IMproving PAtient Care Together Evaluating the Impact of NHS IMPACT*

Rapid Evaluation

Nicola Burgess and Nick Downham,
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LEGITIMACY
SHARED LANGUAGE
CONNECTING PEOPLE
TRANSLATION
DIVERSE INTERPRETATIONS

CHALLENGES & POSSIBILITIES

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Executive Summary

Launched in April 2023, NHS IMPACT aimed to provide a unified framework for improvement across the English NHS. This report presents the findings of an independent evaluation conducted two years after its launch to understand the extent to which NHS IMPACT has influenced and continues to influence the adoption and integration of improvement within NHS provider organisations. Our evaluation gathered insights from over 40 stakeholders across nearly 40 different NHS organisations through semi-structured interviews, supplemented by survey responses from six additional individuals.

Our interviews and analysis reveal insights into how individuals and organisations utilise NHS IMPACT to foster a systematic approach to improvement. We present our findings, on how NHS IMPACT has shaped the conditions for improvement under five interrelated themes:

1. **LEGITIMACY** - NHS IMPACT was frequently described as a valuable lever for elevating the strategic profile of improvement within NHS organisations and instigating discussions about improvement with senior leaders and executive boards.
2. **SHARED LANGUAGE** - As an agnostic framework, NHS IMPACT facilitated a common language of improvement that bridged individual and organisational allegiances to particular approaches.
3. **CONNECTING PEOPLE** - The regular convening of dedicated networks and masterclasses that enable the sharing of learning, promote peer support, and build advanced improvement capability and capacity was a highly valued feature of NHS IMPACT.
4. **TRANSLATION** – NHS IMPACT fostered a shared understanding of what a systematic and holistic approach to improvement should entail.

5. **DIVERSE INTERPRETATIONS** – NHS IMPACT led to healthy dialogue on emerging topics within systematic improvement approaches and their application in healthcare.

To understand NHS IMPACT's influence on improvement efforts within and across NHS provider organisations, our in-depth interviews explored both benefits *and* challenges from diverse perspectives. This report therefore describes and evidences the emergence of the five interrelated themes, complemented by critical reflections that present alternative viewpoints, challenge current practices, and offer constructive insights for improvement. These critical insights, aligned with the five themes, include concerns regarding the evidence base for the widely adopted self-assessment instrument (despite its popularity), the implications of its non-mandatory completion, the tension between prescriptive guidance and autonomy, potential drawbacks of standardising improvement language, the limited integration of NHS IMPACT networks with existing networks, and confusion surrounding the definition of a management system. Our report concludes with a section outlining the challenges and possibilities for NHS IMPACT.

In sum, our analysis demonstrates that NHS IMPACT has established itself as a significant framework for improvement within the English NHS, particularly in fostering a shared language and promoting a unified approach. While ongoing development is needed to address concerns around its evidence base and practical application across diverse settings, its foundational principles are widely supported, suggesting that NHS IMPACT represents an important step towards a more collaborative NHS with continuous improvement at its core.

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Introduction

In April 2023, NHS England launched NHS IMPACT, a framework representing a single, shared improvement approach for the English NHS. Comprising five key pillars, the framework aimed to support NHS organisations in embedding a systematic approach to continuous improvement. This framework was reportedly co-produced by hundreds of individuals from across the NHS.

About NHS IMPACT

Describing the ambition for NHS IMPACT as *'a single improvement approach to shaping strategy'*, this codification of five interconnected components represents a framework to assist NHS organisations in fostering an improvement culture, where a systematic approach to improvement evolves into a sustainable, system-wide practice[1].

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

Descriptions of what each of the five component pillars of NHS IMPACT look like in practice can be accessed via NHS IMPACT's dedicated website: https://www.england.nhs.uk/nhsimpact/about-nhs-impact/. This website also allows users to access various resources and content designed to assist individuals and organisations in embedding the five pillars of NHS IMPACT.

Our evaluation of NHS IMPACT seeks to understand whether the framework has been effective in its ambition of shaping the conditions for improvement among NHS provider

[1] Source: NHS England website: www.england.nhs.uk/nhsimpact (accessed April 2025).

organisations. Commencing in January 2025 with an open invitation to participate distributed by the NHS IMPACT team via their Improvement Directors and Improvement Leaders networks, we received significant interest from over 100 individuals who registered their details. To broaden the mix of possible interviewees the invitation was also sent to a group of Darzi Clinical Fellows – yielding an additional two responses. This enthusiastic response enabled us to conduct forty-one in-depth, semi-structured interviews (approximately 60 minutes each) between mid-January and mid-April 2025. The rich qualitative data gathered from these interviews, totalling over 1000 pages of single-spaced transcripts, reflects the perspectives of a broad spectrum of stakeholders, including representatives from hospital trusts (*n*=21), community health partners and specialist care providers (*n*=7), Integrated Care Boards/ICBs (*n*=6), national health and care leaders (*n*=5), and a patient partner (*n*=1). To further enhance the breadth of our data, a brief online survey was offered to those we could not interview due to time constraints, yielding six additional responses.

Supporting the adoption and implementation of NHS IMPACT

Several mechanisms have been established to support and facilitate the widespread adoption and implementation of NHS IMPACT. These mechanisms include a self-assessment tool, dedicated learning and support networks, 'lunch and learns', and 'masterclasses', a monthly newsletter, and a website hosting a variety of content including descriptions of the five pillars of the NHS IMPACT framework, case study examples, and learning guides. We describe these mechanisms briefly below.

Self-assessment tool[2]

The launch of NHS IMPACT was accompanied by the dissemination of a 'jargon-free[3]' self-assessment tool and maturity matrix designed to help NHS organisations evaluate their maturity in relation to the five components of the framework. Initially, all NHS organisations were required to complete and submit their assessment scores. However, the decision to make the assessment mandatory was reversed due to concerns that some organisations might feel compelled to artificially inflate their scores. Thus, making the completion of the assessment mandatory was seen as counterproductive to its purpose: to facilitate honest discussions about the strengths, weaknesses, and opportunities for the organisation to develop and implement the five components of a systematic approach to improvement.

Dedicated networks

Two networks that dedicate regular time and space to support individuals and their organisations to implement and adopt the five components of NHS IMPACT:

- Improvement Directors Network (IDN) – this monthly meeting connects executive leaders with Board level responsibility for improvement with the National Clinical Director for Improvement at NHS England. The IDN is specifically for provider Trusts, Integrated Care Systems, and NHS England Regional leads for Improvement.

- Improvers Learning Network (ILN) – a learning and professional forum for senior improvement leaders to share practical applications of improvement and building capability for improvement.

[2] The self-assessment tool is available for download from the following link: https://www.england.nhs.uk/publication/nhs-impact-improving-patient-care-together-self-assessment/ (accessed April 2025).

[3] 'In April 2023, NHS chief executives asked for a jargon free NHS IMPACT self-assessment to help systems, providers and partners understand where they are on their journey to embed each of the five components of NHS IMPACT'. Source: https://www.england.nhs.uk/publication/nhs-impact-improving-patient-care-together-self-assessment/ (accessed April 2025).

Lunch and Learns

Hosted by Dr. Amar Shah, National Clinical Director for Improvement, and Ailsa Brotherton, Improvement Director on the National Improvement Board, NHS IMPACT lunch and learns explore topics related to initiating improvement, coproduction, and a thorough examination of the five components of NHS IMPACT.

Masterclasses

NHS IMPACT Improvement masterclasses, again hosted by Dr. Amar Shah, the National Clinical Director for Improvement, offers expert advice and practical tips for enhancing improvement efforts.

Case Studies

Examples of organisations that have integrated all five components of NHS IMPACT can be found on the NHS IMPACT website.[4]

Improvement Guides

The NHS IMPACT website also contains a number of improvement guides aimed at supporting learning. Existing guides cover the following topics:

- improving flow through emergency care (reducing avoidable admissions and optimising admitted care)
- generating greater value for patients from theatres, elective surgery and perioperative care
- generating greater value for patients from outpatient services
- improving medical consultant job planning

[4] See: www.england.nhs.uk/nhsimpact/about-nhs-impact/ (accessed April 2025).

NHS IMPACT Bulletin

This is a monthly bulletin that provides subscribers with the latest news and resources for improving patient care, including updates from the National Improvement Board.

The National Improvement Board

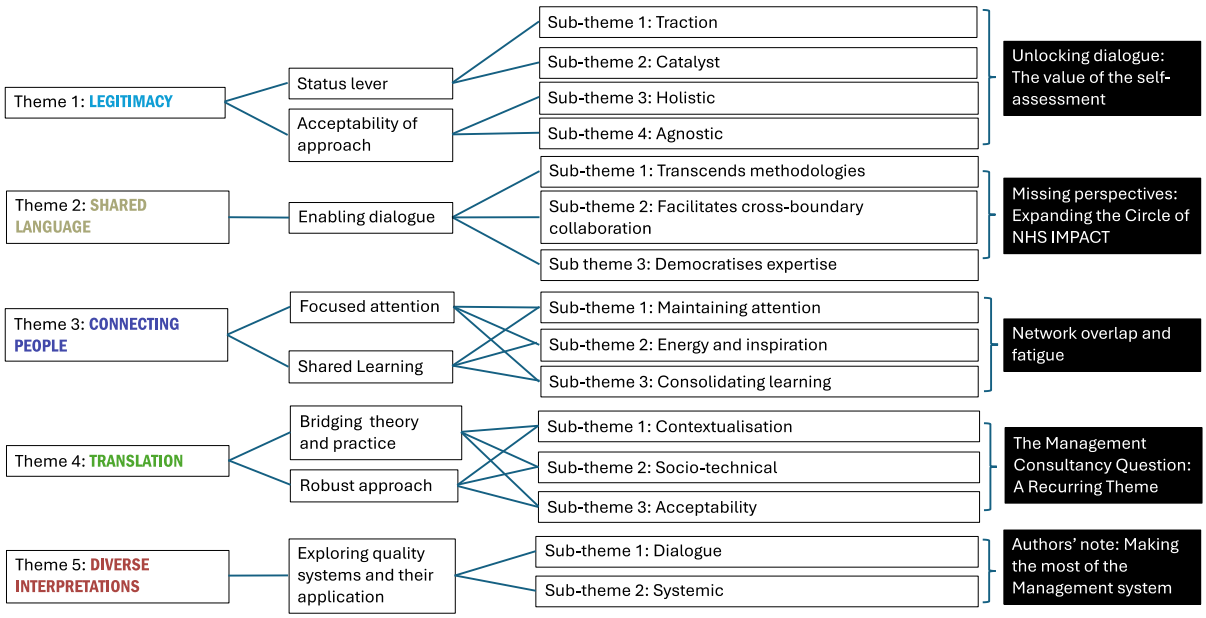
Finally, underpinning NHS IMPACT's work is a National Improvement Board. The Board was established to set the direction of system-wide improvement by bringing together experienced individuals and stakeholders to achieve shared aims through collaboration and co-design.

Thematic analysis: five interrelated themes

Creating the conditions for improvement

Our thematic analysis revealed five interrelated themes that illustrate how NHS IMPACT is shaping the strategy for improvement within and across the NHS organisations included in our evaluation. These key themes are LEGITIMACY, SHARED LANGUAGE, CONNECTING PEOPLE, TRANSLATION, and DIVERSE INTERPRETATIONS. Figure 1 illustrates the five themes alongside corresponding sub-themes; this schematic also serves as a navigation tool, enabling the reader to see the structure of our report at a glance.

Figure 1: How NHS IMPACT is creating the conditions for improvement in the English NHS



Theme 1:

LEGITIMACY

Theme 1: **LEGITIMACY**

Our analysis reveals a strong consensus among participants regarding the legitimising role of NHS IMPACT in raising the status of improvement within their organisations and initiating conversations about improvement and improvement strategy with senior leadership members. This finding was consistent across all types of provider organisations, including hospitals, specialist service providers, community health partnerships, and ICBs.

"NHS IMPACT is our vehicle for introducing everything we've been trying to introduce"

(Improvement Facilitator, Community Health Trust)

"NHS IMPACT gave us a stronger reason to come together if you like… This makes sense, it's the national direction of travel, so let's embrace it and go with it"

(Associate Medical Director for Transformation, ICB)

"It has helped to reinforce the importance, and the narrative around embedded improvement into business as usual for the organisation."

(Director of Transformation and Partnerships, Mental Health Trust, MH1)

"I think having the [NHS IMPACT] framework is really good. I hang everything on it. So any board report I'll always reference it and that's helpful because that gives you the legitimacy in your organisation to say we've got to do this. If we didn't have that it would be, 'Do we do it?' and 'We're all right. We're already doing it'. You know, that kind of thing. Whereas I can push people a bit more and say no. No, we're not doing enough. This [framework] describes what it should be, and there's a national network and you know, I think that has helped because the chief exec's certainly paid attention. Because of that national focus."

(Associate Director for Quality and Improvement, Community Health Trust)

Part of NHS IMPACT's legitimising role can be attributed to the endorsement of NHS England. This leverage conferred a national level of importance; many people told us the NHS England 'badge' was particularly helpful in this regard:

"NHS IMPACT is hugely helpful and the NHS England badge is really good leverage"

(Deputy Director of Improvement, Hospital Trust)

"I think what it has done is to provide the ideology and narrative that this is a national imperative"

(Director of Transformation and Partnerships, Mental Health Provider)

"I think it's helpful that it's badged NHS because of the way it's talked about: 'this is what we're going to do together, this is our way of working' … whether it's a financial problem, a patient problem, a pathway, this is the way the NHS is going to work. I think that's powerful"

(Chief Clinical Improvement Officer, ICB)

"It gives me a framework that is nationally recognised to be able to support the points I've been trying to make for a long time but hadn't had the gravitas or the reference model"

(Director of Improvement, Hospital Trust)

Further, NHS IMPACT was perceived as co-produced by a community of NHS improvement specialists and evidence-based, contributing to its acceptability as a single improvement approach for the NHS.

"Everyone is so complimentary about it because it was produced collaboratively, genuinely with the right people who were going to use it. So that was a massive success…probably one of the best examples of

collaboration I've seen…because it's not normally like that".

(Improvement Director, Hospital Trust)

"The message I think has come across and is part of why we're now seeing improvement mentioned so often by so many people at a senior level"

(Improvement Facilitator, Hospital Trust)

'To explicitly say we are using the evidence base of NHS IMPACT to help us understand and drive what we need to change in [our hospital group] to understand and achieve [our organisational goals] helped me shape the narrative for our strategic plan.

(Group Director of Improvement, Hospital Trust)

While most participants perceived the NHS England branding favourably, some admitted they had initially viewed the NHSE branding of NHS IMPACT with uncertainty and even suspicion. For example, one participant stated: *"At the start it was very much like - Who are NHS impact? What is it? It was a bit scary affiliated with NHS England" (Head of Quality Improvement, Specialist Trust).* This concern about a potential top-down approach is further highlighted by another participant who said: *"I think there's some truth in that anything that comes down from NHSE will be seen with suspicion and will be seen as punitive"* (Clinical Improvement Officer, ICB).

The overarching theme of **LEGITIMACY** revealed four interrelated subthemes, with the first two – 'Traction' and 'Catalyst' – demonstrating how NHS IMPACT's perceived status facilitated constructive conversations with senior leaders and board members; the third and fourth subthemes denote the general acceptability of an approach that is considered both holistic and method agnostic:

1. **'Traction' –a basis for improvement conversations with senior leaders**

The ascribed legitimacy of NHS IMPACT helped participants gain traction with senior leaders and executive board members; leveraging support from these individuals is widely recognised in both research and practice. As one participant notes:

> *"If you don't have [leadership support], you're not going to get anywhere. I know because I've tried. And I'm very persistent"*
>
> *(Director of Quality Improvement, Hospital).*

For many respondents, the branding of NHS IMPACT conferred legitimacy, enabling conversations with senior leaders and the beginning of leveraging the required support. Several respondents explained NHS IMPACT provided a framework for which they could take conversations about improvement 'to the board':

> *"It's enabled that discussion at that board level. You know, getting board members to sponsor quality improvement projects and then being able to take our quality improvement projects to present to the board as well. And I think* ***NHS IMPACT has provided that framework for the two sides to speak to each other****."*
>
> *(Quality and Improvement manager, Community Health Trust, bold italics added for emphasis)*

The participant's reference to 'two sides' in the quote above effectively illustrates the barriers that improvement specialists often encounter when trying to gain traction for improvement initiatives, frequently requiring them to reconcile diverse agendas and viewpoints from various professions, teams, departments, and organisations.

2. **A catalyst for more intentional and focused discussions on establishing the conditions necessary for adopting a systematic approach to continuous improvement.**

NHS IMPACT triggered new, more intentional, and focused conversations about adopting a systematic approach to improvement within and between organisations. Several respondents identified the self-assessment tool as both the catalyst and mechanism for initiating discussions with senior leaders (we discuss the self-assessment in more detail towards the end of Theme 1). The extract below illustrates how the self-assessment highlighted contrasting perspectives that ultimately facilitated discussions about new ways of working:

"The self-assessment allowed us to have a conversation as a senior leadership team on our strategy and our vision and whether that was clear enough. That opened up a big conversation with our senior leadership team because we had a difference between our board and our senior leadership teams self-assessment … our board thought we've got a lovely clear vision and a clear strategy and we all knew what we were doing and our senior leadership team said 'we're over-worked, we've got too many priorities. We don't know what's expected of us. We seem to get blamed if things don't get right'… [so] really quite a challenging conversation we had … I think ***as an organisation we were quite comfortable ignoring each other****… being able to have that frank and open conversation meant we've got to do something different then, haven't we? And so that's led into conversations about 'what could different look like?'"*

(Associate Director of Quality, Community Health Partnership, bold italics added for emphasis)

We added bold font above to highlight the tendency of organisations, departments, and teams to work in silos and how NHS IMPACT acted as a catalyst for breaking down these organisational silos and fostering the open conversations necessary for change to begin.

3. **A Holistic approach to embedding continuous improvement**

Several participants told us they valued the holistic approach adopted by NHS IMPACT, aiming for continuous improvement to become part of NHS culture. As one respondent

said: *"[NHS IMPACT] opened the door for the conversation of improvement to be far wider than just improvement" (Associate Director of Improvement, Hospital Trust).* Similarly, others noted the importance of *"a whole leadership approach with improvement at the heart of everything that we do" (Improvement Director, Hospital Group):*

"Improvement is everybody's business, and we need to promote it through you know, finance and performance behaviours and our systems and our everyday habits and routines. I get very frustrated when [exec member] says, 'Oh, all we need to do is train 1000 people.' And I'd be like, no, no, no, that's really not what we need to do. It's a part of what we need to do. But we need to do more. And so having that evidence base, that is really brilliant."

(Group Director of Improvement, Hospital Trust)

NHS IMPACT has also provided a welcome challenge to existing approaches and enriched understanding of what a holistic and balanced approach to improvement entails.

"I love that it's really helped me engage with execs on the fact that improvement is much, much more than training people."

(Director of Improvement, Hospital Trust)

ICB respondents described how they leveraged the holistic and agnostic nature of NHS IMPACT to shape a narrative of improvement that extends beyond a single organisation, forging a cohesive narrative *across* multiple organisations. For example:

"What I have done in true NHS IMPACT style is sought not to make an add-on and have really tried to send a very strong message into my organisation and our system that says this is not another job that you have to do. This is a way of working that makes the jobs you already have easier to do and more effective."

(ICB Associate Director if Improvement)

The relevance and uptake of NHS IMPACT, as described by ICB stakeholder participants, strike the authors as a remarkable achievement. It illustrates the flexibility of the five pillars that comprise NHS IMPACT, facilitating its transcendence and translation by different organisational archetypes. We return to this point under Themes 3: **SHARED LANGUAGE** and 4: **TRANSLATION**.

Another recurring theme among participants was the existence of distinct teams with overlapping goals but divergent objectives and operational approaches. This organisational structure encouraged siloed working and hindered collaboration. One respondent described this common scenario to us: *"They'd put in place a small improvement team, and my team were very segregated ahead of a similar improvement team, and we had a small [quality] assurance team. And never the twain would meet, never sort of even speak to each other, they sat in separate parts of the office. And it was just very, very weird". (Director of Quality, Community Health Trust).* Some respondents identified NHS IMPACT as the catalyst for uniting these similar but different teams in alignment with the holistic nature of NHS IMPACT:

Up until this point, [CIP, PMO, transformation, quality and improvement teams and programmes] in a typical hospital trust have been very, very separate. Gradually, we are starting to see improvement thinking as a way to bring these together and start to use that approach in how we design and deliver strategy.

(Director Improvement, Hospital Trust)

What the impact framework has allowed us to do is redesign some of our PMO work. It's saying, as well as looking at quantitative metrics, let's look at qualitative metrics that are driving unavoidable admissions. So usually if you look at the admissions to hospital, you'd be looking at bed blockages and you'd be looking at criteria to resolve all of those

kinds of technical things. When you're starting to embed the IMPACT frame, what you're now looking at is what's leading to avoidable admissions from a cultural and qualitative perspective, as well as a quantitative perspective. And when you're then building that into the way you design your programme, it is fundamentally different from the indicators you're using to measure your programmes of work. You can't underestimate the value of that.

(Director of Improvement, ICB)

However, combining similar yet different functions to foster a shared language and expertise in improvement requires careful planning, considering the values and ambitions of diverse roles and expert knowledge, along with investment in capability building, as the following excerpt from interview illustrates:

"We appointed the Director of Improvement [to replace] the Chief Transformation Officer post. So you can see a real deliberate language shift in the organisation and pretty soon after we launched a consultation to bring anyone with improvement or transformation in their job title into a single improvement team. ***And that's been quite a challenging process…there's a lot of healing to be done as part of that****. And part of that I think is normal... So I think the other important thing in that bringing that team together is recognising that … those people had not been recruited against the person spec that included improving knowledge. So, we have had to spend quite a lot of time training the team up to work in a different way.*

(Director of Improvement Capability, Hospital Trust)

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4. **Agnostic**

Most participants welcomed the agnostic approach adopted by NHS IMPACT, which allows for compatibility with existing methods and the freedom to choose an approach that best fits an organisation and its purpose. A few respondents expressed an initial concern that NHS IMPACT would undermine existing improvement efforts. For example, one improvement facilitator told us her line manager had asked her to check for any 'immediate threats':

"I got this email saying [from a senior leader]: "There's this thing that's come down from NHSE called NHS IMPACT. It's all about how we do improvement kind of nationally. I haven't had a chance to look at it. It's just landed in my inbox. Can you just look at it and send me like a one-pager of what you think? Are there any immediate threats? Is it different from what we're trying to do?"

(Quality Improvement Facilitator, Hospital Trust)

Many respondents shared that an agnostic approach complemented, validated, and augmented their organisation's existing improvement strategies. We noted that this was particularly beneficial for organisations with structures encompassing several organisational entities, each potentially endorsing differing approaches based on specific improvement models (for example, IHI's model for improvement, KPMG's Patient First approach, or the Lean-based Virginia Mason model).

"NHS IMPACT has given me that sort of starting point and I've grown that with my own input and my own background reading to develop it into something that I'm delivering"

(Director of Improvement, Hospital Trust)

The fact that NHS IMPACT is method agnostic appears especially relevant for newly formed structures such as mergers, groups, and integrated care models. The following excerpt from an interview illustrates how a recent hospital merger (also part of a group model) leveraged NHS IMPACT to unite organisations with fundamentally different improvement approaches. The participant described how a politically charged environment underscored the value of NHS IMPACT as a neutral and respected improvement framework that provided a crucial platform to bridge these divides and establish a shared and strategic approach for the newly expanded group:

> *"When things got really fraught…the thing I used NHS impact a lot to say that this isn't a question about 'is it model for improvement or not' or 'is it patient first or not'. I said the better question to ask is as an enlarged organisation, how do we deliver on the key principles of NHS impact. It has been so useful for me. I kept dragging people back to that…[I said] 'Let's not get hung up on what we're trying to defend let's focus instead on the destination'".*
>
> *(Director of Improvement and Transformation, Hospital Group)*

While most welcomed the approach, some were critical, admonishing the NHS's tendency to *"keep reinventing the wheel [and] if I'm new to the NHS, can I just go to NHS IMPACT and say, what's the standard methodology that we have at NHS to do improvement?" (Director of Quality Improvement, Hospital Trust).*

Critical Reflection and feedback:

Achieving parity of esteem for improvement as a strategic priority

Among all the competing change agendas an NHS organisation faces, NHS IMPACT has the potential to elevate the profile of improvement to a higher priority at the strategic level. However, achieving parity of esteem during times of financial austerity remains an enduring challenge. To this end, several respondents spoke of a need for improvement to leave behind its popular image of *"fluffy cushions and scented candles"* and promote a hard-edged focus instead. Aligned to this, one respondent describes a key moment in their organisation where, when asked to focus on efficiencies, the improvement team sought to integrate this work with the overarching improvement framework, rather than treating it as a separate initiative.

"If I think of what we're doing locally, we have taken the [IMPACT] framework and said that that framework is everything and that is how we are going to organise ourselves. And we've had conversations around our priorities and how they align to it… And so we've done that work as a senior team, and then our Finance Director said, 'Oh, now you need to do some work on efficiencies'. As a team, our maturity showed because they turned around and went 'No. We've got to make this mechanism deliver everything. It can't deliver only part of the stuff. It's got to deliver everything, and that's where I think the NHS has to kind of come. You know, if you think about the way the NHS works, it works in these kind of separate planning streams, as a finance planning stream here, a workforce planning stream there. So that's kind of a hard-edge side of things."

(Associate Director of Quality Improvement, Community Health Partnership)

However, while there is some consensus among respondents that improvement should be the mechanism through which NHS organisations and the NHS more broadly tackle complex problems, including finance, most agree that there is still some way to go before improvement achieves 'parity of esteem'. Citing evidence suggesting the best-performing NHS organisations have a systematic approach to quality improvement embedded within

their organisations, the quote below highlights the distraction of diverse programmes in NHS England that are each fighting for status and resources:

"I think improvement needs to be seen as important as oversight and assurance and performance management. You know, we know, don't we, that those organisations that have been rated outstanding by the CQC are all over improvement and have got a really good embedded cultural approach to continuous improvement within their organisations… It doesn't feel like that in NHS England at the moment and obviously NHS impact has been put into motion and...if you can convince people who are running the other programmes in NHS England of the benefit of the improvement programme I think that would be an amazing thing … I'd like to see it achieve a bit more parity of esteem, I suppose, for continuous improvement.

(Deputy Director of Improvement, ICB)

Unlocking Dialogue: The Value of the Self-Assessment

When asked about NHS IMPACT, many participants began by describing the self-assessment tool. This finding highlights the tool's perceived importance and strong connection to theme 1: **LEGITIMACY**.

Several respondents told us how the self-assessment served as both a catalyst and a mechanism for engaging in structured conversations with senior leaders and board members. These discussions were viewed as highly valuable, often fostering honest and sometimes challenging dialogues about the organisation's maturity regarding its improvement strategy and approach. However, many respondents acknowledged the self-assessment as an imperfect measurement tool, emphasising its true value lies in the structured conversation that it generates. The following quote exemplifies the strong feelings many respondents had regarding the tool's value compared to its imperfect nature:

*"**I hate the self-assessment tool**. I absolutely hate it with a passion. **But I love everything about it at the same time**. The conversations are amazing. I facilitated a lot of the conversations with the management teams around NHS IMPACT. These are really important things to talk about, and the value of the conversation is fundamental because it's about people thinking differently. That's what generates organisational change. So, **the real value is the conversation**."*

(Quality Improvement Leader, Community Health Trust)

Participants held differing views on the NHS IMPACT self-assessment. Some appreciated its *"evidence-based challenge"* that *"flushes out a lot of things,"* and others spoke of its focus on key areas like *"investment, culture and people."* Conversely, others criticised the tool for lacking a robust evidence base, using hospital-centric language, and employing overly

broad questions.

"The questions were very high-level and very broad … there's no way we can measure it like that. [The self-assessment] could have started a conversation. However, the way that the questions were, because it was multiple choice, there was a yes or no, the executives could just say, 'Oh, do you have an improvement methodology?' And if they say yes, they will look good. So, it just lacked, how can I say, it didn't take us to the reality"

(Director of Quality Improvement, Hospital Trust)

Others reflected on the need to handle the self-assessment process carefully, recognising the potential to provoke defensiveness from those they aimed to engage.

"I got all very excited thinking this [self-assessment] is fantastic. We can work out where we are and … I was quite new [and] when I went to board it went down like a damp squib. And I've got to say that was partly my fault. I think the board got very defensive…and I messed up there because I probably should have led them more gently and done something a little bit less [head-on]. They felt they were being put on the, you know, in the hot seat."

(Director of Improvement, Hospital Group)

Despite some consensus that the self-assessment was imperfect, several respondents reported having already conducted the survey a second time or planning to do so soon. Notably, some respondents described innovative methods for making the self-assessment results visible, including variations across professional and managerial groups. See **Appendix A** for an excellent example from North Bristol NHS Trust.

Opinion was divided on whether the self-assessment should remain mandatory (as initially conceived) or if it was the right decision to make its completion voluntary. The argument

for making the self-assessment mandatory was presented by respondents who cited the benefits of benchmarking performance against others; moreover, they argued that benchmarking (even anonymised) was a key lever for gaining traction with senior leaders and raising the profile of improvement.

"I was hoping it would go on to like Model Hospital and stuff like that in terms of you know, your maturity. Seeing where you are as an organisation relative to everyone else would help drive that conversation, particularly at the board level…show them where you sit compared to your competition… it doesn't have to be named, but if you know that you're in the lowest centile for your maturity of improvement. You might start wanting to have that conversation about what we need to do to get ourselves more mature."

(Director of Improvement, Hospital Group)

Others expressed relief: *"[The switch to make it voluntary] just made me feel less anxious that somebody would be judging it at the other end and not knowing what they would do with it. But [the self-assessment] was still helpful to us".* (Associate Director, ICB)

A missed opportunity?

Although some participants valued the move towards voluntary self-assessment and the rationale for preventing score inflation, a significant number expressed their disappointment. One participant captured this sentiment by saying: *"it took the teeth out of it".* Our analysis points to the potential of regulatory mechanisms in more firmly establishing improvement within NHS provider organisations, shifting its image from *"fluffy cushions and scented candles"* to a necessary *"hard edge"* for tackling complex challenges such as reducing waiting times and improving finances.

"I think the finance side of things has to become stronger, I think we have to show that by approaching stuff from an improvement science perspective. You know, this is how

we will tackle our challenges. It's recognising the seriousness of it… People have talked about a thousand flowers blooming and stuff like that. But it's not just fluffy stuff. This is quite hard … and I think we have to be stronger on that. You know, everything we do has that kind of approach".

(Associate Director of Quality, Mental Health Trust)

"There's a sense that the centre tells us stuff and we have to kind of jump, you know, and we say how high to an extent. That improvement is one of those things, and there's an expectation that we build an approach to it and measure how we're doing. I think it would be very difficult to do our job if it didn't exist."

(Quality Improvement Facilitator, Hospital Trust)

In line with the overarching theme of legitimacy, some respondents told us they felt NHS England should *"crank the handle"* and hold organisations and their boards accountable to sustain attention on NHS IMPACT and support improvement professionals in their role:

"When you find yourself in a meeting with loads of ops managers or a nursing director, that's probably not your home space in an organisation if you're working in improvement. Because they're always challenging you and telling you that they just need to crack on with performance and just get on with it while you're bringing in theories and abstract concepts. In the improvement community, ***I think there was an expectation that NHSE would just crank the handle a bit and hold people accountable for implementing NHS impact****."*

(Director of Improvement and Transformation, Hospital Group, bold emphasis added)

In conclusion, while the self-assessment tool served as a valuable starting point for conversations with senior leaders and boards and in identifying areas for enhancement, our findings suggest a potential missed opportunity to establish it as a robust lever for

prioritising improvement within the NHS IMPACT framework amidst other organisational demands.

Theme 2:

SHARED LANGUAGE

Theme 2: SHARED LANGUAGE

As a single improvement framework for the NHS, NHS IMPACT has established a 'shared language' for improvement that transcends various improvement methodologies, organisations, and organisational types. The emergence of a shared language for improvement was a significant aspect of NHS IMPACT's influence, as highlighted by participants:

"IMPACT has given us the language to make it conscious. And we can very clearly use language that we are all familiar with to describe improvement"

(Director of Improvement, Hospital Trust)

"I think that the framework gives us a common language to talk about you know, what is your management system? How do you build a capability? You can ask those questions because you're coming from a common framework irrespective of what improvement methodology you are using"

(Associate Director of Improvement, Hospital Trust)

Within the overarching theme of shared language, we identified three sub-themes that support and enable the development of an improvement strategy and culture across the NHS:

1. **NHS IMPACT enables transcending methodological differences.**

Several respondents described how both individuals and organisations often exhibit strong preference and allegiance to specific methods and methodological approaches. For some, the ability to transcend these methodological differences helped mitigate tensions where different individuals and organisations held competing preferences for specific

improvement approaches; for others, it was a mechanism enabling the alignment of NHS IMPACT principles with a favoured improvement approach, accelerating its acceptance.

"Post-merger, we inherited two distinct improvement methods, but progress stalled due to regulatory demands and then COVID happened. Post-COVID, the hospital wants to resume attention to improvement, but the arrival of a nurse director with an IHI background introduced a third approach to mix. NHS IMPACT offered a national framework and expectation, helping to consolidate our improvement approach and raise the profile of it."

(Associate Director of Improvement, Hospital Trust)

"We chose the IHI-type programme of bringing joy to work because it was something that we thought everybody would get behind. We did a six-month programme of just bringing self-selected staff together with about 30-40 of our organisation to design little projects they thought would improve joy at work. And the learning and the legacy from that was awesome. So, I think if you can somehow shoehorn the thinking and the principles and the tools into something that people are passionate about, that is about them, that answers the 'what's in it for me', and you can get traction really quickly."

(Chief Clinical Improvement Officer, ICB)

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2. **NHS IMPACT enables cross-boundary collaboration for improvement.** This finding was prominent among participants working within enlarged organisational structures such as hospital groups, community partnerships and ICBs. The quote below highlights the value of NHS IMPACT at an inter-organisational, system level:

"Providers had a very strong identity of what they were and what they wanted to be and a very well-developed infrastructure for improvement, but it was then a big leap to consider what can they contribute to the system and what they might need to compromise on their improvement journeys to get the greater good, especially when the benefit lands out with their particular silo."

(Clinical Improvement Officer, ICB3)

However, one participant noted the benefit of a shared language within and across organisational boundaries from the patient perspective:

"We want the patient to recognise that they're still in the network even though they're moving from different sites. We found NHS IMPACT's approach really helpful to kind of have that common set of standards and common language so that the patient recognises that they're still in the network and they're not going from the [specialist] Centre to our extended rehab, and seeing it is an entirely different part of their journey. They still feel like they're on the pathway really."

(Associate Director of Quality Improvement, Community Health Trust)

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3. **NHS IMPACT enables the democratisation of improvement expertise**. The accessibility of language and content of NHS IMPACT (including the learning and support networks, lunch and learns and masterclasses) enhances the accessibility of knowledge and understanding of the conditions that support improvement accessible to non-experts and those with limited time, while also supporting the continued growth of those who consider themselves knowledgeable.

"As an ICB, the place we wanted to get to [whilst respecting the science of improvement] was 'How do we democratise that and make it a set of tools that people can use even if they don't understand the science?' And that's where the NHS IMPACT bit came together, and the five different [pillars]allowed us to have some structured conversations around how we take things forward"

(Improvement Director, ICB)

Critical reflections and feedback

Promoting diversity of voice and application. A key benefit of the shared language within NHS IMPACT lies in its ability to transcend diverse improvement methodologies, effectively resolving tensions that often arise from competing approaches. This has been particularly helpful for those navigating conflicting improvement initiatives within their organisations, between teams, and across integrated care pathways and systems. The improvement networks (discussed under Theme 3: CONNECTING PEOPLE) have played a vital role in nurturing and reinforcing this common language, a feature highly valued by participants.

Nevertheless, the very strength of this shared language – its commonality – can also present disadvantages. For example, the drive for linguistic commonality can lead to the oversimplification of intricate challenges, overlooking critical contextual factors, and potentially cultivating an echo-chamber where diverse perspectives are lost. To counteract this, actively seeking and valuing a broad spectrum of voices, interpretations, and varied case studies will cultivate an environment rich in perspective, capable of respectful challenge, while continuing to strengthen and embed a common language for improvement across the NHS.

Missing perspectives: Expanding the Circle of NHS IMPACT

Our evaluation primarily engaged improvement experts who were actively involved in relevant networks. However, interviews with a few individuals outside this core group – three doctors (whose insights are explored in Theme 3: CONNECTING PEOPLE) and a patient partner – provided valuable alternative perspectives. The patient partner's experience, in particular, illuminated critical challenges related to inclusivity. The patient partner highlighted his inability to engage with or even be informed about NHS IMPACT due to the lack of an NHS email account and expressed feeling *"not really valued"* despite extensive experience leading improvement across diverse sectors.

"I haven't got an NHS account…. I googled [NHS IMPACT] to be honest… I'm not really valued. [For example] we had a meeting with the Chair of the Board of [English Region] last week. And some of the questions that I've been asking had led to his conclusion that we were holding him and his board to account, that we were scrutinising the work that he was doing and that we had to stop. It wasn't the way that he wanted us to behave."

(Patient Partner)

The above comment raises the issue of patient involvement in NHS IMPACT. Most improvement methodologies advocate including the voice of the customer. While improvement methodologies and NHS research typically mandate public involvement, and the NHS itself espouses this commitment, the experience of this patient partner suggests that actively and effectively engaging patient partners requires more consideration.

In sum, while NHS IMPACT has been successfully embedded within the improvement community and shows signs of leveraging a more intentional and systematic approach to improvement within and across NHS organisations, it has yet to extend its direct influence beyond this group to include patient partners as well as other senior leaders, middle managers, medical doctors and other healthcare professionals within the system.

Theme 3:

CONNECTING PEOPLE

Theme 3: CONNECTING PEOPLE

The third dominant theme emerging from the analysis is CONNECTING PEOPLE. This has been driven by the Improvement Directors Network (IDN) and the Improvement Leaders Network (ILN), which focus on using NHS IMPACT in practice. Our findings highlight the value people attributed to the networks regarding peer support, a protected space for improvement-related conversations, capability building, and the opportunity to share learning and 'go-see' improvement in practice.

"So they're a lifeline. And it just gives me just that space to think and be around like-minded people. So yeah, the IDN is hugely supportive."

(Improvement Director, Hospital Trust)

"You know, the real connectors are the people who you say to them all 'I've got this problem. What do you think?' And they'll go. 'Oh, I know someone who's doing that and they'll connect you and they'll give [their time] for free. And this is what I quite like about [ILN]."

(Associate Director of Improvement, Community Trust)

"Talking through the networks and that exchange of information, how people have applied [the five pillars] in practice, I think that's what's generating the energy behind NHS IMPACT."

(Director, ICB)

As illustrated by the quotes above, several participants described the network-enabling benefits of the IDN and ILN networks as a core part of NHS IMPACT's impact. People told us that the quality of the IDN and ILN meetings, which form the core artefact of each network, was very high, ensuring their value to those who participate in them.

"It's been quite practical. 45 minutes, once a month, you get one or two presentations... the sorts of networks that have certainly over the last

year, year and a half, have fertilised our thinking within the organisation."

(Director of Partnerships, Hospital Group)

"[The Improvement] Director's Network is fantastic. I think that's really good. And then the leaders network as well is really good. So I find them really useful actually."

(Director of Quality, Community Mental Health Trust)

"I do think those networks have been good in sort of genuinely sharing what people are doing, doing that in a way that follows the framework within NHS IMPACT itself."

(Director of Improvement, Hospital Trust)

Within the overarching theme of **CONNECTING PEOPLE**, we identified three interrelated subthemes:

1. **Improvement networks help maintain attention to improvement.**

The context in which improvement approaches are used is continuously changing, perhaps increasingly so in recent times, driven by large-scale reorganisation and staff cuts. Participants stated that the improvement networks, as well as the NHS IMPACT framework, have helped maintain organisational attention to improvement and the elements that support it.

"The message, I think, has come across. And it is part of why we're now seeing improvement mentioned so often by so many people at a senior level."

(Quality Improvement Facilitator, Hospital Trust)

"So internally in the Trust, it's just helped us reinforce [improvement] and I would say what we're doing on patient experience, NHS impact

has absolutely reinforced where we were deficient, and we've done something about it."

(Deputy Director of Improvement, Hospital Trust)

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2. **Improvement networks as a source of energy and inspiration.**

All change requires energy, and participants reported that leading improvement can be lonely. Some commented that the IDN and ILN networks have provided a welcome source of support and energy in this challenging context.

"I couldn't be without the IDN. They're like my life source, because it's lonely."

(Director of Improvement, Hospital Group)

"When you've got that passion for improvement it's nice to know what people are doing and probably within that hour of a period of reflection and learning as well, so that that's good for me."

(Head of Improvement, Non-Hospital Trust)

"Talking through [challenges and making sense of the NHS IMPACT domains] the networks and that exchange of information [about] how people have applied them in practice, I think that's what's generating the energy behind [NHS] IMPACT."

(Director, ICB)

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3. **Improvement networks help consolidate learning**

The sharing of experience, methods and approaches supported and catalysed by NHS IMPACT was valued by respondents. Enabled by the IDN and ILN masterclasses, the inherent shared language, and organic networking, respondents reported sharing how different organisations have overcome various challenges. Part of the value of this was seen as avoiding the re-invention of existing solutions and improvement approaches.

"There's the Improvers Network [ILN], a little group on a WhatsApp as well. I'm part of that, just to kind of get the flavour of what's out there, learning from how other trusts are doing things to kind of not reinvent the wheel really."

(Pathway Lead, Hospital Trust)

"The networks have been good in sort of genuinely sharing what people are doing. So you're reinforcing the, the messaging and what it's trying to achieve, but also recognising that organisations will have different approaches by the kind of showcases and the master classes, so I think those have been helpful."

(Director of Improvement, Hospital Trust)

Some participants described how the network relationships created and promoted through the IDN, ILN and other informal NHS IMPACT networks instigated 'go-see' visits between participant members and their organisations: *"You know if I'm struggling with something conceptually, I just get on a train or to get in the car and go and see someone who's doing it well and I can bring that back to the [organisation]." (Improvement Director, Hospital Trust).* These organically organised visits help improvement leaders to understand what others are doing and discuss the approaches used:

"It all has to come together around the business of what you're trying to do. So that like kind of has led me to understanding some of the evidence and research and visiting places, but also it makes me think of things all the time."

(Associate Director, Hospital Trust)

Critical reflections and feedback:

Network membership:

As part of the process of developing both networks, the IDN membership was reviewed and refined to separate executive directors with responsibility for improvement from other, less senior improvement leaders. With the IDN membership refined and the ILN membership more open, interviewees commented on the benefits of these changes.

"I think since we've had a bit of a review of the last couple of 18 months and we've become smaller and a bit more focused on I think titles and people. So a much smaller group with people who hold kind of directorate portfolio, which is really safe I suppose and helpful."

(Director of Improvement, Hospital Group)

"I personally feel that it has just been incredibly helpful. I mean the improvement directors network is so much better than it used to be."

(Director, Community Health Trust)

However, a significant and seemingly enduring issue raised by participants was the restrictive rationalisation of network membership. This was particularly problematic regarding the inclusion of deputies or individuals with portfolio titles that differed from traditional structures across organisations. The exclusionary nature of these decisions, as illustrated by the following quotes, created frustration and a sense of hierarchical rigidity:

"So for me I was on the IDN as it was and then they went through quite a kind of aggressive profiling exercise of who could or couldn't be in the network."

(Director of Improvement, Hospital Group)

"When my boss left and we couldn't replace her I wasn't allowed into the Improvement Director's network [to stand in] - I found it intensely

frustrating."

(Deputy Director, ICB)

Interviewees also reflected on the design of both network meetings. Some valued the set format and good contributors, and some noticed the meetings were characterised by 'broadcasting information', and a stronger sense of hierarchy, as opposed to more inclusive networking.

"They've got like a good set format. I think it's really great. So you know in that regard I like it, but I think it's not as joined up as it could be."

(National Improvement Stakeholder)

"The Improvement Learners Network, there are again regular sort of webinars on that. I find them very broadcast in their design, they don't seem to be designed to create connections between people. They seem to be designed for NHS England to tell us things. So, they're not very networky [sic]."

(Associate Director, ICB)

There was the Q Community development I think earlier on as well. You know you've got a lot more connection of people. It [the IDN] doesn't feel like that connects [people] very well now because there's this rigid hierarchy of you're in the improvement directors network or you're not.

(National Improvement Stakeholder)

Those not yet 'connected':

Contributors identified a number of different groups that were less connected, and in some cases less represented, with NHS IMPACT's work and improvement approaches more generally.

- **Minority staff groups:**

While there has been concerted effort to begin to address the underrepresentation of minority ethnic staff groups in NHS leadership positions, it is perhaps unsurprising that one respondent, through lived experience, saw the inequalities faced by minority ethnic staff groups as present in their access to and involvement in improvement approaches and initiatives. The following quote is from an interview with a participant who was not involved in the IDN or ILN:

"Being the race I am from, I have been privileged and I have been lucky to have mentors who have seen something in me and have developed me because very few of people of my race will have the opportunity to be where I am. It's an honour to be here [in an improvement role], because we [minority ethnic staff groups] don't have that opportunity…It will not come to you. Unfortunately, some people, it goes to them. It doesn't come to us. You have to go to it. We are not. We are mostly not the table."

(Quality Role, ICB)

This suggests that if a wider spread is desired, minority staff groups need specific prioritisation and engagement in the challenges they face in improvement approaches.

- **Medics:**

Of the contributors coming forward to be part of this evaluation, very few were medics. Some of the reasons for this can be attributed to the research design, with the main channel accessed to invite contributors being the IDN and ILN networks – networks that are predominantly formed from professionals with organisational improvement responsibility in their portfolios. An attempt to balance this was made by inviting the alumni of the London Darzi Fellowship (circa 300 clinicians, majority medics) to contribute, of which one medic came forward.

In discussing this with the medic, it was their view that medics would not go to NHS England for sources of information on how to approach improvement; more likely, they would look at GIRFT (Getting It Right First Time).

"If you're talking about, just a practising jobbing senior registrar or doctor, [with a] particular problem in my department - The most impactful thing is GIRFT because you have people visiting you once a year or once every two years."

(Surgical Registrar, Hospital Trust)

Whether this is a problem or not is a question outside of this evaluation scope, but the medic's view was that the majority of front-line medics would not be aware of NHS IMPACT or understand what they are looking at if they went to the NHS IMPACT website.

"If [improvement] was a world that you were very new to, then it would be incredibly overwhelming. And I don't think you would understand much of what you're looking at it [on the NHS IMPACT website]. It looks like it'd be fantastic for someone who's already involved heavily in the work."

(Surgical Registrar, Hospital Trust)

They went on to comment that the most fruitful way of raising awareness of Medics is through postgraduate training: *"I would get much more heavily involved during training. Because when you develop these skills (as a medic). We still have terminology and expectations around requirements that are based off how things were done some years ago. In medical schools and a lot of medical schools now, quality improvement is part of the curriculum. I don't think that's translated across to postgraduate training yet."*

GPs:

ICB, GP, and Patient Representative respondents identified GPs as a challenging group to engage, particularly with NHS IMPACTS stated aim of establishing a common

improvement approach across the NHS. Some respondents commented that it was unclear what value NHS IMPACT would provide to a GP or GP practice.

"[When working with GPs] The first question they will ask when I walk into the room is well, 'what's in it for me?' And if I can't answer that question, I might as well go home. Because it's, you know, [GPs] are independent businesses."

"So what is the motivation for them to do something different that might fail that might cost them money from their back pocket? So if a hospital department tries something and it ends up costing a couple 100,000 extra, well, that was an unfortunate we need to try something. If we could do it in practice. And there's five of you, that's 40 grand each that that focuses the mind on either not trying in the first place."

(Chief Improvement Officer, ICB)

The workload challenges and lack of infrastructure in general practice were also identified as barriers to NHS IMPACT with GPs. An ICB participant spoke of the response of a GP to being asked about NHS IMPACT in a questionnaire: *"Haven't I got enough to do? Don't you? Don't you know how difficult it is out here? We're drowning and you're asking us if we want to do some fancy improvement stuff" (Associate Medical Director, ICB).* Another ICB participant described a lack of headspace and bandwidth for participating with NHS IMPACT and its improvement networks:

"You have to be mindful of scaling infrastructure there - [GPs] are not the same. There's no headspace, is there? You know you're not going to [engage GPs with QI] without something giving or something putting in. You're not going to get people to come to an improvement leaders network."

(Chief Improvement Officer, ICB)

Again, whether GPs and their engagement are or should be a strategic priority for NHS IMPACT is out of scope for this evaluation, especially in light of existing NHS England practice improvement initiatives such as the General Practice Improvement Programme (GPIP). However, the fact remains that general practice plays a larger pivotal role in the government's NHS priorities now than ever before.

Network overlap and fatigue:

Networks are proliferating across the NHS and are viewed as a powerful mechanism to facilitate change, collaboration, and sharing of learning across the traditionally siloed NHS landscape. This growth has been partially supported by investment in the NHS Futures collaboration platform. Specifically regarding improvement approaches, there has been sustained investment in large-scale networks such as the Q Community, Proud2bOps, and Health Improvement Alliance Europe.

Against this backdrop, as discussed earlier in this section, NHS IMPACT has successfully developed and expanded the IDN and ILN networks, thereby increasing the mix of networks available. Through the evaluation interviews, the advantages and disadvantages of the NHS IMPACT networks emerged as common themes. One example of a potential consequence of the broader trend of an increasing number of networks is network fatigue:

"I could spend my entire life going to networks, talking about what we're trying to do and what we're managing to do, and sharing best practices, but I would run out of time because there are so many networks. They've set up a regional network for UEC improvement, mental health improvement, elective recovery, urgent care, etc."

(Medical Director, ICB)

This issue may be exacerbated by the 'production pressure' felt by many front-line professionals and operational leads, which restricts the time they have to engage with networks or other best practice sharing channels.

"[It is important to consider] staff headroom at the moment, most units have lost all their resources. We used to have resource rooms and had 10-15 minutes for reflections. We've used all of that for, you know, for beds. So there's no room for anywhere to anybody to go and read anything [or engage in a network or briefing]. You don't have staff. That's what they're dealing with. People have gone off sick. That's what they are dealing with. So NHS IMPACT, yes, I've seen the e-mail, but I haven't read it."

(Quality Role, ICB – referring to leading front-line teams)

Alongside the fatigue potentially caused by the sheer number of networks, another theme that emerged was the perceived overlap between networks in the 'improvement space'. Some interviewees identified a need to consolidate information sources:

"Is there a way that NHS Impact can tell me everything that I need to know about improving? It will be a great way to also help other networks [Q Community, Proud2bOps, other networks within NHS Futures]."

(Director of Quality Improvement, Hospital Trust)

While other contributors, viewing improvement systemically, identified a potential missed opportunity of creating a wider improvement movement by building on what already existed:

"I think there was a kind of principle that [NHS England] were going to try to create a movement. They were going to work with and build on it. In practice, however, it feels

like the opposite of that. I would say it has become something different that doesn't actually build on the existing infrastructure or networks."

(National Improvement Stakeholder)

The discussion raised by interviewees on the theme of building on existing capability extended beyond the network elements of NHS IMPACT and reflected the wider programme development: *"So they're talking about creating a national learning and improvement system, and yet they [NHS IMPACT] they're kind of thinking about just some separate programmes and maybe taking for granted some of the things that already existed."* (National Improvement Stakeholder)

Specifically regarding existing formal network membership and advocacy organisations with stable membership bases, such as NHS providers and NHS Confederation.

Theme 4:

TRANSLATION

Theme 4: TRANSLATION

The fourth theme emerging from the analysis is that of **TRANSLATION**. As with any socio-technical approach to change, knowing where to start, what to include, and what good looks like is complex and challenging due to the range of research, arguments, case studies, literature, and perspectives. NHS IMPACT has facilitated the translation of what good looks like in a trusted, method-agnostic manner that provides flexibility for future development and local interpretation, regardless of context, experience, or history.

"I would describe NHS IMPACT as a template for how you should approach developing an improvement culture that delivers in your organisation"

(Deputy Director of Improvement, Hospital trust)

"I was trying to translate what an improvement approach looks like for the board and let them see what [good] looks like five years from now - NHS IMPACT was very helpful."

(Improvement leader, Ambulance Trust)

"I suppose it holds the assurance around what good quality improvement looks like, and that I think is the benefit of NHS IMPACT."

(Quality Improvement Lead, ICB)

"In having this framework, I've returned to it and said, well, a good Trust looks like this based on what [NHS IMPACT] is saying. So I can tell what we should be doing.

(Quality Improvement Trainer, Hospital Trust)

For some participants, the translational benefits of the NHS IMPACT framework held value for improvement leaders across the NHS as a whole: *"It's a way to bring together a*

vast pool of experience and perspectives across the country. It's a focus point for 100's of trust improvement leader]".

Within this overarching theme of **TRANSLATION**, we identified three interrelated subthemes:

1. **Contextualisation - NHS IMPACT supports understanding improvement theory in the context of the NHS and different provider organisations.**

Multiple participants described the importance of making sense of systematic approaches to improvement within individual organisational contexts, in this case with reference to GPs: *"You have to be mindful of context. You have to be mindful of scaling the infrastructure there. [GPs] are not the same" (Chief Improvement Officer, ICB).*

The importance of contextualisation extends beyond the differences driven by organisational type, such as those between a hospital and a community services provider. It also encompasses the priorities and local context variations among similar provider types.

"I like that it's not a mandated framework. I like that there's flexibility in it and I like that there's really room to make it bespoke to your own service."

(Pathway Lead, Hospital Trust)

"It's a single place that people can go. So, there is one framework that we're all looking at. I think the point about the framework is you can interpret it for yourself."

(Quality Improvement Lead, ICB)

The ability of NHS IMPACT to be successfully contextualised across multiply contexts is reflected in the inclusive array of organisational types that have embraced it. Participants in this evaluation came from a spectrum of provider organisations, including teaching

hospitals, general hospitals and hospital groups, integrated care boards (ICBs) with their diverse responsibilities, general practice, community providers, and ambulance trusts.

Furthermore, several interviewees expressed value in the role NHS IMPACT plays in helping people understand improvement within a broader NHS context. For example helping people make sense of what 'good' improvement approaches might look like:

"So it takes this huge body of work and evidence, from a huge number of sources and NHS IMPACT brings all this, using evidence, into one place and framework."

(Quality Improvement Lead, ICB)

"So I like that, and that's enabled me to do more within the organisation to actually paint that picture [of what a good improvement approach looks like]."

(Head of Improvement, Hospital Trust)

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2. **NHS IMPACT promotes understanding of improvement requiring a socio-technical approach to change.**

Many participants told us that NHS IMPACT has led to a greater understanding of improvement as a holistic, socio-technical approach to change. This requires actively shifting senior leaders' understanding of improvement away from the assumption that it is solely about training staff or merely applying commonly associated tools, towards appreciating the socio-cultural aspects of change and thinking further about creating the system conditions for improvement to happen.

"If you work within the NHS, they'll talk very much about the PDSA cycle and stakeholder mapping. But what NHS IMPACT did was introduce the notion of having to galvanise your people around you to change effort before you engage"

(Director, ICB)

"What I really like about NHS IMPACT is the fact that it focuses on the enabling environment that needs to be in place for improvement to take place. So yes, we might have a [change] idea, but in order for it to seed, you do need a fertile ground for that to happen. You do need the right conditions for that to happen."

(Head of Improvement, Hospital Trust)

While others explicitly linked to the important role that a management system plays in a more holistic improvement approach:

'The idea of [improvement] being part of an actual organisational management system until recently, has never really been said...It's like because our whole approach to improvement in the NHS has been, this is great - just do it, go on, just get inspired, find something, improve it… but yet you really need to have a system that supports these people or they get crushed and it's really unfair … What NHS IMPACT does is it says it's [improvement] not separate, it has to be part of how you operate [part of the management system].'

(Quality Improvement Lead, Community Trust)

Furthermore, several contributors emphasised the importance of establishing a more holistic definition of quality when developing improvement approaches:

"So, the quality equation isn't separate from the resource issue."

(National Improvement Stakeholder)

"IHI have taken a very broad definition of quality. To essentially be almost everything. In fact, everything a health system or health provider is trying to deliver, including cost efficiency."

(Quality Improvement Lead, Community Trust)

This ambition recognises that many organisations, along with their respective professions, perceive and organise quality and finances as distinct entities. This may help explain in part the current lack of integration of change approaches in some organisations discussed under Theme 3: SHARED LANGUAGE.

"We're definitely not integrated. In terms of improvement teams, we've got a cost improvement team that sits in the finance world. So, a PMO-type function in a financial PMO. We've then got a reset and recovery team who are absolutely involved in improvement work, and we've also got the patient first improvement team. You've then got other people in corporate infrastructure who do improvement work associated with, you know, patient safety incidents and quality."

(Director of Improvement, Hospital Trust)

"If you're balancing quality and cost all the time, they are different entities. It [then] doesn't make any sense to most of our frontline staff for us to say quality includes efficiency and cost."

(Director of Partnerships, Hospital Group)

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3. NHS IMPACT was valued for its widespread acceptability.

A fundamental aspect of NHS IMPACT's success was that it resonated as a sensible and logical framework with a diverse audience. Participants described NHS IMPACT as 'sensible', denoting its uncontested acceptance as a single framework for guiding improvement efforts across the NHS. This removes a key barrier to the general adoption of the NHS IMPACT approach:

"I haven't had anyone in an improvement role like myself have any objections to [NHS] IMPACT"

(Director of Improvement, Hospital Trust)

"The five domains in the self-assessment seem to have stood the test of time a bit better than other things - NHS IMPACT nicely coined the

simplistic number of things and said, you know, these are these are antecedents, these are things that you need to be working on."

((Assistant Director of Quality Improvement, Hospital Trust)

Of particular importance, this has contributed to easier collaboration across groups and local systems, where the different perspectives of stakeholders on what an improvement approach should look like often serve as a barrier.

"With NHS IMPACT, there were a bunch of things we could align [our newly integrated organisations] on and be more relaxed about working together even at the highest level in the organisation. Whereas previously different improvement approaches have been a bone of contention that has held us back a bit."

(Director of Partnerships, Hospital Group)

"NHS IMPACT came about and we thought it's perfect because we had this framework [and] we could basically adopt it across the ICB – which we've done"

(Deputy Director, ICB)

Critical reflections and feedback:

Guides and materials:

Several interviewees noted that the resources and materials available on the NHS IMPACT website were useful, especially for developing their own understanding:

"I'm not trained in it. So personally I found the resources very helpful."

(Chief Improvement Officer, ICB)

"I've found those resources and master classes so helpful."

(Pathway Lead, Hospital Trust)

"Providing ideas and materials and sharing the learning continues to be very helpful."

(Associate Medical Director, ICB)

While others found value in utilising the available materials to revamp and help educate and guide others:

"[My organisation's] improvement leaders training. - I revamped that based on NHS IMPACT.

(Quality Improvement Trainer, Hospital Trust)

"We do translate. So we've taken some of the improvement guides and shared those."

(Lead for Quality Improvement, Hospital Trust)

"There's sort of links to resources, all that kind of stuff. That's all good and helpful and I share that."

(Director of Improvement, Hospital Trust)

In addition to those who found value in the materials, others did not. In some cases, this was due to organisations already having developed similar materials or more mature approaches:

"I don't think we use the guides - they've never been mentioned to me, they've never been brought up. I think I got the e-mail forwarded to me when our chief exec got it. Saying can you look at these? And I remember looking at them thinking. Yes, but I won't do anything about them because we're already doing this stuff.

(Associate Director of Improvement, Hospital Trust)

"Are they currently being used? Probably not. Would you pick up some of those tools that NHS England publishing on their website? Probably not."

(Director, ICB)

"We don't use [the materials]. We've got a really good set of materials by the way. So a lot of our stuff aligns with the NHS IMPACT".

(Deputy Director of Quality Improvement, Hospital Trust)

After taking time to understand the depth and breadth of improvement knowledge held by most of those interviewed, one of the more organic observations made by the evaluation team was the level of expertise within the system—particularly in hospital trusts. This observation may explain the limited value attributed by some to the materials and resources associated with NHS IMPACT; the knowledge and method are often already present. As illustrated by this quote from a national stakeholder:

"Organisations that are already doing good quality improvement tend to have their own language, syntax, and understanding of vision."

(National Improvement Stakeholder)

It also explains the value many interviewees placed on the flexibility of method within the NHS IMPACT approach, achieving the critical balance of complementing and adding to expertise rather than prescribing, specifying, or instructing a certain approach to a largely expert audience.

Accessing resources:

Several interviewees identified the format and placement of the resources on NHS England's website as complicating factors in the use of these resources and materials.

"NHS Impact has a lot of great resources and everything, but it's just like people are, are not aware of it unless you're in the improvement world."

(Director of Improvement, Hospital Trust)

"I'm talking about NHS IMPACT as an online resource at the moment, which is principally where I see it and the way it's presented to a visitor needs to be more user friendly or more designed towards potential types of customer beginner or a medium experience."

(Patient Partner)

"I mean, I did have a quick look at the NHS IMPACT website with their resources and there's big lists of lots of different resources for each of the categories and it does make it a little bit tricky to know where to start."

(Surgical Registrar, Hospital Trust)

Truly transformational?

It is not explicit from the NHS IMPACT website literature whether it is intended to be transformational. Its opening aims statement describes the aim to help systems and organisations to "Respond to today's challenges, deliver better care for patients and give better outcomes for communities" (NHS IMPACT website 2025).

Despite this, much of the aspiration for large-scale improvement is transformational. During the interviews, some contributors queried whether there was a common

understanding of what transformational improvement looks like in the system, particularly referring to the knowledge in regional systems that are soon to be taking on more responsibility for shaping improvement in those regions.

"The real opportunity to do that with a genuine improvement lens and like, actually think like systemically, what would it take to evolve the way the health system operates? As opposed to something that [just improves things] a little bit more. I think they'll [the regions] have a disconnect of what is actually understood and what is meant by transformational improvement."

(Associate Director of Quality Improvement, Mental Health Trust)

The Management Consultancy Question: A Recurring Theme

Organisations offering consulting services, which include large multinational management consultancies, international hospital systems, NHS hospital trust internal consulting services, membership bodies, independent consultancies and consultants, as well as universities providing expertise, are part of the fabric of understanding, TRANSLATING, developing, enabling, providing capacity for, supporting and evaluating improvement approaches across the NHS. In particular, the subject of large management consultancies was frequently raised during the evaluation interviews.

Fundamental to the genesis of NHS IMPACT, and illustrating the deep links to consulting support, some participants connected NHS IMPACT's prominent positioning and acceptance in the NHS to the positive NHS VMI programme, a programme enabled by a collaboration that provided intensive consulting support to hospital trusts from the Virginia Mason hospital system[5]:

"[NHS IMPACT] rode really well on the back of the VMI evaluation -it has created a kind of VMI based [consulting] market"

((Associate Director of Quality Improvement, Mental Health Trust))

"The work with Virginia Mason [was turned] into a framework which is NHS impact, so it [NHS IMPACT has its roots in Virginia Mason."

(National Improvement Stakeholder)

Differing translations of systematic improvement

[5] To read the NHS-VMI evaluation, see: Burgess, N., Currie, G., Crump, B. and Dawson, A., 2022. Leading change across a healthcare system: how to build improvement capability and foster a culture of continuous improvement: lessons from an evaluation of the NHS-VMI partnership, available at: https://warwick.ac.uk/fac/soc/wbs/research/vmi-nhs/reports/

One of the main reasons for bringing in management consultancies was a lack of knowledge about systematic improvement approaches. In recognising this, contributors also noted that over time this need may be decreasing.

"That's why you bringing consultants in into healthcare and I think up until now, we haven't had the knowledge. I think we've now got the knowledge and expertise within the NHS."

"So the value for me of NHS IMPACT is it provides some sense of clarity for those individuals who are struggling for clarity [of a good improvement approach], although actually those organisations are typically also the ones that then go to external consultancies and say help us and expect them to have a model."

(National Improvement Stakeholder)

Some interviewees commented on the differing translations of systematic improvement approaches from different consultancy providers:

"[Named consultancy X] sites tend to be really good at doing top-to-bottom management systems, and [named consultancy Y] sites are said to be really good at doing cross-cutting processes - but never the two shall meet."

"[Named consultancy Z tend to be really good, at deploying [certain elements of systematic improvement approaches] and the more I've worked with them the more I think there are people that genuinely care about doing this well in healthcare"

(Associate Director of Improvement, Hospital Trust)

"A big negative impact on us has been the predominance of [named consultancy] and PMO structures - which is driven by bureaucracy and an approach which ignores anything else that is in front of it."

(Deputy Director of Quality Improvement, Hospital Trust)

The differing translations by management consultancies have resulted, in the view of some interviewees, in certain improvement approaches that don't align with NHS IMPACT:

"I would happily be challenged by anybody in our system who can demonstrate an alignment between their external consultancy and the impact framework. I don't think it happens."

(Director, ICB)

Making the most of consultancy support

Moving to a system-wide perspective, some contributors identified a role for more strategic commissioning of improvement support, aimed at making support more affordable:

"If you're a national organisation, you need to be a strategic commissioner of the system. The improvement system in the UK is going to rely on a ecosystem of support providers within the NHS. Because if you don't do that, then you're going to end up continuing to put money into big consultancies or international organisations. Which is fine, but it's not going to be affordable."

(National Improvement Stakeholder)

At the level of individual providers or local groups and systems, one key to more effective use of consultancies is ensuring ownership by executive teams:

"It has to be owned by [executives]. You can't outsource this. This has to be hearts and minds of the exec team and the organisation involved."

(National Improvement Stakeholder)

Another key principle was to ensure the lived experience and expertise of consultants in the field of systematic improvement within an organisation's context:

"Management consultants might, might help in certain ways, but I think you want the expertise. You want people who understand this and who have done this."

(National Improvement Stakeholder)

Uneven resource contexts:

The various starting contexts of organisations attempting to develop improvement approaches were a common theme, noting that some organisations possess more financial resources for contracting external consulting support than others.

"There are different models going around the country now. There are, you know, those who have got the millions of pounds to spend and those who haven't... You've got [named consultancy X's] market, you've got [named consultancy Y] literally taking over everywhere. You know, I don't like [consultancy Y's] model, but they're very slick on it, incredibly slick, and then you've got, like, ***we call ours, a kind of Heath Robinson model. Because we've got no resources whatsoever****. So we're kind of knitting it together…it's really organic because there's nothing we can spend any money on to do anything with."*

(Associate Director of Quality, Mental Health Trust, bold font added for emphasis)

The participant above called for greater acknowledgement and support for the challenge of systematic improvement without financial resources, particularly in smaller and non-acute organisations: *"We need backing for those chief execs that are trying to do things without the money. You know, kind of amplifying those that are, you know, in some of the smaller services like the mental health or ambulance or stuff like that. So less of the acute focus."* Others agreed:

"I just think it needs calling out and explaining because a lot of it does fit very nicely for a big provider with a transformation team of 20 and improvement team of 20 and the resource and the time to pull people out of clinics and stuff and get them in a big room and do it [improvement activities]. None of that exists [in non-acute providers]. So ***every step with a non-acute provider is 1000 times more difficult. It takes more time****."*

(Chief Improvement Officer, ICB, bold font added for emphasis)

In some cases, financial constraints were perceived as limiting work on NHS IMPACT.

"And I think the other thing it does when you're thinking about operating against the financial backdrop, the pressure is to reduce the financial bottom line. What it stops doing is allowing NHS IMPACT to work."

(Director, ICB)

"[Some organisations] don't really need an [improvement] brand and the narrative. They just need resources."

(National Improvement Stakeholder)

Caution and consideration should be exercised in seeking to understand sometimes subtle differences in context that can lead to progress in developing improvement approaches, even in the absence of financial resources, as in the example of this participant: *"I think showing that you can develop and change through sharing progress and learning, and also saying, actually where you are going is good enough" (Associate Director of Quality, Mental Health Trust).* In contrast, in other cases such progress may not be possible.

Theme 5:

DIVERSE INTERPRETATIONS

Theme 5: DIVERSE INTERPRETATIONS

Enabled by the method-agnostic nature and the SHARED LANGUAGE NHS IMPACT has surfaced DIVERSE INTERPRETATIONS and sparked meaningful dialogue, debate, and development across various elements of large-scale systematic improvement.

The interview data revealed that no element had sparked more dialogue and debate than management systems. Within the improvement community created by NHS IMPACT, and extending into the broader improvement community, there has been significant dialogue and development regarding what management systems signify for improvement approaches, their intent, and their application across the various organisational archetypes within the NHS. For the purposes of this theme on DIVERSE INTERPRETATIONS of aspects of improvement approaches, we use management systems as the core example.

"Until NHS IMPACT came along, no one was talking about management systems. We're just doing improvement. So I think it's really prompted the agenda to be more thoughtful, more thorough, about how do we change in the organisation, not how do I just deliver improvement."

(Director of Improvement, Hospital Trust)

"I think the management system discussions are really interesting and I find them really interesting in that group."

(Associate Director of Improvement, Hospital Trust)

Within the overarching theme of DIVERSE INTERPRETATIONS, we identified two interrelated subthemes:

1. **NHS IMPACT prompts dialogue on important aspects of improvement.**
    a) **Prompting dialogue:**

NHS Impact triggers discussion and dialogue on important and complex aspects of improvement approaches – in the case of management systems, aspects that have traditionally not received much emphasis previously. This dialogue occurs at the level of the provider, but also across regional systems – often catalysed by the IDN and ILN network relationships (see Theme 3: CONNECTING PEOPLE) and also SHARED LANGUAGE (see Theme 2).

"[NHS IMPACT] has allowed richer conversation and richer debate. A richer challenge in terms of why we maybe need to do things. "

(Trust Lead for Quality Improvement, Mental Health Trust)

"Up until now, I don't think that that discussion and knowledge [on management systems] has really been pulled out."

(Director of Transformation, Hospital Trust)

"We have a whole network of all the improvers together. I host the management system part of that, we've got 9 themes under that network and in June we had 125 people all meet together."

(Deputy Director of Quality Improvement, Hospital Trust)

While recognising the value of dialogue on complex improvement topics, contributors cited the pressure to be decisive and 'know how to do things' even when dealing with new concepts – they noted this was at odds with making sense of the range of perspectives usually found:

"There's a drive and an urgency and sometimes, from both the centre and providers, to know what this thing is and know I'm doing it. But if you read the research, there are lots of different ways of having a look at this - all these things are at play."

(Director of Improvement, Hospital Trust)

"I'm quite conscious that a lot of other people talk about a QMS in a much more rounded approach in terms of improvement, quality control and stuff like that"

(Director of Transformation, Mental Health Trust)

b) **Prompting organisational attention to important improvement topics**:

Several interviewees appreciated the role NHS IMPACT played in drawing the attention of senior leaders towards important aspects of improvement, such as management systems:

"[Referring to executive discussions about management systems] That's really handy because now instead of having to convince people. This is why I love talking about NHS impact. We'd already been trying to do this but didn't have the vehicle [to get it heard].

(Associate Director, Community Trust)

"The QMS [discussion] is just starting to be part of our conversations to the point that I've spoken to the Director of Quality."

(Associate Director, Hospital Trust)

While some contributors were comfortable with more developmental, less specified aspects of improvement approaches, others encountered challenges due to the ambiguity:

"The part around the management system and processes is a little bit confusing. I think that the phrase quality management systems is quite

loosely used, with no real understanding of what that means, and that can become a little bit confusing at times and not very clear."

(Head of Quality Improvement, Non-Hospital Provider)

"I think there is a lot of misunderstanding about management systems and what management systems actually are."

(Director of Transformation, Mental Health Trust)

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2. NHS IMPACT moves improvement thinking from localised to systemic

One of the historic challenges facing improvement approaches is their often localised nature, with many associating these approaches with bottom-up organic improvement. Data from the interviews showed that NHS IMPACT has helped move the thinking about improvement approaches in organisations away from this localised view and prompted leaders to consider integrating their improvement approaches into the wider operational management structures:

"It all has to come together around the business of what you're trying to do. So that kind of has led me to understanding some of the evidence and research, and makes me think there's no point in doing improvements separate to our operational team. I have to work with the things they need to fix and the things they need to improve."

(Director of Improvement, Hospital Trust)

"You have two jobs: do your job, improve your job. And that applies to everybody - we're never going to achieve that unless we embed it into the operational management of the organisation".

(Improvement lead, Community Health Trust)

Others commented that the move away from a localised view of improvement has led to greater integration with strategy and strategic processes within organisations:

"More importantly for me, more excitingly, we have strategy deployment with an improvement approach. I've been at [hospital trust] for many years and I've never seen the strategy delivered in that way before. Now there's a little bit of an opportunity for me to get in with an improvement approach to how you deliver strategy and how you connect every single member of staff to that common purpose."

(Director of Improvement, Hospital Trust)

"I had a lot of challenges with our exec about 'we don't need organisational strategy because we've got clinical strategy and a people strategy'. But a whole organisational approach is critically important in delivering this [improvement] – this emerged from the NHS IMPACT self-assessment".

(Director of Improvement, Hospital Trust)

"They've just started using weekly huddles, but also directorate huddles now and that's about strategy deployment. So improvement becomes part of what we do, not me in a room teaching 30 people."

(Director of Improvement, Hospital Group)

Worthy of special mention, one interviewee linked NHS IMPACT to a profound recalibration of the organisational understanding of purpose, demonstrating how far beyond localised improvement NHS IMPACT has the potential to take improvement approaches:

"It was almost a call to action to say, we are not clear on the purpose of the business. We don't talk about it that explicitly. These are the elements that we can really lean into. I don't think we would, we wouldn't have been having the conversations without impact."

(Assistant Director of Improvement, Hospital Trust)

Critical reflections and feedback:

Authors' note: Making the most of management systems

The management systems topic was prominent in the interview data and sparked significant consideration and reflection among the evaluation authors. Without straying too far from an evaluation's traditional scope and not wishing to reiterate much of the valuable literature available on management systems, the following commentary aims to highlight a small number of important considerations that are often marginalised. These considerations stem from the organic discussions of extensive data, combined with the multi-disciplinary expertise of the authors, which integrates both deep academic and applied knowledge of systematic improvement approaches in healthcare and industry.

Don't rush to prescribe and specify: The current local, regional, and national sense-making, prototyping, and learning are crucial for the NHS in contextualising management systems, understanding their potential benefits, and finding appropriate ways to apply them across various organisational archetypes and contexts. Maintaining the flexible ethos of NHS IMPACT and resisting premature, prescriptive definition of form and application will enable innovation through more effective reframing and, consequently, application in the long run.

Avoid trying to control processes that are fundamentally not capable: Along with concepts from the fields of policy and strategy deployment, the works of Joseph Juran, one of the big three quality thinkers of our time[6], often form the basis of thinking on management systems – in particular his quality trilogy featuring the domains of Quality Planning, Quality Improvement and Quality Control.

In interpreting the domains of quality control, organisational systems of audit and scrutiny are often mentioned. In fact, practical experience tells us that in many

[6] Along with Edwards Deming and Philip Crosby.

organisations, audit, scrutiny, and performance management systems are more established, larger in scale, and further developed than most improvement approaches. It can be argued that systems of control are the primary mode of intervention for quality across the NHS.

This does not mean that during the development of management systems, the emphasis on quality control should not be subject to critique. Juran's quality trilogy suggests using quality control methods when processes are capable of the required quality, including cost. In other words, they have relatively low levels of variability (they are reliable). This is often not the case on processes where systems of quality control are applied – we are frequently trying to control the quality of processes that are simply not capable of achieving the desired quality – clues to which can be seen in the slowing of safety improvement[7], failure demand[8], decline in patient satisfaction[9] and the continual rise in NHS overall spend[10] despite relentless and painful cost cutting. Thus, a more fundamental change is often required, beyond the scope of quality control and often beyond quality improvement. To use a different typology, moving from 'Doing Things Well or Better, to Doing Better Things[11] - which brings us to the domain of quality planning.

The core questions of quality planning. Juran's summary definition of quality planning is deceptively simple, and his writing, and the writing of others[12] [13], provide plenty of visualisation of what is involved in quality planning.

"Quality Planning is the activity of (a) determining customer needs and (b) developing the products and processes required to meet those needs."

[7] https://www.imperial.ac.uk/Stories/National-State-Patient-Safety-2024/
[8] https://www.cressbrookltd.co.uk/sources-of-failure-demand-in-healthcare/
[9] https://www.kingsfund.org.uk/insight-and-analysis/press-releases/public-satisfaction-nhs-new-record-low
[10] https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-budget-nutshell
[11] Anderson-Wallace M, Downham N (2024) Improving Quality in Healthcare: Questioning the Work for Effective Change. Sage Publications.
[12] https://www.england.nhs.uk/nhsimpact/assessment-and-improvement/quality-management-systems/
[13] https://q.health.org.uk/evidence-and-insights/opinion-pieces/designing-a-quality-management-system-for-the-nhs

Joseph Juran

The key to success in quality planning is how the questions are interpreted and how the resulting dialogue is conducted. For transformational change, we must consider the fundamental meaning of the two prompts:

1. Determining customer needs. To avoid endemic misidentification of needs or requirements, this entails carefully surfacing assumptions and understanding often the distorting nature of systems of labelling needs and resulting data sources. Key to this is ensuring new perspectives on needs and requirements. Even with initiatives such as 'what matters to you', our institutions find it exceedingly difficult to listen, understand, retain, communicate, and act upon what matters to patients. The result is often over-treatment, poor outcomes, and a negative experience. Methods like true patient co-discovery and production, as opposed to consultation, help change perspectives. Other straightforward steps like, for example, meaningfully ensuring GP perspectives when planning inpatient care, would add valuable insight into needs, risk, and diagnostic use in quality planning.

2. Developing responses required to meet those needs. Juran's second quality planning prompt, requires equal care to ensure fundamental consideration. A more powerful question in healthcare is perhaps to ask: *'how capable are we, really, of meeting these needs (outcomes, safety, equality, timeliness, efficiency, experience)?'.* Honesty on this question will determine how fundamentally the current model of care is challenged and will be the difference between *Doing Things Better* and *Doing Better Things*, the difference between incremental and transformational change.

Two core considerations are key to understanding the barriers to open and honest dialogue. The first is that the *work as disclosed or measured* is often not the same as *the*

work done[14]; discussion often doesn't get to the truth of true current process capability. The second consideration is that for transformative improvements in models of care, services often have to let go of what is familiar, and often the funding that goes with it, for example, due to a fundamental change in care setting or procedural mode.

High levels of psychological safety are essential to overcome both of these challenges. Achieving this demands careful methods, curation, and time to establish; otherwise, there will always be a distorted view of the actual process capability and thus distorted quality planning.

[14] The wise words of Human Factors expert Steve Shorrock https://humanisticsystems.com/2020/11/01/proxies-for-work-as-done-3-work-as-disclosed/

CHALLENGES & POSSIBILITIES

CHALLENGES & POSSIBILITIES

To conclude our report, we present thoughts and reflections on the future trajectory of NHS IMPACT, outlining its potential and the challenges to its ongoing success. Focusing on seven themes:

1. Not all Fields are Similarly Fertile.
2. Tell or Sell
3. Talismans
4. Mandate Confusion
5. Polarising Positioning
6. Club Tensions
7. Longevity

In line with other sections, this final section is informed by participant responses to questions about the future of NHS IMPACT and how NHS Trusts can be better supported in their alignment.

1. Not all Fields are Similarly Fertile

A notable achievement of NHS IMPACT has been its ability to cross professional, hierarchical, and organisational boundaries to instigate and enable dialogue that transcends methodological allegiance, improvement expertise, and differences in organisational types. The *how* of this achievement has been vividly brought to life throughout this report, particularly under themes of LEGITIMACY and SHARED LANGUAGE.

However, we must also recognise the crucial role of context in shaping efficacy. Financial position, access to funding, population inequities, and other contextual factors play a significant role in an organisation's ability, motivation and opportunity to invest in the five pillars of NHS IMPACT. Many NHS Trusts are facing severe financial constraints and calls to make substantial financial savings – and many interviewees were of the view this burden

in not uniform across trusts. While a robust and systematic improvement culture can and should be part of the solution, it is challenging to achieve in organisations where an improvement culture is yet to embed. As one participant told us: "we've got no resources whatsoever". In light of this, some respondents commented that the networks and resources could be better tailored to meet individuals and organisations where they're at in terms of their maturity and resource.

On the other hand, some organisations have contracted with the big external consultancies to help them embed an organisation-wide improvement approach. (We touched on the topic of management consultants in Theme 4: TRANSLATION). The important issue here, as highlighted by a National Improvement Stakeholder, is to remember that NHS IMPACT aims for lasting cultural change, while management consultants can and do help NHS organisations on their journey, it's not something an external organisation can do for you:

"NHS IMPACT, first and foremost, has to be owned by the teams that are doing it. Management consultants might help in certain ways, but you want people who understand this and who have done it… It's very context and situationally dependent. You can't outsource it. This has to be the hearts and minds of the executive team and the organisation involved."

(National Improvement Stakeholder)

2. Tell or Sell

The nuanced challenge of balancing top-down prescription with bottom-up discovery is captured in our sub-heading 'tell or sell'. Aligned to our discussion about different organisational contexts requiring different types of assistance, our data suggests that organisations and individuals with limited improvement expertise and resources appeared to rely more on the online resources to assist them in developing and sharing improvement

knowledge and techniques. In other words, they expressed a preference for a 'tell' style of approach.

In contrast, participants possessing a high level of improvement knowledge and expertise, particularly those within the NHS context, largely favoured NHS IMPACT's more collaborative approach. However, a different viewpoint emerged from experienced improvers with backgrounds outside the NHS. They argued that the lack of prescription in some areas was frustrating, akin to constantly having to *'reinvent the wheel'*: *"It drives me nuts… like how are we going to make the coaching program more standard… can you just tell us what the standard is? So that that would be my number one ask.*

Other participants shared a similar view, particularly in respect of developing training materials:

"I would love you know, if a national improvement effort could develop some standard training materials. Why are we all going through this bloody pain? There's only so many different ways you can teach PDSA cycle. And we got a video on it. Boom'

(Associate Director of Quality, Hospital)

Standardising training materials offers an opportunity to reduce redundant efforts, as highlighted by participants. They also emphasised the importance of board-level training for fostering an organisation-wide improvement culture. However, we caution the need to balance standardised processes with context-specific development is crucial to avoid ineffective, resource-consuming approaches. This challenge of achieving a balance between top-down prescription and bottom-up discovery is summarised by a participant below:

"Are we allowing a little bit too much leeway, and do we need to now have more sanitisation in order to do it well in certain areas? How do we get that right balance? …

How do we nudge the system in the right way? How do you incorporate the hard stuff as well as the soft stuff? And how do you make sure you are focusing on the things that make the difference?"

(National Improvement Stakeholder)

3. Talismans

The data showed that a small number of individuals were heavily associated with the high profile and trust of NHS IMPACT in the wider service. It was sometimes challenging to differentiate the NHS IMPACT approach from those individuals. Some interviewees identified a clear link between NHS IMPACT's articulation of an improvement approach and the background, experience, and vision of this small number of individuals.

While such a strong individual presence and brand is clearly beneficial according to the data, it also poses challenges regarding longevity, as well as in terms of the perception of openness to critique and innovative interpretations from other sources.

4. Mandate Confusion

The specific confusion created by the decision to reverse the mandatory nature of the NHS IMPACT self-assessment was prominent in the data, suggesting a lasting legacy of the decision-making process. There was data indicating that several interviewees agreed with the eventual position, while others preferred the original, for reasons explored in detail in Theme 1: LEGITIMACY.

"[On changing the decision on the mandatory nature of the self assessment] So that wasn't really helpful, I don't think it was helpful for lots of people."

(Director of Improvement, Hospital Group)

"[The switch to make it voluntary] just made me feel less anxious that somebody was gonna be judging it at the other end and not knowing what they were gonna do with it. But it was still helpful to us."

(Associate Director, ICB)

The experience highlights the value of reflecting on the decision-making process that led to both the original and subsequent decisions. This learning is especially important when considering the implications of using a mandate during any improvement approach.

5. Polarising Positioning

Overall, the data suggested a clear positive association with NHS England, as discussed, contributing to the LEGITIMACY of the approach. However, consideration needs to be given to the groups who view the NHS England association less positively. The data suggests that groups like medics and some non-hospital settings may have less familiarity and engagement with NHS England as a primary source and location for improvement expertise. This could potentially hinder the widespread adoption of the approach in these future areas.

On the same theme. some participants felt that the NHS England branding was limiting the ability of NHS IMPACT to become more of a social movement based on its allegiance to the 'policy machine', falling into 'the same old pattern of creating a slightly new top-down infrastructure rather than building and working through what already exists.

6. Club tensions

Echoing the theme of Talismans, this theme captures feedback concerning the close association of NHS IMPACT with NHS England and a small number of individuals. Many people expressed their appreciation of the leadership, value, and expertise that these individuals contributed, and in particular, they noted their accessibility and support as an unusual and extremely welcome feature of a national initiative. A few people, whilst also appreciative, signalled that this group perpetuated a particular brand or 'flavour' of improvement. Suggesting that while the IDN and ILN networks have proven extremely popular, there may be an opportunity to include more diverse voices through working more closely with other popular networks that would help NHS IMPACT and

improvement professionals reach other healthcare professionals representing professions outside of the improvement space.

7. Longevity

Several participants spoke of the importance of LEGITIMACY and the NHS England branding with respect to gaining traction and catalysing conversations with senior leaders and executive boards. When asked about the future of NHS IMPACT and how they might be supported in their improvement role, most participants responded, "keep it going!" In April 2025, news broke of the government's decision to 'abolish' NHS England over the next two years. It is not within the scope of this evaluation to comment on the continuation of NHS England, but it is important to represent the many voices who told us they value attributed to a national directive and drive to embed improvement across the NHS alongside the message that 'longevity' really is key to embedded a sustainable approach to improvement and changing the dial on all aspects of performance, from staff morale, to patient outcomes and financial steering.

For example, one participant reflected on the government funded NHS-Virginia Mason partnership and said that it worked because there was longevity in the initial contract: *"You can't do this work in two years; you're probably going to struggle to do it in three. And we had a five-year commitment"* (Director of Improvement, Hospital). In a similar vein, another spoke of their frustration that the timeline is commonly misunderstood:

> *"Every year we want to 'do it in a year', whereas actually some of the stuff I want to set up is five years. Are you willing to hold the nerve for five years around something? 'cause the outcome or the impact of this is gonna be felt more substantively in five years time and it will in the next two to three."*
>
> *(Director of Improvement, Hospital)*

Another participant also issued a plea to *'hold your nerve'*:

"[We have to] hold our nerve on this stuff. It's all the right stuff in the right order. Don't be swayed into, you know, there's all the talk about the money now, the productivity agenda. The Senate may be changing again and any number of restructures. You've just got to hold your nerve"

(Associate Director, Hospital)

A Patient Partner, with extensive experience in improvement in industry, made a plea for reassurance:

"I could really use some reassurance that the NHS's IMPACT is going to grow and become more persuasive. And you know, how is it going to? You can tell I'm passionate. I think it's the solution."

(Patient Partner)

Many respondents remarked that improvement has a reputation for being a 'soft' methodology that lacks a 'hard-edge'. Capturing its modest status, several participants likened improvement to 'scented candles and fluffy cushions', arguing that it needs to be more explicitly linked to the most critical and important issues the organisation faces, from financial steering to productivity, to staff wellbeing and patient outcomes:

"I think the finance side of things has to become stronger. I think we have to show that by approaching stuff from an improvement science perspective. You know, this is how we will tackle our challenges. I think it's recognising the seriousness of it. It's not. I think people have talked like 1000 flowers and stuff like that. It's not fluffy stuff. This is quite hard and this is how professional businesses get their competitive edge...by applying that kind of OpEx approach and I think we have to be stronger on that. I like the fact that they're combining with the kind of proud to be OPS, network and stuff like that, but I think it needs even stronger in the centre around. You know, everything we do has that kind of approach."

(Associate Director of Improvement, Community Health Trust)

In sum, LEGITIMACY and longevity are vital elements of the support required across the NHS to enable continued investment and belief in the principles of NHS IMPACT and the achievement of its aims. Aligned to this, some participants suggested a prospective role for regulatory bodies such as the Care Quality Commission (CQC):

"Improvement needs to be seen as important as oversight and assurance and performance management. You know, we know, don't we, that those organisations have been rated outstanding by the CQC are all over improvement and have got a really good embedded cultural approach to continuous improvement within their organisations. It doesn't feel like that in NHS England."

(Improvement Director, ICB)

Currently, as one participant notes, the 'well-led' criteria used by the CQC is limited in its ability to assess (and therefore encourage) the organisations use of an improvement approach and its efficacy in achieving change for the better.

"CQC tops everything... But the whole improvement piece just got literally shoved to one side and everyone just runs around like headless chickens doing, you know, well led tick box. 'We need to do this. We need to say we've done that' and for me none of that's going to give me any assurance because all that is saying is we've trained staff. We know that training staff does not change behaviour and practice"

(Group Director of Improvement, Hospital)

We spoke to a National Improvement Stakeholder who supported this idea, suggesting an appropriate role for the CQC might be in a formative rather than summative capacity:

"[I think the] CQC [could potentially] do its work in a more formative rather than summative way. For example, to agree a plan with trusts where and providers where it sets out the improvements and ultimately an important marker of 'well-led' could be around what improvement approach does that organisation have and how is it deployed across the organisation to deliver for patients and people that use services."

(National Improvement Stakeholder)

APPENDICIES

Appendix A: Innovative methods for making the self-assessment results visible, including variations across professional and managerial groups.