maylor 2002; Reeves et al. 2005; Kirkham et al. 2006). Managers pride themselves on their own emphasis on quality concerns relative to their colleagues:

Managers gave more importance to maintaining quality within their own priorities than they attributed to most service/business managers, taking the view that they had a more conscientious attitude to quality than had most of their peers.

Crilly and Le Grand 2004: 1817

There are more explicit links made between quality improvement, individual and organisational performance, clinical leadership and professionalism in the NHS (for example Dickinson and Ham 2008; Levenson et al. 2008; Hamilton et al. 2007; NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges 2009; RCN 2008a,b; 2009).

During recent years there has been an increasing focus on quality improvement and patient safety in the UK NHS, particularly through the introduction of specific initiatives to address these. The Institute for Healthcare Improvement (IHI) in the USA has led with the 100,000 Lives Campaign (launched in 2004) and this has underpinned and driven UK initiatives such as the Safer Patients Initiative, led by the Health Foundation.

With pilot sites in each UK country, the Safer Patients Initiative aimed to test ways of improving patient safety on an organisation-wide basis and provided training for staff and included specific roles for each organisation's chief executive and senior management teams.

NHS Scotland has taken this forward from the pilot site to develop the Scottish Patient Safety Programme, supported by the Scottish Government.

In NHS Wales a similar campaign was launched in 2008 (the 1,000 Lives Campaign) aiming to prevent 1,000 avoidable deaths and 50,000 incidents of patient harm in the next two years.

Northern Ireland's Safety Forum saw their unique position of providing integrated health and social care as of great significance to their collaboration with the Safer Patients Initiative.

In NHS England, the establishment of the National Patient Safety Agency and its National Reporting and Learning System expanded efforts to improve patient safety nationally. In addition to the UK exemplar sites for the IHI programme, the campaign has enrolled hospitals in several European countries and more widely, in Canada, New Zealand, Japan, India, Saudi Arabia and Africa (Powell et al. 2009a).

The engagement of clinicians has been a central theme in the IHI programmes (Reinerstein et al. 2007).

The Engaging with Quality Improvement (EwQI) initiative also supported by the Health Foundation began in 2004, with projects in acute and primary care, led by professional bodies or specialist societies. The focus of these was on developing clinician-led approaches to identifying areas for improvement and auditing care against the standards which they developed, engaging others in the quality improvement process in the creation and implementation of improvement plans (Ling et al. 2009).

While evaluations of the IHI campaign in the USA, the Safer Patients Initiative in the UK and the EwQI have been undertaken (McCannon et al. 2006; Chan et al. 2008; Benn et al. 2009a,b; Ling et al. 2009 respectively), there are difficulties in objectively assessing the extent of their impact. This is mainly due to the multi-dimensional aspects of these programmes and challenges in evaluating complex programmes, each with considerable scope for local adaptation in implementation (Benn et al. 2009a).

These challenges are not exclusive to these programmes and have been recognised in evaluating other complex initiatives aimed at improving care (Wilkinson et al. 2009). While the difficulties of attribution and objective measurement of improvement or engagement are recognised, it is not the purpose of this review to report on the success of these initiatives. However, these programmes and initiatives have increased the focus on specific issues at local level, such as infection control or adverse drug reactions and at national level, by raising the profile of patient safety and quality improvement. The re-introduction of matrons to the NHS, while not directly part of these initiatives, illustrates the way this heightened focus caught the attention of both NHS staff and the public:

Suddenly the matron was going to make everything better. The papers have picked up that they are going to reintroduce a matron to get the hospital clean like it used to be.

Modern matron quoted in Currie et al. 2009: 305

Another modern matron also recognised the importance of her role in raising the profile of infection control locally:

People do things for so long that they become blind to it until somebody points it out to them. The last few audits... showed a sharp improvement. I think that's because people like me have been given that infection control role.

Quoted in Currie et al. 2009: 307

There has recently been a greater focus on quality in healthcare through the *NHS Next Stage Review – High Quality Care for All (DH 2008a)*. Department of Health documents continue to present this positive view as the reality of the NHS:

We recognised the substantial improvements that have been made in the NHS over the past decade and agreed that achieving high quality care for all should be the ambition that we all share. Placing quality at the heart of the NHS has sparked an uprising of energy, enthusiasm and creativity across the service, which cannot be extinguished.

Darzi quoted in DH 2009c: 3

While there is a belief from some authors that quality of care has improved (Leatherman and Sutherland 2008) and specific attempts to engage clinicians have had some impact (Ling et al. 2009), there is still a concern expressed by professional groups that widespread engagement in quality improvement remains a worthy goal, but one, as yet, difficult to achieve. (Shekelle 2002; Leatherman and Sutherland 2003; Degeling et al. 2004; Jorm and Kam 2004; Gollop et al. 2004; Leatherman and Sutherland 2004; Dickinson and Ham 2008; Ham and Dickinson 2008; Smith et al. 2009).

This renewed focus on quality has seen an increasing tendency in the literature to separate the concepts of quality and safety. Some papers relating to patient safety do not mention quality and some relating to quality make the distinction by describing quality and safety. Patient safety is now the focus of entire editions of scholarly journals just as quality was in the past.

This separation moves away from the influential definition of quality from the Institute of Medicine which has safety as one of the six dimensions (safety, effectiveness, patient-centredness, timeliness, efficiency and equity) through which the overall concept of quality is expressed.

It also departs from the NHS Next Stage Review report *High Quality Care for All (DH, 2008a)* which defines quality of healthcare as: patient safety, patient experience and effectiveness of care. The separation may reflect the specific focus on patient safety in the UK (through the initiatives described above), but in undertaking this review we have not sought to see them as separate, other than when they are reported in the literature as so.

While the impact of the non-engagement of doctors is seen as more significant than that of other professional groups, by virtue of their sphere of influence (NHS Institute for Improvement and Innovation & Academy of Royal Colleges 2009), there are themes relating to the provision of quality care that cut across professional boundaries, such as the need for leadership, professional autonomy, supportive structures and the development and maintenance of knowledge and technical skills (DH 2008c; NHS Institute for Innovation and Improvement and the Academy of Royal Colleges 2009; RCN 2009c).

This review examines UK literature (and occasionally draws on international studies to illustrate a specific point or highlight a gap in the UK literature) on healthcare professionals' attitudes to quality and quality improvement to uncover reasons why clinicians may be involved but are not yet fully engaged.

Chapter 2

Our approach

2.1 Our research method

Research was undertaken on UK healthcare professionals' attitudes to quality and quality improvement published during the period 1990-2009, using a broad definition of 'healthcare professionals' to include both clinicians (for example, doctors, nurses, midwives, allied healthcare professionals) and managers (both clinically-qualified and managers). We took as the working definition of 'quality in healthcare' the definition used by the US Institute of Medicine and adopted by the Health Foundation for the current review:

...the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Lohr 1990

The literature search contained four interrelated components. Searches of:

- key databases
- contents tables of relevant medical, nursing, allied health professional and management journals
- reference lists of retrieved papers; and a review of other material including policy reports and 'grey literature'.

Further details of the search terms employed, the databases searched and methods of selecting relevant papers are available from the authors.

Policy reports and related material were traced using a range of strategies. These included consulting individuals with knowledge of the field and searches of the websites of relevant government bodies, professional organisations and research centres.

For example, the Audit Commission, Department of Health, Healthcare Commission, National Primary Care Research and Development Centre, National Co-ordinating Centre for NHS Service Delivery & Organisation R&D Programme, Nuffield Trust, Quality Improvement Scotland, Royal College of General Practitioners, Royal College of Nursing, and the Health Foundation.

Papers and other material (reports) on UK healthcare professionals' attitudes to quality and quality improvement were gathered and divided into two broad categories: empirical studies (around 120 papers), and commentary, debate and other miscellaneous papers that made direct observations on healthcare professionals' attitudes to quality and quality improvement (a further 170 sources). The main empirical studies (n=100) are listed and summarised in the Technical Appendix, highlighting their key findings relating to healthcare professionals' attitudes to quality. It is material from these empirical studies that informs the bulk of this review.

2.2 Our review of the evidence

Much of what we know about healthcare professionals' attitudes to quality and quality improvement comes from research carried out on specific quality initiatives (for example, clinical governance) rather than research on attitudes towards quality as such. Attitudes towards specific quality initiatives are influenced by the political and local contexts and by other events occurring at the same time.

By examining a range of studies published in the period 1990-2009, we gain insights into the diversity and complexity of attitudes demonstrated by healthcare professionals across this period.

There are areas that have received more research attention than others and there are gaps in the existing literature. For example, the literature is not balanced in its coverage of the different health professions.

Research shows that much of the UK literature on quality improvement focuses on the medical and (to a lesser extent) nursing professions and on managers.

Little research exists on allied healthcare professionals' views about evidence-based practice (Stevenson et al. 2004). There is also a marked emphasis in the literature on the NHS, with only a few papers referring to the independent sector (for example, Gray 1998; Shirley 2000; Vallance-Owen and Cubbin 2002; Thomson et al. 2004; Davies and Goodman Crippacc 2008; Commodore et al. 2009).

Devolution of responsibility for health services in the four countries of the UK in 1999 means that healthcare professionals in these constituent parts of the UK are subject to different policy initiatives, and there is a marked emphasis in the research literature on England (which has been subject to the highest number of these initiatives).

Although there was no indication from the literature of any distinct differences between healthcare professionals' attitudes by UK country, there has been no systematic evaluation of this issue and so it is possible that such differences do exist but have not yet been explored empirically.

This review includes empirical research on a range of quality improvement strategies in the UK health service including audit, comparative data and its public release, external review, clinical guidelines and evidence-based practice, Quality Accounts, the Quality and Outcomes Framework for General Medical Services, and the Scottish and National (England and Wales) patient safety initiatives.

It is not that the design and operation of these initiatives themselves is our primary concern. Our aim is to try to use reactions to such initiatives as a means of drawing out the views of healthcare professionals on clinician engagement with quality improvement initiatives more generally. In doing so, we also draw on published commentaries on healthcare professionals' attitudes towards, and engagement with, quality improvement, and on related literature in the field of organisational change.

In reviewing this widespread literature, we aim to address six key issues:

- Healthcare professionals' understanding of, and attitudes towards, quality and quality improvement.
- What activities healthcare professionals are involved in that they would describe as quality improvement.
- Where healthcare professionals think responsibility should lie for quality and quality improvement.
- What activities healthcare professionals would like to do to improve quality and what would enable them to do so.
- What we currently know about any relationships between clinician engagement (or not) with quality issues and other clinician attributes (for example, attitudes and beliefs).
- To what extent there are trends in clinician engagement, activities related to engagement, or in the underlying beliefs and attitudes that may be precursors to engagement.

The following questions provide a helpful framework for understanding clinician engagement in quality improvement and we will therefore use them to structure the review.

These questions emerged inductively from a reading of the wide literature documenting how healthcare professionals have responded to various quality initiatives in the UK since 1990.

2.3 Key issues to address

This report addresses 10 key questions, to share what is known about each of these issues in a UK context, drawing on international literature on occasion to illuminate specific points, highlight the gaps in UK literature or provide a contrasting view.

10 key questions on healthcare professionals' attitudes to quality and quality improvement

1. Do different healthcare professional groups define quality in the same way?
2. Do healthcare professionals think that the quality of care needs to be improved?
3. What are healthcare professionals' attitudes towards initiatives aimed at quality improvement?
4. Do healthcare professionals have a clear understanding of the concepts and methods of quality improvement?
5. Where do healthcare professionals think that responsibility for quality improvement should lie?
6. What do healthcare professionals think about clinical guidelines, and evidence-based practice (EBP) and their contribution to quality?
7. What are healthcare professionals' attitudes to the measurement of healthcare quality for quality improvement purposes?
8. What are healthcare professionals' attitudes to measures of quality being made public and used for external judgement and accountability?
9. What do healthcare professionals see as the barriers and enablers to quality improvement?
10. What trends are discernible from the literature that (do or might) relate to clinicians' views of engagement with quality improvement?

Chapter 3

Defining quality

3.1 Do different healthcare professional groups define quality in the same way?

Quality has lacked a shared understanding, a set of common standards, and explicitly stated common goals.

Leatherman and Sutherland 1998: S54

Quality is a term which defies precise definition... [it] is a contested concept, and is defined by individual actors according to their particular experiences, value systems, and deeply held assumptions.

Sutherland and Dawson 1998: S20-21

This notion of quality care is difficult because it contains both objective and subjective elements, and it also depends on who's giving their opinion. Should we consider quality of care from the healthcare provider's point of view or from the patient's point of view?

Nurse quoted in Hudelson et al. 2008: 33

Quality has become a 'battleground' on which professions compete for ownership and definition of quality.

Ovretveit 1997: 221

The way people think about risk, error and clinical governance varies across specialities.

**Clinical Governance Co-ordinator
quoted in Currie et al 2007: 372**

Clinical nurses emphasized their belief that QI [quality improvement] focuses on issues related to management and is largely irrelevant to practice. Conversely, nurse managers reported a 'shortsightedness', lack of knowledge and negative attitude among clinical nurses towards QI.

Price et al. 2007: 49

Quality of care is not a static concept: it depends on such factors as whose perspective is taken, the timescale over which it is examined, and the purpose of any measures applied (Chin and Muramatsu 2003; Currie et al. 2005). Different healthcare professionals have different views on what constitutes quality or a good outcome of healthcare (for example, Degeling et al. 1998; Firth-Cozens 2001).

Indeed, getting diverse professional groups to reach a consensus on quality criteria was one of the factors that hampered the implementation of Total Quality Management (TQM) in NHS units in the early 1990s (Joss and Kogan 1995), and one which made TQM implementation more challenging in the NHS than in the private sector.

This difficulty persists despite the introduction of nationwide approaches to quality improvement, such as clinical governance, and has hindered its implementation at local level (Som 2009).

Medical staff may define quality patient care as care which leads to control or resolution of illness and improvement of function (Attree 2001; Degeling et al. 2001) and can tend to disregard patient satisfaction as a specific marker of quality care (Newman and Pyne 1996).

Nurses, in contrast, may place greater emphasis on achieving patient satisfaction, on meeting the patient's psychosocial and physical care needs, and on the relationship between patient and health professional, (Attree 2001; Degeling et al. 2001) viewing this holistic approach to care as a core value of nursing and a marker of quality in itself (McGregor et al. 2008).

Professional groups are not themselves homogeneous, and members of the same professional group may differ (for example, between specialties and between sectors; Sutherland and Dawson 1998; Ferguson and Lim 2001; Willcocks 2004; Currie and Suhomlinova 2006; Currie et al. 2008; Price et al. 2007; Lundqvist and Asa Axelsson 2007; Hamilton et al. 2007; Som 2009).

Indeed, individuals' views or definitions of quality may change over time, often reflecting changes to policy or local contextual focus on specific aspects of quality (Lundqvist and Asa Axelsson 2007).

A study of the National Reporting and Learning system in an operating department of a hospital in England found that views of the nature of an incident varied between staff groups.

In addition, an individual's interpretation of the seriousness of these in relation to patient safety could shift, which indicates that views and definitions can be influenced temporarily by the views of others (Currie et al. 2008).

Terms relating to quality improvement used in policy or at local level may become more familiar to staff, but this does not necessarily reflect either a shared understanding of these or a consensus on their use (Som 2009).

In addition, healthcare professionals do not necessarily use the same terminology of quality initiatives or approaches, or of 'quality experts' (Hudelson et al. 2008) or as it is defined in policy or other official documents (Som 2009). Staff adopt terms that are perceived as being 'in vogue' which can suggest consensus or shared understanding, but this is often lacking (Currie and Watterson 2007).

As well as the difficulties of reaching a shared definition of quality, there are a number of different facets to quality and the emphasis placed on these varies between professional groups.

So, while all staff in an organisation may agree that quality is important and needs to be improved, the specific approach to this or the focus of this varies (Som 2009). Performance measurement or assessment may be a greater focus for managers, while doctors may be more concerned with diagnostic and technical aspects of care provision as markers of quality:

You can see patient safety in terms of whether the appropriate diagnosis was made, whether an accurate assessment of the information was made, whether the appropriate treatment was given.

Doctor quoted in Currie et al. 2008: 374

Notions of professional power and its role in the identification of the need for quality improvement have also been recognised (Ovretveit 2009b). Lundqvist and Asa Axelsson (2007) in a study of nurses' views of quality assurance found that for nurses the marker of quality was patient and staff satisfaction with a healthcare encounter.

Despite this, widespread consultations undertaken by the Royal College of Nursing (RCN) in relation to new policy continue to reflect the persisting challenge of achieving consensus or a definition of quality that reflects all views (RCN 2008c,d), even within a single professional group.

In addition to these broad differences between health professional groups about the domains which they prioritise in thinking about quality (for example, patient satisfaction), the detail of what constitutes good practice also varies for different groups.

'Evidence' is contested and socially negotiated (for example, Dopson and Fitzgerald 2005; Ferlie et al. 2005). The processes by which evidence is accepted and incorporated into practice are complex and dependent on a range of factors including the source of the evidence and local pressure for change.

Thus what constitutes good practice is subject to social processes and filtering through professional networks and local hierarchies. How these networks operate differs between professions (West et al. 1999) and there is little diffusion between the professions (Dopson et al. 2002; Currie and Suhomlinova 2006). Indeed, if particular activities are associated with a particular profession, this may make other healthcare professionals reluctant to engage with them.

There is also recognition that the influence of doctors can (and does) impact on the way in which nurses define and engage with quality and safety (Attree 2007; Currie et al. 2008), often causing considerable concern about the tensions arising when reporting quality failings (Attree 2007) and concerns that this may impact negatively on the maintenance of a working relationship with medical staff (Currie et al. 2008).

The complexity of definitions is further confounded by the views of clinical and non-clinical managers. There is widespread recognition that the way in which managers define quality and the focus that they give to specific aspects of this varies considerably from those of clinical 'front-line' staff (for example, Price et al. 2007; Parker et al. 2009):

Nurse managers' and clinical nurses' understanding of the concept of quality improvement and how it applies to nursing differed. Each group identified that quality improvement can be beneficial to nursing practice, but blamed each other for potential benefits not being realised.

Price et al. 2007:43

Managers may be more likely to concentrate on the organisational and system, process or financial aspects of quality while clinicians may be more likely to take a patient-focused perspective in relation to consultations, adequate resources and workload and their impact on quality.

Parker et al. 2009

Medical managers and doctors are not necessarily any closer to shared definitions or understandings:

It's about looking at your systems and processes and all the information that you get and actually reviewing that, using complaints, risk management as lessons learned rather than... blaming people for things going wrong.

Directorate Manager quoted in Som 2009: 108

In the same organisation however, medical staff had a differing view:

[Clinical governance] is about trying ... to encourage me to remain fit to practice, to allow others to see that I am fit to practice, to encourage me to monitor my practice, to demonstrate to others that I monitor my practice, that I reflect on my practice.

Consultant anaesthetist cited in Som 2009: 108

In summary, different health professional groups do not define quality in the same way. Different professional groups largely inhabit separate hierarchies and networks with little inter-communication.

The processes of determining what constitutes good or quality practice within an individual profession are complex and sometimes divergent between different professional groups and can cause conflict in their working relationships.

A study of the clinical governance leads views on cultural attributes and quality found there was:

Greater convergence than divergence in the views and perspectives of key stakeholder groups around the particular cultural attributes that underpin high quality care...

Mannion et al. 2009: 1

However, while there may be agreement around defining the important cultural attributes of high quality care, there is still considerable divergence between stakeholders and between care providers in defining quality.

These differing definitions have been viewed by some authors as having an adverse impact on quality care (Currie et al. 2008; Som 2009) in terms of clinicians' willingness to become involved with, for example, clinical governance or patient safety initiatives.

Chapter 4

Improving quality of care

4.1 Do healthcare professionals think that the quality of care needs to be improved?

They're doing their best under very difficult circumstances and very limited resources and I think the patients are actually not getting a bad deal.

Consultant anaesthetist, quoted Powell 2006: 211

No one would disagree that quality care should be at the centre of health policy design...

RCN 2008a: 1

Improvement is desired by everyone.

Teasdale 2008: 3

Assessing whether clinicians feel that quality needs to be improved is challenging because of the numerous definitions of quality and the scope that these provide for individual interpretation. Nevertheless, the default belief among many clinicians (particularly doctors) seems to be that 'being a professional' is a near-automatic guarantee of quality care, and with sufficient resources and with mechanisms in place to weed out 'bad apples' (for example, via professional self-regulation), the professions will continue to provide quality care (Leatherman and Sutherland 1998):

Most of us believe that we've been practising evidence-based medicine all our lives.

Newman et al. 1998: 157

This may arise partly because healthcare professionals are assessing quality of care using unreliable measures (for example, absence of patient complaints) rather than by systematic assessments:

There was still the prevalent view that an absence of complaints [from patients, visitors and other users such as GPs] equalled high satisfaction.

Potter et al. 1994: 24

Additionally, the notion of professionalism (although recognised as written explicitly into codes of practice for doctors, nurses and midwives), can be seen as a means of justifying particular approaches to care and quality:

I don't work to protocols because I use my judgement all the time and that is what I have developed...I can't justify in black and white but I have an understanding of what I do and I think that's the difference between a nurse and a doctor.

Doctor quoted in Levenson et al. 2008: 19

Many doctors are concerned that their professionalism in relation to quality and safety had been questioned as the result of the Shipman Inquiry. It was not so much that it should not have questioned the specific circumstances that led to the Inquiry, but:

The mistake that then happened was to believe that Shipman represented a systemic failure across medicine.

London GP, quoted in Levenson et al. 2008: 26

Despite this, the majority of doctors widely regard their innate professionalism as the mark of quality and feel they are sufficiently held to account through this for their clinical performance (Levenson et al. 2008).

In contrast, nurses are often much more constrained by codes of conduct where quality is at issue:

They have a professional duty to do something. It's not a choice, they might have individual difficulty with it, but they have a professional obligation.

Nurse quoted in Attree 2007: 395

Individual clinicians may have difficulty in either identifying or accepting that their practice or healthcare organisation may be responsible for quality or safety failings (Ovretveit 2009b). Despite a widespread recognition of a general need to improve, clinicians have difficulty in moving from the general to the personal and often regard organisational issues or the practice of others to be behind poorer quality care.

A survey undertaken in primary care in 11 countries by the Commonwealth Fund found 51% of doctors felt that quality had improved, 37% felt that it has stayed the same and 18% felt it had worsened (Schoen et al. 2009). This suggests that despite the inclusion of quality in professional codes, ethics, practice and duties (Teasdale 2008), many clinicians, including nurses, feel there is still some way to go (Attree 2007; Davies and Goodman Cripacc 2008).

Local evidence is required to shift healthcare professionals' belief that current care is satisfactory. Evidence from the research literature and from national policy reports on deficiencies in a particular area of care is unlikely to provide sufficient stimulus for local change (Mannion and Goddard 2001; Powell 2006). Even when such local data are overwhelmingly critical, healthcare professionals may continue to assess the deficiencies in the current service as relatively minor.

Some nurses' concerns about quality have translated into action at local level in an attempt to address these (Stanley et al. 2008).

For example, some nurses have been active in trying to improve working across health and social care boundaries (Davies and Goodman Cripacc 2008) and have expressed concerns about care quality or safety issues.

However, these are unlikely to be openly expressed (Attree 2007) due to fears about repercussions for them or a perception that if concerns are expressed these might be mediated or 'downgraded' (in terms of the seriousness that they attach to them) by others, particularly doctors (Currie et al. 2008).

In summary, healthcare professionals may assert that high quality care is already being provided. Paradoxically, however, with a little prompting they are often capable of identifying important deficits in care that they believe need to be addressed (Attree 2007; Davies and Goodman Cripacc 2008).

Confusion around definitions of what constitutes quality and some of the initiatives that have been introduced to improve quality of care add to the complexity of unpicking whether, and to what extent, clinicians believe improvements are needed.

Chapter 5

Quality improvement initiatives

5.1 What are healthcare professionals' attitudes towards initiatives aimed at quality improvement?

Clinical governance leads reported that many GPs and nurses were at best ambivalent about clinical governance, and at worst suspicious, reluctant, apathetic or fearful.

Campbell et al. 2001b: 92

The results indicate that clinical governance creates more confusion, debate and disagreement on quality of care, making it a more contentious issue.

Som 2009: 98

Far more important than the requirement to participate in audit is the desire to want to for appropriate reasons.

HQIP 2009

As one consultant put it, 'it is a process that is not really wanted by most doctors.'

Som 2009: 109

Many healthcare professionals, and particularly doctors (Sewell 1997), are involved in local quality initiatives such as clinical audit. However, it is recognised that these can be used to promote clinicians' own agendas for improvement or development of additional services, rather than being shared with the aim of broader improvement (Neale et al. 2007).

Healthcare professionals are generally reluctant to get actively involved in broader initiatives aimed at quality improvement. These include organisation-wide programmes like total quality management (TQM) or continuous quality improvement (CQI) (Joss and Kogan 1995; Ovretveit 1996; Pollitt 1996; Jorm and Kam 2004; Powell et al. 2009a-i), in which the level of participation of UK doctors has been low (Gollop et al. 2004).

Many clinicians are detached from, ambivalent about, hostile towards, or confused about, the concept of 'clinical governance' (Roland et al. 2001; Wallace et al. 2001b; Campbell and Sweeney 2002; Campbell et al. 2002; Goodman 2002; Clinical Governance Support Team 2003; Sheaff et al. 2004; Konteh et al. 2008; Som 2009) introduced in 1997 with the stated aim of bringing together the many fragmented approaches to quality (National Audit Office 2003).

While it is now over 10 years since the introduction of Clinical Governance, the working out of this at local level and in different organisations is still a considerable challenge (Currie et al. 2008; Som 2009). Clinicians and managers have differing views on the role of the organisation and the individual in the overall framework and responsibility of either is often not clear to staff:

The way top-management look at clinical governance is different from the way a clinical director understands it, and frontline staff perceive clinical governance in a different manner again. There are also wide variations between departments in the understanding of clinical governance and its implementation.

Som 2009: 103

Despite clear efforts to involve staff, it is still largely viewed as a:

Management driven exercise that has little to do with clinicians at the ground level.

Singh 2009: 192

In addition, managers themselves recognise there are still significant organisational cultural factors that have to be overcome in relation to clinical governance (Konteh et al. 2008).

In the recent UK Engaging with Quality Initiative (EwQI), a Delphi survey of 97 clinicians showed the majority perceived clinician engagement with quality improvement as:

Fairly important or very important.

Ling et al. 2009: 206

However, they were less confident that the initiative had enabled this to take place and, although involved with the initiative, some were lukewarm in their appraisal of the extent to which it had engaged them with quality improvement rating it as either:

Neither unsuccessfully nor successfully. Or Fairly successfully.

Ling et al. 2009: 206

Respondents' views of the reasons for this illustrates that some believed that quality was already excellent, the sense that their engagement in the project had dwindled over time and their recognition of the substantial challenges and hard work involved.

Healthcare professionals' attitudes towards initiatives aimed at quality improvement can be broadly divided into two categories: beliefs that the initiatives will have no or limited effects on quality; and beliefs that the initiatives will have a range of adverse effects on patient care and professional work. Of those who view such initiatives as ineffectual, some healthcare professionals are sceptical about the inappropriate application of what they see as 'management fads' like TQM and CQI to healthcare (Potter et al. 1994; Pollitt 1996; Locock 2003) and are disparaging about the standard of training programmes in quality methods provided to doctors (Ovretveit 1996):

The managerial accent of [such] approaches is anathema to many healthcare professionals for whom the terms these approaches use are jargon and subjugate professional autonomy.

Buetow and Roland 1999: 188

Many clinicians believe that each 'fad' will soon pass and will be replaced by another, and so there is little point in investing heavily in any one initiative (Goodman 2002; Gollop et al. 2004).

The particular initiative may be less the focus of this scepticism than the ways in which they are introduced or applied in organisations. While many share core principles or approaches (for example BPR; Lean and Six Sigma, Powell et al. 2009a-i; Walshe 2009), there is also a recognition that the way these are presented often suggests they are quite different and that:

The repeated redesign of QI improvement programmes may have damaged or limited their effectiveness in many healthcare organisations.

Walshe 2009: 153

Healthcare professionals are often sceptical that quality initiatives, such as audit, will lead to any changes in practice or improvements in quality (Reeve 1997; Leatherman and Sutherland 1998; Buetow and Roland 1999; Johnston et al. 2000):

Audit is frequently regarded by individual professionals as an expensive addition to clinical practice rather than an intrinsic and effective part of it. They apply it periodically and perceive it to be tedious, compromising to routine clinical practice, lacking in strategic orientation, and too time consuming to be operationally useful.

Buetow and Roland 1999: 187

Some healthcare professionals believe quality initiatives may have some benefit in some settings but that these benefits will not be realised locally because of particular constraints (for example, inadequate resources, poor relationships between team members, hierarchical working; Dean et al. 2004; Johnston et al. 2000). Concerns may vary between professional groups. In one study in primary care, GPs and administrative staff expressed concerns about understanding of and involvement in quality initiatives, while nurses and allied health professionals expressed more concerns about the impact of poor teamwork (Dean et al. 2004).

The Quality and Outcomes Framework (QOF) is an example of a national initiative aimed at quality improvement. Doctors working in primary care are, by default, involved with QOF. Its introduction to the general medical services contract in 2004 has been the focus of much of the recent literature, both within the UK and elsewhere. Clinicians are often divided on many aspects of the introduction of such explicit financial incentives for care. In the time that elapsed between the introduction of QOF and the emergence of findings from empirical research, there was a plethora of commentaries, letters and analysis papers expressing strong views. More recently, empirical studies have shown that job satisfaction has improved overall due to shorter working hours and better salaries (Whalley et al. 2008). At the outset, some GPs were concerned that QOF would have negative impacts on workload and professional autonomy. A postal survey of GPs in England found that:

The perceived gains in quality of preventative care and the care of chronic diseases exceeded their expectations and the potential negative effects on acute illness were less than anticipated.

Whalley et al. 2008: 12

In addition, a detailed ethnographic study (McDonald et al. 2007) of staff in two (different to the previous study) practices in England found that GPs were positive about QOF and did not feel that it had diminished their motivation or professional autonomy.

Despite this research, some doubts remain about whether the QOF has led to better quality care (Ashworth et al. 2007; Steel et al. 2007; McGregor et al. 2008). Concerns about continuity of care (Lester and Roland 2007), disadvantaging patients living in more socially deprived areas (Ashworth et al. 2007), poorer quality of care for patients with non-incentivised conditions (Steel et al. 2007) and changes to nursing workload or perceptions of increased surveillance of individual's practice (McDonald et al. 2007; McGregor et al. 2008) remain for many.

Studies from the UK and beyond also demonstrate that the link between financial incentives and engagement in quality improvement is not straightforward.

Quality of care improves for patients with incentivised conditions, leaving those with non-incentivised illnesses or conditions receiving poorer care in a review of outcomes from QOF (Steel et al. 2008).

Other concerns relating to quality improvement initiatives include the substantial additional workload involved in many initiatives and the diversion of effort, time and resources from direct patient care (Newman and Pyne 1996; Johnston et al. 2000; Renshaw and Ireland 2003; Dean et al. 2004; Degeling et al. 2004; Roberts et al. 2004; RCN 2009a).

For example, senior clinicians and managers involved in clinical governance external reviews commented on the heavy burden of preparing for the visit of the review team (Walshe et al. 2001; Benson et al. 2006). Many felt the workload was not matched by the benefits, since the reviews rarely generated new knowledge about quality problems, although they did raise awareness and provide some stimulus to action (Walshe et al. 2001; Benson et al. 2006).

Some healthcare professionals are concerned that national programmes that focus on particular services (for example, cancer services) are inappropriate and inequitable in diverting attention and resources away from other clinical areas (Gollop et al. 2004).

Payment by results has been perceived by clinicians as shifting the focus away from quality to increased throughput of patients which not only puts increased pressure on consultant time (Freeman 2009) but may also lead to poorer quality care overall (RCN 2009a).

Doctors in particular may be suspicious of the underlying motives behind quality initiatives, seeing them as:

A management Trojan horse... a strategy in disguise for cutting costs.

Ovretveit 1996: 24

Some initiatives aimed at improving quality leach time and goodwill from other organisational activities, often with little benefit to show for it (Powell et al 2009a). Doctors are suspicious of what they perceive as managerial control over professional work (Levenson et al. 2008). They may fear loss of autonomy, power, status and income if they become team players in redesigned organisations (Jorm and Kam 2004). They believe quality initiatives like audit increase governmental and managerial control over doctors (Ovretveit 1996; Johnston et al. 2000; Degeling and Maxwell 2004; Sheaff et al. 2004), restrict clinical freedom and inhibit their ability to provide optimum care for patients (Johnston et al. 2000). For many doctors, quality improvement initiatives are seen as a means of cost cutting:

Frontline staff members were not interested in discussing business issues (for example, cost effectiveness and cost savings) [they were] interested in whether a program was of practical value (improves care).

Parker et al. 2009

For many doctors, professional identity is bound up with autonomy, the ability to exercise discretion and to act as advocate for an individual patient. Quality initiatives that appear to be about standardising practice and imposing a 'one size fits all' model are therefore resisted.

Some clinicians fear that intimidation and denigration of individual practitioners may result from quality activities, and fear that such initiatives may increase discord between professionals (Johnston et al. 2000). Some medical managers are uneasy about their remit and the extent to which they are responsible for quality, particularly if they view quality as largely:

Determined by the personal competence of other professions and doctors, rather than by the way care is organised.

Ovretveit 1996: 23

They are unsure as to whether they have or should have authority over other professionals and are concerned that fellow professionals may view them as having 'sold out' by taking up a managerial role (Ovretveit 1996; Degeling et al. 1998; Iedema et al. 2003; Forbes et al. 2004; Forbes and Hallier 2006).

Fears about the motives behind quality initiatives are shared by other professionals: AHPs (particularly more junior staff) have expressed concerns that audit means 'checking up' on their practice, with the longer-term aim of service reorganisation, reducing professional autonomy and cutting jobs (Johnston et al. 2000).

In summary, although some studies (for example, Roberts et al. 2004; Ling et al. 2009) show healthcare professionals may respond positively to involvement in certain quality initiatives, overall, healthcare professionals are reluctant to engage. In part this is because they perceive certain initiatives as ineffective and a waste of resources.

In addition, healthcare professionals may be concerned about a range of harmful effects that may result from quality initiatives. The level of engagement with QOF (which is a mandatory initiative for GPs) cannot be seen as indicative of wider involvement in other quality improvement initiatives.

Chapter 6

Understanding quality improvement

6.1 Do healthcare professionals have a clear understanding of the concepts and methods of quality improvement?

Improvement in the quality of healthcare is desired by everyone. Delivering this however, is hindered by lack of clear, widely embraced perceptions of what is encompassed within quality and how improvement can be brought about.

Teasdale 2008: 3

Clinicians who are asked to participate in quality improvement programmes in healthcare organisations are often heard to ask for the evidence that they ‘work’. By that, they often mean they want randomized controlled trials... this point of view needs to be challenged. It is founded on a fundamental misunderstanding of the place of experimental methods in investigating and understanding complex social interventions.

Walshe 2009: 157

Understanding and awareness of current concepts and methods of quality improvement are limited among healthcare professionals (Rogers 2001):

Many doctors do not recognise the difference between the traditional and newer quality methods, or know about the measured improvements to clinical quality which these methods have achieved.

Ovretveit 1996: 21

Many clinicians have a limited understanding of such key concepts in quality improvement as the notion of other staff within the trust or practice as internal ‘customers’, or the interdependence of departments and processes throughout the organisation (Potter et al. 1994):

There was a low appreciation of the fact that every organisational member is someone else’s ‘client’ and there was a general lack of interest on the part of staff with whom we worked to find out what users of their services really wanted... there was however no shortage of complaints about the service received from other departments.

Potter et al. 1994: 24

Many clinicians appear to have limited interest in looking beyond their immediate department. Many had limited or no awareness of how similar services are run elsewhere (Potter et al. 1994). Similarly, although there are exceptions in some organisations (Sewell 1997), awareness of national quality initiatives or understanding of how these might be integrated into local strategies is often limited (Curley et al. 2002).

Although it might be expected that healthcare professionals would by now be familiar with concepts like clinical governance (Trueland 2002; Clinical Governance Support Team 2003; Murray et al. 2004), these have still taken a considerable time to take hold in organisations and to ‘make sense’ to individuals (Som 2009), although some staff, as a result of their particular role in relation to clinical governance, are beginning to get to grips with the wider concepts involved (Konteh et al. 2008).

Even those healthcare professionals (for example, clinical governance leads) who have a direct role in managing the implementation of quality initiatives in their organisation may lack knowledge and skills in current methods of quality improvement.

Many clinical governance leads are optimistic that clinical governance will have a positive impact on patient outcomes and on relationships between managers and clinicians but do not specify any mechanism or intervention through which these desirable goals will be achieved (Wallace et al. 2001a).

Instead of developing more systemic and trust-wide approaches, they may continue to use historical voluntary 'opt-in' approaches (for example, educational programmes and protocols and guidelines) to influence clinician behaviour even when they recognise that these methods are ineffective (Wallace et al. 2001a; Wallace et al. 2004):

Trusts seem to have been backing approaches that rely upon clinicians acquiring best practice through multiple optional means, and expecting organisation wide change to occur through some unspecified diffusion process.

Wallace et al. 2001a: 82

Understanding is limited even in relation to older initiatives like audit (Curley et al. 2002). Thus many projects labelled as audit emphasise only the first part of the audit cycle (i.e. identification of deficiencies) and the full audit cycle of setting standards, implementing changes and quantifying subsequent improvements in care is never completed (Hearnshaw et al. 1998a; McLeod 2002; Renshaw and Ireland 2003). This may reflect a broader tendency to use quality approaches and terms loosely:

The hospitals studied used a variety of methods and systems to assure and improve quality, but there was little awareness of, or emphasis on, a disciplined scientific approach to quality improvement in the sense of running small scale experiments... It appeared that any activity could be renamed a quality project, and could then be eligible for resources.

Ovretveit 1997: 227

This lack of deeper understanding of quality improvement remains a hindrance (Ovretveit 2009b). Even in organisations where priority had been given to the implementation of specific initiatives for quality improvement, staff were often unaware of them or did not consider them to be important (Hudelson et al. 2008).

Overall, clinicians and managers seem to have a limited understanding of the latest concepts and methods underlying quality improvement, and many show relatively little interest in learning about them.

The increased focus on patient safety has increased the number of quality improvement initiatives and may have further complicated an already complex landscape for managers and clinicians, particularly given the difficulties arising from lack of clear or agreed definitions and the pseudo-innovation of improvement methodologies (Walshe 2009).

Greater knowledge of organisational cultures and professional relationships (which could aid understanding or inform thinking about quality improvement) while adding to academic knowledge of the ways in which clinicians perceive quality concepts and methods, does not necessarily indicate greater or clearer clinician understanding of the detail of these (Currie et al. 2008; Konteh et al. 2008; Ovretveit, 2009a; Som 2009).

Chapter 7

Taking responsibility

7.1 Where do healthcare professionals think that responsibility for quality improvement should lie?

Clinical governance is everyone's business.

Maddock et al. 2006: 198

Improving the quality and safety of care is of critical importance to all who work in healthcare.

Thomson and Moss 2008: i12

Clinicians regard themselves as being the guardians of professional standards and best clinical practice... One director of finance had a very different view: 'managers are the rational level-headed engine of the health service ensuring that there are sufficient resources to keep health services operating... clinicians are not necessarily good managers, because I think they are needs-led not resource-led. They tell us what people should have, but not how to get the resources for that.'

Guyen-Uslu 2006: 98

There has been a discernible change to the ways that responsibility for quality is discussed in recent literature, with greater emphasis on the healthcare system or organisation rather than the individual clinician.

However, healthcare professionals generally believe that responsibility for defining and regulating healthcare quality should rest with clinicians (Buetow and Roland 1999; Hurst 2003).

Clinicians believe that assessment of the quality of care is a clinical issue and is only acceptable if it is done by peers from the same profession.

Thus the credibility of external assessors and the likelihood that their recommendations will be accepted hinge on their proximity to the profession they are assessing (Exworthy et al. 2003).

Similarly, leadership by members of their own profession is key to clinicians' engagement with quality initiatives:

While engaging doctors in leadership may be important in its own right, it is usually seen as a means to improving the quality of health care.

NHS Institute for Improvement and Innovation and The Academy of Royal Colleges: 2008: 13

This has not necessarily been trouble-free however (NHS Institute for Improvement and Innovation and The Academy of Royal Colleges 2008; Levenson et al. 2008).

For example, many GPs perceive that understanding of, interest in, and confidence in medical audit was increased by the development of medically-led audit advisory groups (Hearnshaw et al. 1998a) and the relative success of NCEPOD has been attributed to the fact that clinicians perceive it as professionally-led (Simpson 2004).¹

The dominant position of the medical profession among the health professions (Thorne 2001; Brown and Crawford 2003; Currie and Suhomlinova 2006) means that in practice 'professionally-led' is often a euphemism for 'medically-led'.

¹National Confidential Enquiry into Patient Outcome and Death. (<http://www.ncepod.org.uk/>).

Medicine remains an occupation with legislative and ideological backing for its claimed mandate to define ... what constitutes knowledge and expertise in clinical work performance.

Degeling and Maxwell 2004: 121

Other healthcare professionals such as nurses believe they have the ability and responsibility to define clinical quality, and resent being marginalised when new initiatives are discussed (for example, Newton et al. 2003). 'Turf battles' around quality between clinicians from different professions are common (McNulty 2003).

The continued dominance of the medical profession over nursing has an ongoing impact on the way responsibility for quality is viewed. The introduction of the modern matron, a role seen as having specific responsibilities for improving quality, may not have been the solution either promised or hoped for. A detailed study of their role in one English NHS Trust demonstrates that professional hierarchies may limit their jurisdiction over doctors and nurses:

We recently had a report where management carried out a check audit on one of my areas. They split the results down into nurses, professions allied to medicine and doctors. Doctors' hand-washing was absolutely terrible, terrible, terrible. But there was nobody really that would take that on.

Modern Matron quoted in Currie et al. 2009: 305

Evaluation of similar roles introduced in the US have shown that there is positive acceptance of the role from other professions and it is seen as having significant potential for nurses to take a lead in improving quality and safety (Stanley et al. 2008).

It is a role that separates quality from overall care and therefore may appear to absolve other staff from the responsibility of engaging with this, which may explain its positive reception.

The clinical nurse leader has some parallels with the UK's modern matron, although this role carries with it the responsibility to report directly to the Care Quality Commission (RCN 2009d).

In addition to the introduction of the modern matron, the review of the role of charge nurses in both Scotland and England has placed much greater emphasis on the leadership qualities of charge nurses as an important aspect of quality improvement (The Scottish Government 2008; RCN 2009c).

While nurses recognise their own responsibility for providing quality care, several studies have shown that this causes confusion and conflict for them when they are required to act in relation to quality shortfalls (Attree, 2007; Price et al. 2007; Currie et al. 2008).

In a detailed case study in acute care, nurses were not only seen to differ from doctors about the definition of 'near misses', but also deferred to them before submitting incident reports, to ensure that they agreed with the way in which the nurse had described the incident (Currie et al. 2008).

The latter was also a means of gaining support from the medical staff and of siding with doctors against management, thus presenting a united front from the practice perspective.

Managers and doctors often clash over quality:

Quality has been used as a weapon in the fight against limits to healthcare funding. In one corner of the ring stands the clinician, outraged that a paper pushing manager concerned with throughputs and efficiency does not understand or care that quality of care is adversely affected by cost cutting. In the other corner stands the manager, convinced that quality is the last refuge of the medical scoundrel – a convenient, vague, and all embracing term used to block any attempts to question or change clinical behaviour.

Buchan 1998: S62

A lack of trust between doctors and managers persists that appears to be deeply rooted in their respective cultures continues to create difficulties in progressing the patient safety agenda (Currie et al. 2008).

A recent study of patient safety in one acute healthcare trust revealed, risk managers (without a clinical background) were unable to understand the technical detail on 'near-miss' incident reports and saw this as attempts by clinicians to confound the managers' efforts to investigate. In response, managers:

Appeared to collude and unite against some of the clinical staff when talking about reported incidents, suggesting that information had been withheld on purpose.

Currie et al. 2008: 375

Clinicians often believe that the responsibility for providing resources for quality improvement lies with managers, but this can also be seen by clinicians as an unhelpful focus on finance and the administrative aspects to the detriment of care (Price et al. 2007). The role of managers as 'judges' of clinical quality is repeatedly called into question by clinicians (Currie et al. 2008, because they are not considered to have the knowledge to enable them to fulfil this role.

There is much debate in the literature about whether managers or doctors have 'won' in the contest for power and dominance at different times of NHS change and development, and about whether the traditional tensions between doctors and managers are now easing (for example, Young 1997; Sutherland and Dawson 1998; Thorne 2002; Davies and Harrison 2003; Davies et al. 2003; Edwards 2003; Crilly and Le Grand 2004; Degeling et al. 2006; Fitzgerald et al. 2006; Sheps 2006). One reviewer commented:

While at a collective level it is useful to continue to think of doctors and managers as adversarial superpowers, the micro-level reality is more complex and reveals some fascinating compromises, alliances and innovations.

McKee et al. 1999: 90

However, there is also evidence that relationships on the ground between doctors and managers continue to reflect traditional tensions:

Management here plays a modest facilitative role rather than a directive function and has, by itself, little power to impose radical change in respect of practices involved in the actual organization and delivery of care.

McNulty 2003: S34

Managers have expressed frustration about the degree to which initiatives are medically-led, in that if doctors do not support an initiative (or particular changes proposed under an initiative), it is likely to fail (Hearnshaw et al. 1998b).

Some managers have resolved this tactically by bypassing doctors and working instead with more amenable members of the practice team like practice managers and nurses when implementing quality initiatives (Marshall 1999).

Although healthcare professionals usually believe that clinical quality is a professional issue that should remain under their overall control, this does not mean individual healthcare professionals necessarily see quality or quality improvement as the responsibility of all professionals.

The tendency towards 'silo-based' working in large and complex organisations like hospitals is well recognised (Mintzberg 1979; Pollitt 1996; Ham et al. 2003, McNulty 2003). In relation to quality issues, there is a tendency for healthcare professionals to rely on the designated team or lead individual for a particular issue (for example, infection control, clinical governance, pain management) to carry that role for the whole organisation (Mytton and Adams 2003; Jack et al. 2004; Powell 2006; Stanley et al. 2008; Currie et al. 2009).

Thus quality in relation to specific aspects of care like pain management or infection control is seen not as a shared responsibility but as the responsibility of the designated individual or team:

When you do offer a service, you kind of get dumped on you know. So it's like, 'Oh, this patient's got pain, we don't need to think about it, we'll get the acute pain team to come and sort it out.

Anaesthetist, quoted in Powell 2006: 213

The efforts made by specialist teams to improve good practice throughout an organisation (for example, by leadership, providing up-to-date guidelines, training and strategic direction) may be frustrated by the very existence of a dedicated or specialist team. This may arise from a range of factors including resentment of colleagues who have been promoted to specialist posts (Sieloff 2004; Powell 2006), local deskilling, or concerns about lack of competence:

I think a lot of nurses nowadays think, “well I can’t do that because there’s a specialist who’ll know more.”

Specialist nurse, quoted in Powell 2006: 259

It is not yet possible to draw firm conclusions from the existing literature on specialist teams about the extent of adverse effects of specialist teams on the work of other healthcare professionals, but it is clear that some healthcare professionals respond to increasing specialisation in ways that reduce their engagement in quality improvement.

The role of the patient in having a responsibility for care quality is a developing theme in the literature and reflects both recent policy on quality (DH 2008a) and on engaging patients to a greater extent in all aspects of their care (Entwistle 2006). In primary care, GPs are required (by QOF) to undertake patient surveys to:

Stimulate improvements in the quality of care.

Reeves and Seccombe 2008: 437

While ethical concerns and issues of the propriety of giving this responsibility to patients remain (Entwistle 2006), empirical work undertaken to explore the willingness of patients to question clinicians about quality or safety aspects of their care, shows that their level of comfort in asking nurses or doctors varies and this is not yet a strategy with which all patients are able to engage (Davis et al. 2009). Despite this, patient organisations such as the Patients Association are involved in providing views on quality and increasingly in a representative role in consultations relating to the development of policy or the implementation of quality initiatives (The King’s Fund 2009b).

This involvement of patients in aspects of quality and safety appears to be welcomed by clinicians, some seeing this as merely a more explicit form of an approach to care that they have long since taken. There is also recognition that the nature of the relationship between the doctor and patient is changing as patients become better informed:

My grandparents would never question a doctor, whereas we go to the doctor now and if we want further information we just go and get it.

Medical student quoted in Levenson et al. 2008: 16

However, just as the positive language used in policy about quality may make it difficult for clinicians to openly express views, the explicit involvement of patients in care provision detailed in policy may make it difficult to express views counter to this orthodoxy.

Nonetheless, some clinicians have expressed general concerns about some aspects of this involvement, particularly in relation to the specific aspects of care to which patients will give precedence; patients’ ability to ‘make sense’ of the huge amounts of information available to them and how relevant they will consider this information to be in making choices about their care (Kmietowicz 2009); and the potential for inequities (such as socioeconomic deprivation or educational level) to disadvantage some patients. So while the overall concept is largely accepted, some specific concerns remain.

In summary, quality improvement is often the scene of ‘turf battles’ between different professionals. Nevertheless, many healthcare professionals will readily devolve responsibility for quality-related issues (such as pain management, or infection control) to a designated individual or team if a ready candidate exists.

The dominance of the medical profession poses problems for nurses in engaging more fully in some aspects of reporting quality failures and even senior nurses may be disempowered in taking action to improve quality when strategies require either the agreement or support of doctors.

Quality improvement is also the subject of conflict between doctors and managers. Doctors think that responsibility for defining and assessing healthcare quality should rest with the medical profession rather than with managers, and quality improvement initiatives that appear to erode this fundamental tenet and to give what is seen as undue power to others (for example, managers or non-clinical assessors) are often vigorously resisted.

Managers may struggle to implement quality improvement initiatives against the sometimes entrenched attitudes and at times intransigence of clinicians (Hoque et al. 2004; Currie et al. 2008) and may have to devise strategies to circumvent such opposition.

Chapter 8

Routes to quality

8.1 What do healthcare professionals think about clinical guidelines and 'evidence-based practice' (EBP) as routes to quality?

Managers and policy-makers have been keen to develop more systematised approaches to clinical work and increase the degree of standardisation and uniformity between practitioners, with the aim of increasing efficiency and performance (Davies and Harrison 2003; Degeling et al. 2001; Degeling et al. 2003). However, clinicians, especially doctors, are relatively less enthusiastic about moves towards greater codification and transparency of clinical practice (Degeling et al. 2001; Degeling et al. 2003; McNulty 2003), and clinicians' attitudes towards clinical guidelines provide one illustration of this difference.

There is a wealth of evidence that demonstrates limited awareness, limited support and limited use of clinical guidelines by clinicians (for example, Blendon et al. 2001; Foy et al. 2001; Lane et al. 2001; Michie and Johnston 2004; Richens et al. 2004; Grol and Buchan 2006). However, this is not uniform across all professional groups and, where guidelines do exist and are known about, there are differences in attitude between professional groups.

For example, a study of surgeons, anaesthetists and nurses (McDonald et al. 2005) found that the doctors' views about clinical guidelines in relation to patient safety differed from nurses' views, suggesting deeply ingrained divergent beliefs about what constituted professional conduct.

The doctors rejected written rules and instead adhered to their own (unwritten) codes of practice. To the nurses, following the guidelines was synonymous with professionalism and they criticised the doctors for not complying.

Differences have also been found between GPs, with younger GPs and those with the Royal College of GP membership exam more likely to express positive views about guidelines (Siriwardena 1995).

Evidence-based practice and in particular 'evidence-based medicine' attract prolonged and intensive debate in the literature (for example, Miles et al. 2003; Holmes et al. 2006).

For many healthcare professionals, 'evidence-based practice' (EBP) is not synonymous with quality care. They believe that healthcare professionals can provide quality care without being signed up to EBP in the technical sense and that over-emphasis on evidence-based practice may actually inhibit rather than enhance their ability to provide quality care to individual patients (Ferlie et al 1999; Freeman and Sweeney 2001; Cohen et al. 2004).

Some healthcare professionals endorse the idea of EBP in principle, and believe that it improves patient care, but do not take this forward (for example, by reading research papers and applying them to their own practice; McColl et al. 1998).

A large proportion (39%) of GP principal respondents in one study stated they had no personal interest in research (Robinson and Gould 2000). While few respondents felt that primary care research was unimportant, one-third reported that they were not using research directly to influence their clinical practice.

Another study found that awareness, use and perceived impact of evidence-based guidelines was much greater at health authority level among those directing policy than it was among practising consultants and GPs (Coleman and Nicholl 2001).

Concerns about EBP are centred around three of the following main areas.

First, there is the problem of the nature of evidence that is often perceived as excluding tacit and experiential knowledge which clinicians value in diagnosing and treating individual patients (Ferlie et al. 1999; Rycroft-Malone et al. 2002).

Second, doctors and nurses have expressed concerns about the role of EBP, or it is viewed as a means of imposing cost savings and restricting practices rather than allowing them to consider the needs of each patient as an individual.

Third, there have been widespread concerns that clinicians have neither the time nor the skills to access and appraise the growing amount of evidence that is becoming available.

There is a recognition that EBP requires technical, information management and interpersonal skills that nurses and AHPs, more so than doctors, are perceived as lacking (Newman et al. 1998; Stevenson et al. 2004). An evaluation of a quality improvement initiative introduced in NHS Scotland (Wilkinson et al. 2009) demonstrated that nurses and midwives experienced a perceived or actual lack of IT skills which limited their access to online resources for EBP.

While some of these issues may be less prominent than before, EBP leaves a remnant of controversy, with enthusiastic supporters and vociferous detractors.

Many clinicians view EBP as only one tool amongst many for improving quality and others believe it impedes professionalism and the ability to provide individualised, holistic patient care.

While many of the beliefs held by clinicians about guidelines and EBP may be deeply entrenched, more recently there is a declining focus in the literature on guidelines and EBP.

The incorporation of evidence into other quality initiatives or programmes, such as QOF, means that evidence-based guidelines are being used, but perhaps without clinicians' explicit knowledge of the provenance of some of that evidence.

Recent empirical work on clinicians attitudes to evidence or guidelines in the UK is scarce.

A study from Canada (Brouwers et al. 2009) of clinicians' intentions to use guidelines has shown it is conducive to present guidelines as part of the narrative on quality, rather than focusing on the evidence or objective properties of the guidelines. Even clinicians' negative attitudes to specific guidelines (or the evidence contained therein) did improve over time. The authors also recognise this may be the result of greater incorporation of guidelines into the wider organisation or increased general acceptance of guidelines and evidence overall. Those clinicians who showed the least favourable beliefs and attitudes made the biggest gains over time in terms of use of guidelines and evidence. The authors suggest this should encourage those with a role in engaging clinicians to persist in their efforts, rather than disregard staff who are initially less keen.

In summary, although managers support greater systematisation of clinical work through the use of such tools as clinical guidelines, the majority of clinicians do not always regard these guidelines and related initiatives as useful tools in providing quality care. Clinicians may even resist them because they are perceived as hampering clinical freedom and impeding local practice. These perceptions and attitudes may be subtly changing over time, reflecting the greater integration of guidelines and EBP into organisations and quality initiatives or programmes.

Chapter 9

Measuring quality

9.1 What are healthcare professionals' attitudes to the measurement of healthcare quality for quality improvement purposes?

While most people are in favour of measurement, few are comfortable being measured.

Loeb 2004: i6

The NHS has yet to harness the power of data... Many in the NHS often view data with indifference or as a necessary evil... not as a useful tool to improve quality of care for patients within the local context.

Leatherman and Sutherland 2003: 179

Monitoring health care quality is impossible without the use of quality indicators. They create the basis for accountability, quality improvement, prioritization and transparency in the health care system.

Mainz 2004: i1

The literature distinguishes between two main uses of measures of healthcare quality (often referred to by the generic term 'indicators'): measurement for insight and learning in internal quality improvement (by identifying possible areas of good and poor practice) and measurement for judgement in external accountability systems (Solberg et al. 1997; Freeman 2002; Pringle et al. 2002; Mannion and Goddard 2003; Thomson et al. 2004).

In this section, we examine attitudes of healthcare professionals, including the use of indicators for developmental purposes, to inform learning in quality improvement. In the next section, we will consider healthcare professionals' attitudes to making such data public and using the information to make judgements in external accountability systems.

With an increasing focus on the use of measures of quality, greater awareness of the meaning of these emerges, although this is not always trouble free in terms of demonstrating or understanding quality improvement:

Bizarrely it looks as if we're having many more ... clinical incidents or non-clinical incidents, I think the reality is that actually our reporting regimes are so much better.

Executive Director quoted in Som 2009: 108

The recognition of this 'J' shaped curve, where performance can dip before improvements occur, is an aspect of the increasing focus and awareness of quality and its measurement (Ham 2009).

Other studies suggest healthcare professionals have limited awareness of, and interest in, comparative indicators:

I know that most of the clinicians do not use comparative data and do not know anything about coding of clinical procedures.

Consultant, quoted in Guven-Uslu 2006: 99

Performance data may have enough credibility to prompt individuals across the professional groups to reflect on their own practice (Wilkinson et al. 2000) but GPs are unlikely to suggest using them to identify and address inequalities between practices (Wilkinson et al. 2000).

Moreover, strongly-held prior beliefs about safe practice are resistant to change even when detailed and credible data are presented (Parry and Tucker 2004).

For comparative data to evoke any interest on the part of clinicians they need to be appropriate, timely and close to the practice of the individual clinician (Wilkinson et al. 2000; Pringle et al. 2002; Davies 2005; Royal College of Physicians 2006).

For example, individual healthcare professionals are more interested in comparing themselves to others in the same discipline (Smith 2002).

Low levels of engagement with comparative indicators have also been seen among healthcare professionals in the independent sector:

Knowledge and understanding of indicators and their use varied widely across the [independent] sector... not all of the sector is yet convinced of the value of the project.

Thomson et al. 2004: i55-i56

Attitudes towards comparative indicators vary between professional groups and between individual practitioners as a result of the following factors: knowledge and understanding, practice issues, and perceptions about the purposes to which the indicators will or may be put:

[There were] differences in meanings, relevance and importance attached to performance indicators across professional groups.

Wilkinson et al. 2000: 173

However, in addition to complaints about the burden of data collection (Harvey 2004), healthcare professionals' attitudes to indicators surround the following five main concerns:

- the measures themselves are flawed (Harvey 2004; Steel et al. 2008)
- the local data are inaccurate (Mannion and Goddard 2003; RCN 2009b)

- the measures are difficult to understand and interpret (Marshall et al. 2004) or provide an unhelpful focus on financial or numerical targets as they are easier to understand (Teasdale 2008)
- the data or indicators do not capture or reflect the complexity of care delivery (for example, Ashworth et al. 2007; Hankins et al. 2007)
- the data will be misused (Leatherman and Sutherland 2003).

In addition, specifically in relation to the introduction of QOF, there are widespread concerns that data arising from patient surveys are both limited in their usefulness and do not adequately demonstrate quality since some aspects relate to patients' subjective experience (Steel et al. 2008; Teasdale 2008; Roland et al. 2009).

With a greater recognition of the complexity of measurement and the problems (perceived or real) of developing indicators and making sense of the data provided, there are ongoing concerns raised in the literature from doctors and nurses, that the easily measured and recorded data will take precedence over the aspects of quality which are difficult to measure but may actually be the more important aspects (Currie and Watterson 2007; Teasdale 2008; RCN 2009b).

Meanwhile QOF is like a large cuckoo in our nest. It is certainly time consuming and must tend to squeeze out the care of individuals whose needs don't 'tick the boxes'. The risk of the measurable crowding out the valuable is real.

Freeman 2009: 484

In summary, clinicians have strong and diverse concerns about the measurement of healthcare quality, even when these indicators are only being used for internal quality improvement purposes. Indicators are often perceived to be flawed, based on inaccurate data and difficult to interpret. There are fears that the data will be used for managerial and cost-cutting purposes that may impose significant constraints and control on healthcare professionals. Clinicians are also concerned that the use of patient experiences of measures of quality will draw attention to aspects of service organisation rather than focus on clinical care.

9.2 What are healthcare professionals' attitudes to measures of quality being made public and used for external judgement and accountability?

The increasing emphasis on both regulation of healthcare and the need to make outcomes explicit has sharpened the focus on measurement for judgement and accountability. While there is a paucity of empirical data relating to professionals' attitudes to this, there is no scarcity of views expressed in the literature through commentaries, editorials and analysis papers.

As a result, these form the main sources for this section. The debate on the accessibility of data for accountability and judgement in the public domain has been to some extent superseded by the Freedom of Information Act (2000) but nonetheless the specific concerns expressed by healthcare professionals may be more focused now on different aspects of the information, rather than on whether or not this should be made public.

Concerns expressed by cardiac surgeons in the UK regarding the format of performance data for public release, specifically that it might lead to the practice of defensive medicine thus disadvantaging patients with high risk conditions (Bridgewater et al. 2003), have not been borne out from empirical work (Bridgewater et al. 2007).

Overall, healthcare professionals' attitudes to measures of healthcare quality being made public and used for external judgement and accountability purposes are an amplified form of the concerns described previously, with some additional features. For example, concerns that indicators are flawed and do not reflect the care provided, that they are based on inaccurate data, and that the data will be misused for political ends become more pressing when the results will be made public:

Something that's measurable may not be worth measuring, and maybe you can't measure the things that are worth measuring. What damage do you do by releasing information just because you can measure it?

GP, quoted in Marshall et al. 2002a: 1280

This is a particular concern for nurses. Although the development of specific metrics for nursing is now underway and in use in NHS Scotland (The Scottish Government 2008), concerns remain about how this information can be, and is, measured and how meaningful it is in relation to overall quality of care:

More needs to be done to develop quality measures more sensitive to interventions by the whole nursing family. Current outcome measures still focus very much on medical interventions and omit the essential contribution of nurses and other members of the MDT.

RCN 2008d:4

Where there has been a recognition of this in policy or national reviews (DH 2008a,b) the detail is often lacking.

Concerns persist about the format of data or the ways in which it is presented, particularly in relation to composite or aggregated data (Guthrie 2008).

As 'Quality Reports' emerge (DH 2009b) with their focus on safety, effectiveness and patient experience, there are widespread concerns about the aggregation of data, about composite data being presented under a single category such as 'good, fair, poor or excellent' (O'Dowd 2009) and about publishing data without the necessary contextual information or benchmarks to provide comparisons (Guthrie 2008; Raleigh 2009).

Indeed the Care Quality Commission has commented:

It [the ratings system] covers about 200 indicators and tries to summarise the performance of a very complex hospital in a word...we need a much more sophisticated system that does not just look at data...

Young quoted in O'Dowd 2009: b5129

A national consultation conducted by The King's Fund similarly expressed concerns about the limitations of 'Quality Accounts' as a way of providing information for and accountability to the public (The King's Fund 2009a).

The focus on performance has also stirred strong feelings and links to ideas of individuals' performance or competence (for example, though re-validation or annual reviews).

However, increasingly performance is expressed as a measure of the healthcare system or organisation rather than the individual (Hamilton et al. 2007). While nurses appear to be acutely aware of the individual focus of performance and the dilemmas that this poses for them in relation to quality (Attree 2007; Currie and Watterson 2007), doctors in the USA have moved away from considering individual performance.

The focus is perceived to have shifted to the performance of the wider organisation and this carries with it a sense that there is:

No risk to the individual.

Kane and Mosser 2006: 10

There are two aspects of the public availability of healthcare data for accountability or judgement that provokes most debate and concern among clinicians: firstly, the extent to which patients and the wider public should be involved in generating this data and secondly, the ability of the public to understand the data provided.

Although the need to involve patients is generally accepted (The King's Fund 2009b), the capability of the patient in making judgements about services are regarded with some suspicion, either from a belief that patient surveys (for example) are not reliable or valid (DH 2009a) and may reflect aspects of quality that are not necessarily viewed by staff as of equal importance to ease of access (Goodlee 2009). Elwyn et al. (2007: 1021) succinctly summarise this argument:

Is what patients say they want the same as good quality care?

Elwyn et al. (2007: 1021)

In addition, there are concerns that patients will be overwhelmed by the amount of data available now, particularly data that can appear to be conflicting or confusing (Kmietowicz 2009; Mohammed et al. 2008).

These fears may be unfounded. A recent survey has shown that few patients consult official data sources on hospital performance when making decisions about healthcare; instead, many prefer to rely on their own experience, the experience of family or friends, or the advice of their GP (The King's Fund 2009b). Nonetheless, clinicians remain concerned that many health care statistics are flawed, unreliable or misleading.

In summary, while there is widespread acceptance that data will be available to the public for both judgement and accountability, healthcare professionals still express significant concerns.

These concerns include: appropriateness of measures; the validity and reliability of patients' contributions to data on quality of care; the format and presentation of data; the concept of performance; the accuracy of data; and the ability of the public to make judgements on the quality of care from the large amount of data available.

Chapter 10

Quality improvement barriers and enablers

10.1 What do healthcare professionals see as the barriers and enablers to quality improvement?

A review of the main barriers and facilitators to clinical and medical audit (Johnston et al. 2000) generated a diverse list of barriers, which the reviewers grouped under five main headings.

In addition to lack of resources were: lack of expertise or advice on project design and analysis; problems between groups and members of groups; lack of an overall plan for audit; and organisational impediments (for example, clinician-manager battles; organisational mergers). This literature review identifies these and some additional factors as follows:

Time, resources and workload

Medical and nursing staff perceived that the service was 'under resourced' in terms of staff and equipment, and viewed specific quality problems as being caused by lack of financial resources. Virtually all the suggestions from nurses, doctors and patients to improve care quality involved increasing resources to provide more staff, time and beds ... some managers viewed these suggestions [i.e. for more resources] as automatic, predictable and unrealistic in the current era of economic control and restraint, suggesting instead that more effective use should be made of existing resources.

Attree 2001: 72

Many delegates [at a consultation event with nurses and midwives specifically asked about barriers to delivering high quality care] reported quality initiatives being squeezed between other competing priorities as suffering from a short-term approach to service planning and benefit realisation.

RCN 2008d: 4

I'd like to be given a fair chance to deliver what's expected of me and that's to deliver a good quality patient service, reducing the risks to patients, including infection. However, I'm told that I can't recruit to nursing vacancies, I'm having to cut beds, I'm having to reduce staff and I don't have any input over the staff that provide that health care.

Modern matron: quoted in Currie et al. 2009: 304

The big difficulty is the invasion of routine care by administrative and bureaucratic work. It's an enormous problem that, in my opinion, leads to a reduction in the amount of time that we spend with patients, in our availability. It lengthens the working day, leads to fatigue and demoralisation.

Doctor quoted in Hudelson et al. 2008: 34

The first barrier to quality improvement identified by healthcare professionals is lack of time, both 'integrated time' (time to consider quality issues during routine work) and 'shared time' (time to meet colleagues to plan and report on quality improvement; Roland 2001).

Lack of time and lack of direct and indirect resources for quality improvement are the two major barriers identified by healthcare professionals, and to some extent managers in most studies on healthcare professionals and quality improvement.

For example, Sewell 1997; McColl et al. 1998; Johnston et al. 2000; Wilkinson et al. 2000; Attree 2001; Wallace et al. 2001b; Shekelle 2002; Summerskill and Pope 2002; Renshaw and Ireland 2003; O'Donnell 2004; Maddock et al. 2006; Currie et al. 2008; Price et al. 2007; Hudelson et al. 2008; RCN 2008a,b; Parker et al. 2009; Solberg et al. 2009. This 'rhetoric of scarcity' may persist even when conditions change:

We've certainly gone through a phase when there's been a lot of vacancies ... we're now improving a great deal ... it's quite interesting that people get stuck in the culture of we're really short-staffed, when actually you're not short-staffed.

Nurse, quoted in Rycroft-Malone et al. 2004: 919

In addition, the pressure of high workloads and low staffing levels make it difficult to engage with improving care and contribute to poorer or unsafe care:

Some nurses felt that where workload levels are high many things get missed in terms of patient safety, primarily because nurses have to constantly prioritize. Such prioritization means that basic care, like nutrition and hygiene drops down the list of priorities and in some cases, may not get done.

Price et al. 2007: 165

There is a recognition by ward sisters and charge nurses that the multiple demands of their role (management and practice responsibilities) have led to poorer care and an inability to engage with the explicit quality improvement or assurance facets of their role (The Scottish Government 2008; RCN 2009c).

In addition to the most obvious and frequently mentioned barriers of lack of time and resources, different health professional groups refer to a range of further barriers, which reflect their respective roles and positions in health organisations.

For example, increased administration related to quality improvement initiatives is often regarded as a direct barrier by clinicians (Hudelson et al. 2008).

Knowledge, skills or conceptual aspects of quality improvement

Therapists refer to the barriers of high workload, inadequate managerial support, and 'inadequate skills' to access and implement evidence (Welch 2002), but they are by no means the only clinicians who felt that lack of knowledge or skills was at least a hindrance to greater engagement with quality improvement.

Barriers referred to by doctors include conceptual factors (for example, 'clinical aspects of care too difficult to audit', uncertainty about how to take forward the results of audit), practical factors (incompatible computer systems, not enough secretarial time), psychological factors (fear of being undermined by assessment and criticism), skills factors (for example, lack of IT skills), inter-professional issues (for example, 'language barriers') and competing demands (for example, from contractual changes and increased paperwork; Johnston et al. 2000).

A lack of skills to use IT or a lack of knowledge about IT systems is also reported by clinicians as a barrier (Ward et al. 2008; Powell et al. 2009c), but a lack of confidence in using IT to access, for example, evidence-based resources, has also been recognised by staff as a barrier:

The problem for me, is that I am just not that confident with computers, I can do email and shop online, but I'm not good at searching for evidence and the training that we got was set way too high for me, it just went over my head. It's very difficult to say that you don't understand.

Practice development nurse quoted in Wilkinson et al. 2009: 15

'On-the-job' training (where it is provided) in relation to quality improvement, has been viewed by clinicians as inadequate (Jones et al. 2009; Solberg et al. 2009).

The opposite situation is also seen by clinicians as problematic, in that they feel that they do not lack knowledge about quality improvement (or often specific initiatives) and they have good knowledge of local context, but lack knowledge or information about how to combine the two.

A UK study of patient safety in relation to assisted conception found that incident ‘alerts’ that came into the organisation and were required to be acted upon were often too vague to allow clinicians to take any specific action:

The idea of the incident alert that the HFEA have set up is good in principle and to some extent I would support it...because they are protecting the anonymity of the lab that’s reported the incident, very often the amount of information is too sketchy to really understand what the problem was.

Clinician quoted in Kerr 2009: 1747

Overload of information (reporting locally and nationally) about what clinicians in this study perceived as ‘minor errors’ was also seen as an inhibitor because clinicians felt there was considerable scope for such a broad spectrum of interpretation of the meaning or importance of these at local level.

On a related theme, the difficulties of measuring specific aspects of care are repeatedly raised as a barrier or confounding factor in engagement with quality improvement. Views of what should be measured and how these might be measured and fears that the easily measured will take precedence over the important continue to be aired:

Outcome measures still focus very much on medical interventions and omit the essential contribution of nursing and other members of the MDT.

RCN 2008d:4

The nurses in this consultation felt the dominant medical focus on quality and the lack of wider perspectives were significant barriers to wider nurse engagement.

Although it is more dominant in the US literature, one final aspect of conceptual barriers is also noted from the UK – that of the perceived low status of quality improvement in comparison to other types of clinical/academic activities.

This under-estimation of the importance, contribution and significant workload of quality improvement is presented as a specific barrier to greater clinician engagement (Jones et al. 2009; Shojania and Levinson 2009).

One clinician involved with the EwQI recognised that, as compared with his/her other experiences of involvement with research, quality improvement was under-recognised in terms of the amount of effort involved:

EwQI has been a steep learning curve and leading the project has probably been the hardest project that I have ever undertaken but also the most rewarding. I have 30 years of experience on research and have been a principal investigator on laboratory and clinical projects, including RCTs. The challenges presented by a quality improvement project are quite different and I think much greater. It is therefore baffling that quality improvement projects still have such a low regard in academic circles.

EwQI project lead quoted in Ling et al. 2009: 206

Contextual and cultural barriers

Perceptions of policy overload, the difficulties of deciding on priorities, and the tensions that arise locally due to conflicts between policy and quality improvement initiatives, are reported as barriers (RCN 2008a,b; 2009).

[At the hospital, there] is this sense that the professionalism of doctors and nurses is being undermined by a tick-box target-setting culture and also partly by the pressure itself: patients lying there, boxes to be ticked, specialities to be satisfied...

Doctor quoted in Levenson et al. 2008: 13

In addition, a perceived disconnect between local services and national initiatives can reduce healthcare professionals' commitment:

A nurse from a professional body said that initiatives from the centre often failed to feel 'joined up' with services provided. This could leave staff feeling they had spent a significant amount of time on tasks which yielded few improvements in their own areas of work.

Finlayson 2002: 6

The local context or the local implementation approach to quality improvement initiatives can dilute the desired impact which affects clinician engagement (Parker et al. 2009; Benn et al. 2009a).

The impact of organisational level decisions on the ability to provide quality care was seen as the most significant barrier to fuller engagement with quality improvement:

I think that sometimes, rather than be at the service of patients and supported by other structures, we practitioners find ourselves at the service of those structures and it's the patient who suffers as a consequence.

Nurse quoted in Hudelson et al. 2008: 34

Cultural aspects of organisations are also widely acknowledged as barriers to greater engagement with quality improvement, with a perception that management expectations of clinicians were detrimental to this:

Management doesn't support doctors in involvement [in quality improvement initiatives] when we need additional time resources – we are not paid to ponder.

Doctor quoted in Brand et al. 2007: 299

Quality improvement is also still seen as an additional aspect of practice, rather than an integral part of it, which was recognised as a barrier by managers and nurses (Price et al. 2007). Where staff may be interested in taking the initiative to improve things locally, the wider organisation does not always see this as appropriate and this type of risk adverse culture in organisations has been identified as a barrier (Price et al. 2007; RCN 2008d).

Evidence suggests that nurses find it difficult to implement evidence-based practice because of various factors such as their perceived lack of authority to bring about change or their reliance on active consultant support (Rycroft-Malone et al. 2004; Wilkinson 2008).

Tensions between different professional groups (particularly nurses and doctors) persist and continue to be presented as barriers to quality improvement, as one modern matron illustrates in relation to improving hand hygiene and infection control:

There's nobody walking around following the doctors, keeping an eye on what they are up to. Nurses get really upset because nobody is watching them [doctors]... I know things are changing, but they can do more or less what they like.

Quoted in Currie et al. 2008: 305

The cultural aspects of operating theatre practice explored by Currie et al. (2009) in relation to patient safety also illustrates the conflicts arising from the different views held by nurses and doctors in relation to incident reporting. Cultural aspects are often reported as having an impact on nurses:

Many nurses reported working in a culture where they would be blamed or ridiculed if they made a mistake. There was also a belief that the culture...left them feeling disempowered and unable to challenge unsafe practice and poor decision making.

Currie and Watterson 2007: 164

Fear of bullying (Currie and Watterson, 2007), anxiety and stress leading to a withdrawal of involvement (McDonald 2008) or from having to reflect on 'near miss' or patient injury instances are not insignificant (Iedema et al. 2009) when considering clinicians' willingness to actively engage.

Fear of reprisal for the individual reporting quality concerns or for the 'reported' individual, while recognised as a responsibility, was not undertaken without considerable reflection and concern:

It's a very hard thing to do, because you feel like you are dropping someone in it and it's going to cause [in the least] friction afterwards. It would depend on who it was and how serious it was whether I would report it, you have to think really carefully and weigh it up.

Nurse quoted in Attree 2007: 395

Doctors' fear of being challenged about their practice has also been raised as a barrier (Neale et al. 2007) to engagement or wholehearted support for quality improvement initiatives (such as revalidation), which are often seen as not fit for purpose:

Shipman never had a single complaint made about him, sadly patients don't know a good doctor from a bad one...

Liverpool doctor quoted in Levenson et al. 2008: 26

In addition challenging practice is seen as distressing to be involved in either as a candidate:

It will be judgemental and nasty...

Plymouth GP quoted in Levenson et al. 2008: 27

or as an assessor:

I tell you, it is a very distressing experience to have to sit in a surgery and watch a barely performing doctor. I have to do so regularly and it is very upsetting.

Plymouth GP quoted in Levenson et al. 2008: 27

The social processes involved in engagement with quality improvement were recognised by many clinicians, whether in relation to working with other individuals or other professional groups and these were identified by some as barriers. The imposition of an outside expert for a quality improvement initiative was rejected by some (Parker et al. 2009). But the involvement of another member of staff could also be a reason for poorer engagement, when responsibility for quality was delegated to them, rather than seen as a shared role (Powell, 2006; Stanley et al. 2008).

A final point that relates to both organisational culture and social process aspects of barriers to quality improvement is that staff repeatedly report poor communication and a lack of involvement in decision making about aspects of their work (Ellins and Ham 2009).

10.2 Managers' perceptions of barriers to quality improvement

Perhaps the richest account of perceived barriers is drawn from studies of healthcare managers. Healthcare managers (including clinicians who undertake managerial roles) cite a wide range of barriers to quality improvement relating to organisational factors, their own role, and the attitudes and position of other healthcare professionals.

These are summarised below.²

Barriers relating to managers' roles

- Political pressure on managers to deliver rapidly on a range of competing and often conflicting targets (for example, providing training and meeting waiting times targets).
- Lack of clarity about the roles of managers and their authority in relation to clinicians.
- The existence of few levers that managers can use to encourage healthcare professional involvement in quality improvement.
- Reluctance of managers to put additional work onto clinicians: 'managers were particularly aware they were asking a great deal from staff who were inadequately rewarded' (Finlayson 2002: 6).
- Managers' own lack of knowledge or skills to implement quality initiatives.
- Leadership seen as relating to medical leaders in formal positions, with little recognition of the need for engagement of other medical staff throughout organisations: 'If doctors are engaged in management then organisational performance will improve.' (NHS Institute of Improvement and Innovation and the Academy of Royal Colleges 2009).

²Derived from: Hearnshaw et al. 1998b; Marshall 1999; Campbell et al. 2001b; Heard et al. 2001; Roland et al. 2001; Wallace et al. 2001b; Campbell et al. 2002; Clark and Smith 2002; Marshall et al. 2002b; National Audit Office 2003; Renshaw and Ireland 2003; Sheaff et al. 2003a; Walshe et al. 2003; Sheaff et al. 2004. Davies and Goodman Cripacc 2007; Hamilton et al. 2007; Currie et al. 2008; Ellins and Ham 2009; Parker et al. 2009.

Barriers relating to the attitudes and position of other healthcare professionals

- Hierarchical organisations that make it harder for staff who are not used to taking a lead to be innovative in changing practice.
- The independence and autonomy of GPs and the attitude of some practices (for example, ‘a high degree of apathy’ among doctors; Marshall 1999).
- Doctors’ suspicions of and cynicism about managerial motives and ‘hidden agendas’ and managers’ concerns that doctors deliberately withhold or confound information to frustrate management efforts, such as incident reporting.
- Poor communication between doctors, and (more so) between professions.
- Disagreements about who is responsible for what, rather than seeing quality as a shared responsibility: ‘Clinical nurses unambiguously reported that nurse managers focus on QI as it relates to hospital accreditation and administration requirements rather than on patient care.’ (Price et al. 2007).
- Difficulties in providing training that fits the needs of professional groups from diverse backgrounds.
- Cultural issues (for example, a ‘blame culture’ that inhibits openness and learning; widespread perceptions that clinicians are not held accountable).

Barriers relating to organisational factors

- Lack of infrastructure support for quality improvement (for example, IT support, admin support from the health authority or primary care group).
- Poor quality – or absent – data on quality of care.
- Difficulties in freeing staff from clinical work to attend training on quality issues.
- The pace of organisational change and frequent mergers leading to ‘initiative fatigue’ and disengagement from quality improvement.

Barriers relating to the initiatives themselves

- Lack of overall direction and impetus for initiatives such as clinical governance:

The long history of independence and autonomy of GPs was perceived to be incompatible with the fundamental principle of collective responsibility underlying clinical governance.

Marshall et al. 2002b: 644

- Tensions between authoritarian and developmental approaches to quality assurance and quality improvement and the subsequent impact on clinicians’ attitudes.

10.3 Healthcare professionals’ views on enablers

The literature does not cover healthcare professionals’ views about what would *enable* quality improvement to the same extent as views about the perceived barriers. Of course, some idea of professionals’ views of potential facilitators can be gained from scrutinising their perceptions of current barriers and considering approaches that might address them. While it could be possible to view enablers as the opposite to barriers, this is not the approach taken here, with only enablers noted in the literature being presented.

Among the facilitating factors identified by healthcare professionals themselves are: modern medical records systems; effective training; dedicated staff; protected time; structured programmes; and shared dialogue between purchasers and providers about the aims and processes of initiatives like audit (Johnston et al. 2000).

A hybrid approach that involves clinicians and quality improvement experts in developing local initiatives was seen as a significant enabler in a large US primary care study to improve mental health practice (Parker et al. 2009).

This study presents many factors that are also recognised in other studies (for example Currie et al. 2008; 2009; Solberg et al 2009) but has taken an approach to reviewing specific enablers in relation to managers’ and clinicians’ views.

Clinicians reported the following as enablers: verbal communication about the initiative and their progress, rather than repeated emails, which they ignored. In particular the need for repeated messages of the importance was noted by clinicians:

Tell me once and I might listen, but tell me regularly, I'll get to believe that it really is that important, but don't email, it's so overused, you'd be better starting a rumour if you want the message to spread.

Doctor quoted in Parker et al. 2009: 234

Also identified as enablers were: frequent group meetings about progress in the workplace to minimise time pressures; honest appraisal at the outset of the workload and potential challenges; a focus on content and practice over business issues; good quality relevant data showing improvement; qualitative data with patient stories as one part of this; and dedicated time and reduced (even temporarily) workload to show a commitment from management to the initiative:

You need to free us up, you can't expect us to have a full clinic and start implementing.

Doctor quoted in Parker et al. 2009: 238

Managers in the same study had slightly different perceptions of enablers: broad objectives rather than prescriptive detail to allow for local adaptation; exploring the business aspects of a programme and providing evidence that costs would be commensurate with potential improved patient outcomes; progress data that would 'sell' the initiative to other (less motivated or difficult to engage) staff; the involvement of frontline staff who are local experts or have clinical credibility rather than quality initiative experts; and using other managers' experiences as data.

There was also some consensus from both clinicians and managers on enablers: the influence of motivated staff was most likely to encourage others to engage and their specific role was less important than their credibility and personal skills and characteristics, and initiatives that increase workload while (objectively) increasing or only maintaining quality were of little interest.

Communication and the need for a repeated message from the experts about the initiative were also seen as crucial factors in enabling engagement:

You've got to tell me three times to do it, because you tell me three times, it must be really important. If you tell me once and I never hear from you again, then it probably wasn't that important, a passing fad and I'll not bother with it.

Medical director quoted in Parker et al. 2009: 235

In summary, healthcare professionals describe a wide range of barriers to quality improvement, and give a limited list of enablers.

Many of the barriers identified arise from the well-documented problems of working effectively between and across health professions (West et al. 1999; Firth-Cozens 2001; Caldwell and Atwal 2003; McNulty 2003; Dopson and Fitzgerald 2005; Ferlie et al. 2005; Price et al. 2007; Currie et al 2008; 2009).

For example, poor relationships between clinicians and managers (for example, Johnston et al. 2000; Currie et al. 2008; 2009), and unclear roles affecting communication between clinicians and audit staff and between primary and secondary care staff, or a perceived disconnect between the two (Roberts et al. 2004; Levenson et al. 2008).

This means that more time and more resources, while they may be necessary or helpful (both directly and in their explicit recognition of healthcare professionals' concerns) are unlikely to be sufficient to overcome the substantial barriers to clinicians' active engagement in successful quality improvement.

Chapter 11

Evidence of trends

11.1 What trends are discernible from the literature that do (or might) relate to clinicians' views of engagement with quality improvement?

There are no empirical studies specifically relating to trends in clinicians' views of engagement with quality improvement, but there is no shortage of other types of literature that provide glimpses of this.

Some of these reflect changes to the policy landscape, others are emerging themes that in time may either impact on clinicians' engagement with quality improvement and therefore their views of it, or be areas that require further research.

We have included these findings as an acknowledgement of wider factors in the UK healthcare context. This final question is presented more as a springboard for future discussion.

11.2 Clinician involvement and clinician engagement in quality improvement

Clinician engagement may be increasing through initiatives such as QOF or through the expression of clinician views in consultations such as the Next Stage Review (DH 2008a) or for the development of 'Quality Reports' (DH 2009b).

The completion of incident reports for patient safety programmes is seen as evidence of this compliance with an initiative, but not necessarily a positive attitude to it (Benn et al. 2009a,b).

However, although it is not explicit in the literature, there does appear to be an important distinction made between the *involvement* of clinicians in initiatives or programmes relating to quality improvement and the *engagement* of clinicians in these.

Involvement, such as the completion of incident reports or reporting 'near miss' occurrences (Currie et al. 2008), is taking place, but as the work of Currie shows, the active engagement of clinicians and their support in the engagement system for improving quality of care is not always demonstrated.

Doctors and nurses working in primary care are involved in the QOF, because they have to be, but the number of ongoing concerns expressed by both (for example, Steel et al. 2007; McDonald et al. 2007; McGregor et al. 2008) suggests that their engagement in all aspects of this is still lacking.

While the distinction may seem subtle, it appears that some clinicians simply go along with engagement initiatives as a tokenistic gesture rather than a sincere willingness to participate (Halligan 2007).

So while GPs, for example, may have been encouraged to take part in QOF, by considering the benefits for themselves or patients, some see it as a badge of honour when achievement of targets is used in job advertisements to attract staff (Harrison 2009). There are many who remain unconvinced or not fully engaged with it as a way to improve care.

Likewise, it is difficult for staff to be uninvolved in aspects of the patient safety agenda, but this does not necessarily translate into deeper support in terms of changed attitudes and beliefs that would indicate a real engagement.

Changes to clinician behaviour such as that sought by the EwQI (Ling et al. 2009) may provide evidence of this, but seeing the distinction between 'involvement with' and 'engaged in' may explain some of the modest results of even well-funded and supported initiatives for quality improvement. Rhodes et al. (2008) in a before and after study of a national (UK) patient safety alert for wrong site surgery found that although self-reported practice of nurses and surgeons did change in response to this, this was not always accompanied by changes in attitudes.

While there was a compliance with the need to mark surgical sites and sign documentation to that effect (as per the safety alert), this was often undertaken in a manner that reflected expediency rather than a wholehearted agreement with the need for either the procedure or the perceived increased bureaucracy that accompanied it. For example one surgeon reported:

All that piece of paper does is bounce the responsibility back on the surgeon, which is where it was anyway. You know great strides are achieved here!

Urologist quoted in Rhodes et al. 2008: 412

The King's Fund (2008) briefing on 'High Quality Care for All' hints that the difference is about how clinicians feel about quality improvement and this may not be evident in what they do. It is not yet possible to say whether involvement is a precursor to greater engagement with, or more positive attitudes towards quality improvement.

11.3 The separation of quality and safety

The second trend that emerges is the increasing separation of quality and safety in the ways both (alone or together) are described in the literature. Reviewing the literature over a time span of 20 years, it is noticeable particularly in recent years that patient safety is becoming increasingly distinct from quality.

Although safety is sometimes seen as one aspect of quality (DH 2008a), this view is not always obvious in wider literature where safety might be the focus and quality scarcely mentioned (for example, Vincent 2009). Clinician engagement with patient safety initiatives may indicate a support of them, rather than an allegiance to wider approaches to quality improvement (Mannion et al. 2009; Wallace et al. 2009).

The increased regulation and monitoring of quality and safety as separate entities is also seen. Again this will involve clinicians in data collection, reporting or changes to the ways in which services are delivered, but this does not necessarily reflect greater clinician support, approval or engagement or indeed reflection on these or learning from them (Evans et al. 2006; O'Dowd 2009).

11.4 Involvement of patients as active participants in their care

It is discernible from the wide literature reviewed here that there is an increase in the involvement of patients as active participants both in their care provision and with quality improvement. No longer the passive recipients of care (at least from a policy viewpoint), there is growing recognition of this:

The relationship between the doctor and the patient was widely thought to be changing.

Levenson et al. 2008

Patients are given a greater role in making decisions about their care, explicitly given responsibility for self-management of some chronic conditions and being encouraged to challenge staff about the quality of care provided (Davies et al. 2008).

The National Patient Safety Agency's 'Please Ask' campaign (NPSA 2006) makes it clear that patients should ask:

If you're having surgery check the marks the surgeon makes are in the right place. If you aren't sure or think the marks may be wrong, tell someone.

NPSA 2006

Patients, through, for example, disease specific support groups or the Patients Association, are seen as having an active voice that cannot be ignored. Surveys of patient opinion or experience are now given greater prominence (Spencer and Walshe 2009) and are a specific aspect of some quality improvement initiatives. Greater emphasis is being given to narratives of patient and staff experience (Iedema et al. 2009) in relation to quality and safety and these are a powerful means of persuading staff of the need to improve (Patients Association 2009), but are only one means of measuring the patient experience (The King's Fund 2009b).

Again, this focus makes it possible for clinicians to be involved with, but not necessarily fully engaged in quality improvement by giving greater scope for patient involvement without necessarily viewing this as a positive step. In 10 consultation events with doctors and other healthcare professionals across England and Wales, the issue of patients becoming more actively involved and empowered and the impact on doctors was recognised as a changing dynamic, but one that would not necessarily be easily put into practice:

I think a lot of the problem seems [to be] because we haven't really engaged terribly well with patients and patient needs...you only meet a patient or family when you are in a clinic or consultation and then you are in a dominant position...

Birmingham GP quoted in Levenson et al. 2008: 16

Concerns about the power of consumerism in healthcare and patient demands were very real to doctors, but there was also a recognition that this could be a lever for quality improvement, particularly in relation to resource allocation.

Others saw this as an opportunity to see the changing relationship with patients as an alliance that could be beneficial in this regard:

The power is to involve the patient in your agenda – I don't necessarily think the power is always with the doctor but if you get the patient on your side, you can build an alliance or allegiance with the patient, then you definitely have the power.

Plymouth GP quoted in Levenson et al. 2008: 18

The changing roles of patients in healthcare encounters may be another way that clinicians are involved with quality improvement, although not explicitly so.

A changing focus in a consultation or the inclusion of patients' views in service development may be a vicarious engagement, but engagement nonetheless.

This kind of adapting may be one way of engaging with quality improvement, without necessarily expressing a view about this, or even a recognition by doctors that it is engagement, given that it is both a necessity and a tide of change that they may be unable to resist.

11.5 Individual focus and systems or organisational focus

While discourses have inevitably changed over the time span of this review, the following becomes clear: there is a subtle change in the focus of responsibility relating to quality and safety:

In the pursuit of patient safety, new forms of organisational learning have been introduced within healthcare services across the developed world.

Waring 2009

The individual clinician becomes less of a focus, although still important, but the system or organisation is much more the locus of control or level of responsibility for quality improvement (Teasdale 2008; Benn et al. 2009a,b; Brady et al. 2009; Kerr 2009; Norris 2009; Waring 2009).

This focus has been recognised as a means of distancing from the responsibility of individuals:

To some extent, turning attention towards organizational issues means individuals don't have any responsibility themselves.

Clinical director quoted in Currie et al. 2008: 374

Even when the human factors of patient safety are taken into consideration, the focus is on how these can contribute to systems or organisational learning (Norris 2009). Where this is less obvious, there is still a focus on the team over the individual (Miller et al. 2009).

This has implications for the extent to which clinicians need to engage on a personal level with improvement programmes and initiatives and therefore may impact on their views of these. This poses challenges for managing individual performance as one aspect of quality improvement within a 'systems thinking' approach.

The move away from individual responsibility for quality failings has predominated as a means of trying to challenge 'blaming' cultures and encourage 'safety cultures' (Smith et al. 2009).

Performance review of individual clinicians (DH 2008c) very much highlights the need to consider context and wider organisational features that might explain individual variation in performance.

Regulation and inspection of healthcare have grown significantly over time and

are likely to become increasingly important

Ham 2009: b4372

and are clearly expressing a 'zero tolerance' approach to lack of action on improvement

Moyes 2009

If the system or organisation is a greater focus for quality improvement, individual clinicians may be less likely to have views on engagement. That said, even an organisational approach to quality improvement, such as QOF (at practice level), has resulted in a greater focus in some practices on the individual clinician, if their performance or approach to care was seen as detrimental to the whole practice:

We developed a zero tolerance to blood pressures... no-one is allowed to say "it's a little bit up leave it." It's not acceptable. If you are not doing something about it [you need to] be able to justify why you're not.

GP quoted in McDonald et al. 2007: 4

The authors comment further that this particular GP was monitoring his colleagues' clinical work on a daily basis which had led to them expressing feelings of being under constant surveillance. The motivation, they recognised, came from a desire to achieve and exceed targets for the practice and provide best care for patients.

However, this specific example illustrates the complexities of untangling the views of individuals in relation to their experience or views of engaging with quality improvement and their recognition of 'the greater good' of this for an organisation or patients.

Despite the greater focus on healthcare organisations and systems approaches to quality improvement, there is still a need to acknowledge the role of the individual within these.

Chapter 12

Conclusion

Using the framework of the 10 questions, we have explored a range of issues relating to UK healthcare professionals' attitudes to quality improvement. The concluding section highlights the need for caution in interpreting the main messages from this body of research, emphasising the context-dependent and contingent nature of the findings.

In this narrative review, we have outlined the six core concerns about healthcare professionals and quality improvement (set out on page 6) through exploring 10 questions which emerge from the literature (introduced on page 7).

Many of the areas we touched upon (for example, evidence-based practice, clinical guidelines, organisational change, and professional identity) have their own substantial and distinctive bodies of literature that can be used to inform further study and research.

Our coverage of these wider literatures has of necessity been partial and selective, but we have been guided always by trying to glean what work in these areas can tell us about clinician engagement with quality.

We believe that the review provides a comprehensive overview of what existing empirical research shows about UK healthcare professionals' attitudes to clinician engagement in quality improvement.

In this review, we draw predominantly on studies that rely on self-reported attitudes (in the form of participants' responses to surveys and in interviews) and on individuals' perceptions of the behaviour of colleagues.

Inevitably, there is a risk of 'social desirability' bias (the desire to present the individual or the organisation in a positive light; Bowling 1997) as healthcare professionals articulate their perceptions in surveys or describe them to researchers in the social setting of an interview.

What we nevertheless gain is a rich picture of healthcare professionals' perceptions. Such perceptions inevitably arise from and contribute to the shared meanings and other aspects of organisational culture (Davies et al. 2000; Harris and Ogbonna 2002; Scott et al. 2003), both in the individual's immediate workplace and in the wider context. Thus a knowledge of the perceptions of healthcare professionals is crucial to our understanding of the gulf between policy and:

Messy real world settings.

Keen and Packwood 1999: 51

The increasing focus on quality that is the central theme of High Quality Care For All (DH 2008a) does highlight the persistence of this gulf:

What strategists in the health service never really understood was that grandiose plans could not move forward one millimetre unless there was a willingness among those who deliver the service to move towards a new way of working.

Halligan 2007: 465

What studies of healthcare professionals' perceptions cannot show, however, is the extent to which these perceptions accord with actual circumstances, and thus they must be used with some care in identifying what may be needed to promote engagement in quality improvement.

For example, the widespread perception that what is needed is more time and more resources is only part of the picture, and is therefore a partial explanation for a lack of clinician engagement. Nevertheless, perceptions, especially when widespread and keenly felt, do matter a great deal in setting a context for change, in constraining what might be achieved at national and local levels.

In undertaking this review, we have been unable to find any reference in the literature to the relationship between clinicians' attitudes and beliefs about other aspects of care, and their engagement with quality improvement.

Only one study from Canada of clinicians' use of guidelines (Brouwers et al. 2009) suggests that clinicians' attitudes (at least to guideline use) may change over time. This gap in the literature may provide scope for further consideration or future research.

Inevitably, attitudes towards specific quality initiatives are influenced by the political and local contexts and by other events occurring at the same time (Pettigrew et al 1988; Greenhalgh et al 2004).

It is therefore important, in looking at the views of healthcare professionals, to acknowledge the potential impact of the wider NHS context. In drawing this review to a close, we will highlight three contextual features that we regard as particularly influential in shaping healthcare professionals' attitudes to quality and quality improvement in this period.

The first feature is the substantial and sustained organisational turbulence in the NHS. Firstly, the 1980s, the decade prior to the period covered by this review, was a period of accelerating change in the NHS (Ashburner et al. 1996) with substantial restructuring and the introduction of 'general management' aimed at changing:

Not only the structure of the NHS, but also its ruling assumptions and much of the service culture.

Pettigrew et al. 1992: 267

Second, the 1990s was a period when the scale and pace of NHS change increased still further (Young 1997).

Many authors argue that the period since 1990 has been one of the most turbulent in the history of the NHS when measured in terms of marked shifts in policy direction, successive structural reorganisations and a plethora of diverse and sometimes conflicting initiatives aimed at changing aspects of the service (Robinson 1996; Davies et al. 2000; Leatherman and Sutherland 2003; Fitzgerald et al. 2006):

A formidable torrent of pledges, policy documents, laws, regulations, advice and guidance has issued from the Department of Health, without let-up since 1997, to knock the system into shape: ironing out disparities, raising standards, improving productivity, increasing responsiveness, extending services, meeting unmet needs.

Appleby and Coote 2002: 5

Organisational change in the NHS in the past has been widely acknowledged to have had a range of impacts, including on clinicians' readiness to engage with quality improvement (and other) initiatives: prompting widespread 'change fatigue' and a reactive rather than proactive approach, and inculcating a 'wait and see' attitude (Garside 1998; Leatherman and Sutherland 1998; McKee et al. 1998; Powell and Davies 2001; Smith et al. 2001; Cortvriend 2004; Fitzgerald et al. 2006).

Such an approach may be characterised by organisational actors as 'surviving' rather than developing, and is likely to have a considerable influence on responses to centrally-planned quality improvement initiatives.

Indeed, Schalk and van Dijk (2005) argue that the motivation of employees to work on quality is dependent on the nature of the exchange relationship they have with the employing organisation, that is, on the psychological contract between the organisation and the employee. It is this relationship that is often substantially disturbed during organisational and policy change.

It is possible that the number of attempts to introduce quality improvement by various policy makers has led to the addition of even more initiatives and these further complicate an already crowded practice and organisational agenda.

This increases the tensions that healthcare professionals feel and describe in relation to one initiative conflicting with another:

[Payment by Results] has created increased pressure to discharge patients quicker to drive down the length of stay, increase throughput and raise income often without obvious consideration of clinical outcomes.

RCN 2009b: 16

A lack of clarity about the overall approach or beliefs about the underlying problems may further fragment and exacerbate these rather than ameliorate the situation:

Practice-based commissioning, a policy designed to engage doctors, in particular, to be more conscious of cost, quality and patient choice in commissioning hospital and community care, has not in many cases been able to bring about the significant change nor widespread clinical engagement that was anticipated in policy.

Smith et al. 2009: 1

A range of UK-wide RCN consultations have found that healthcare systems make it more difficult to focus on delivering high quality care due to policy overload, restructuring and financial considerations taking precedence over clinical care (RCN 2008a). Nurses believe this leads to care being constrained rather than improved. The impatience of policy makers and managers at local level to demonstrate that ‘real change’ (Dixon 2009: 1) is taking place gives little time for effective and informative evaluation. The involvement of patients in assessing the quality of care will increase the pressure (real or perceived) to demonstrate improvement and therefore exacerbate the need for accelerated clinician engagement.

There is a continuing focus on the innate desire of professionals to improve services and efforts to understand and capitalise on that professionalism, particularly of doctors. This is often tied in with ideas of leadership and exposes a tension between leadership qualities that not all have and yet that are needed to encourage and sustain engagement with quality improvement. This is coupled with the sense that all doctors are leaders:

Doctors have a legal duty broader than any other health professional and therefore have an intrinsic leadership role within healthcare services.

NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges: 2009: 6

The nursing contribution to care quality as espoused in ‘Framing the Nursing and Midwifery Contribution: driving up the quality of care’ (DH 2008b) uses the rhetoric of nurses being in a:

powerful position to improve the care that patients’ experience (DH 2008b: 5) and sees nurses as advocates and guardians [of care quality].

DH 2008b: 5

How this fits with the rhetoric around medical leadership and the empirical evidence that demonstrates the difficulties that persist in working with other professional groups is (to date) not adequately addressed by either group.

Nurses are somewhat ‘left behind’ despite being a larger workforce and may find it difficult to reconcile this with the desire and requirement of managers to focus on medical engagement and leadership.

While doctors may identify or express an appetite to collaborate with peers (Ling et al. 2009) this does not necessarily include nurses or other professionals. Deep seated problems remain and manifest in the interest shown in their attendance at events relating to quality and safety (Neale et al 2007) and their lack of willingness to undertake, for example, near-miss reporting:

By virtue of their power and position, doctors are able to block or confound the efforts of managers or politicians to impose change by top-down mechanisms. However by engaging doctors with change processes, improvements may be achieved.

Dickinson and Ham 2008:2

This focus on doctors is clearly important and underpinned by a growing body of evidence, but the engagement of doctors and their leadership is not the only factor that is significant in improving quality (NHS Institute for Improvement and Innovation and Academy of Royal Colleges 2009).

The third feature that we believe has a significant influence on the attitudes of healthcare professionals to quality and quality improvement is that the NHS attracts sustained and largely critical attention from politicians and the media.

It is highly visible, with much media scrutiny, public ‘naming and shaming’, sustained criticism and low coverage of achievements. Against this background, the espoused aim of government policies is to bring about a change in the culture of NHS organisations to one:

Where openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received.

Department of Health website cited in
National Audit Office 2003: 1

To many healthcare professionals this seems to be far removed from their own experience.

Leatherman and Sutherland (2008) conclude that overall quality in the NHS has improved however, they raise important points about the significant resources that have been available to support this.

They also question whether the considerable effort and investment are reflected in the extent of improvement. This review demonstrates that clinician engagement has been a significantly under-recognised aspect of improving care quality.

More recently, it has become a greater focus, but this review has shown that engagement is still patchy and uneven across the NHS and within its constituent organisations. Further, variation is evident with different initiatives and programmes and there may be yet more variation over time.

Many initiatives are new or amended and broader over-arching themes, such as clinical governance, remain poorly understood, which further compounds the problems of clinicians’ engagement.

The active engagement of all clinicians with quality improvement is essential but as yet largely unrealised.

In an NHS that is going to face additional challenges of having to do more with fewer resources, engaging clinicians will become more necessary than ever before (Smith et al. 2009). However, increasing clinician engagement is likely to remain difficult; non-engagement of clinicians is a long-standing, multifactorial and international problem. Addressing the many overlapping structural and cultural factors that contribute to the current situation requires the sort of multi-level long-term approach to organisational change that is difficult to achieve in a highly-politicised complex organisation like the NHS (Pettigrew et al. 1992; Ferlie and Shortell 2001; Ham et al. 2003; Bate et al. 2008), which often relies on overly simplistic rational-linear approaches to change that:

end in disappointment which could be predicted by the ‘person on the street.’

Ovretveit 2009a: 1781

This review has demonstrated the complexities and uncertainties of clinicians’ engagement. While involvement with quality improvement may be taking hold in some areas, there are still problems achieving a more substantial and sustained engagement. Such deeper engagement frequently eludes the continued and multiple efforts made in support.

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ISBN 978-1-906461-27-0

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