The Role of Monitoring and Evaluation in Ensuring Quality Care within the National Health Service, United Kingdom

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ABSTRACT

Monitoring and Evaluation (M&E) frameworks are increasingly recognized as essential tools for improving healthcare quality, accountability and equity within public health systems. This study investigated the role of M&E in enhancing service delivery within the National Health Service (NHS) in Leeds City, United Kingdom. Employing a mixed-methods case study design, the research integrated quantitative data from eighteen (18) questionnaires and qualitative insights from nine (9) semi-structured interviews and four (4) focus group discussions. The findings reveal that while many respondents perceive M&E as critical to healthcare quality, only 50% have received formal training and 38% report limited familiarity with M&E frameworks. Key indicators used included patient satisfaction (61%), clinical effectiveness (22%) and operational metrics such as staff absenteeism. Challenges identified include high workload (46%), limited funding and staffing (31%) and lack of dedicated M&E personnel (22%). The study concluded that strengthening M&E systems through capacity-building, participatory evaluation and digital integration can significantly improve patient outcomes and service efficiency. These insights offer practical recommendations for National Health Service leadership and contribute to the broader discourse on healthcare quality improvement.

INTRODUCTION

The National Health Service (NHS) in the United Kingdom is globally renowned for its commitment to universal healthcare. However, increasing demand, budget constraints and workforce shortages have exposed gaps in service delivery, particularly in urban centres like Leeds City. Monitoring and Evaluation (M&E) systems offer a strategic solution to these challenges by enabling healthcare providers to assess performance, identify inefficiencies and implement targeted improvements. Despite national policies promoting M&E, localized inconsistencies persist, leading to variable patient outcomes and service quality. Leeds City, with its diverse population and complex healthcare infrastructure, presents a compelling case for examining the effectiveness of M&E frameworks. This study explored how M&E is implemented within NHS Leeds, assessed its impact on healthcare quality, and identified barriers to its effective use.

Key Terms: Monitoring & Evaluation, National Health Service, Patient Satisfaction.

METHODOLOGY

This study employed a mixed-methods case study design which explored the role of monitoring and evaluation in the National Health Service in Leeds City, United Kingdom. Sampling was conducted using a combination of purposive and stratified random techniques. Purposive sampling targeted individuals directly involved in monitoring and evaluation activities, while stratified random sampling ensured balanced representation across departments and roles. The final sample included forty-seven (47) participants.

Data analysis was conducted using descriptive statistics for quantitative data and thematic coding for the qualitative data. NVivo software was used to identify recurring patterns and themes. Triangulation across data sources enhanced the reliability and depth of the findings. Ethical approval was obtained from the National

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Health Service and the Institute's Research Ethics Committee. Informed consent was obtained from all participants, and confidentiality was rigorously maintained.

RESULTS AND ANALYSIS OF THE STUDY

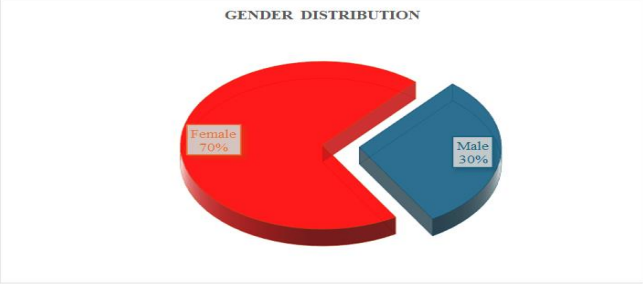
A total of thirty (30) questionnaires were distributed to National Health Service staff across various departments, of which eighteen (18) were completed and returned, yielding a response rate of sixty (60%). In addition, twelve (12) semi-structured interviews were planned and nine (9) were successfully conducted. This high response rate provided sufficient data to explore the research questions and draw relevant conclusions about the role of monitoring and evaluation in ensuring quality health services within the National Health Service at Leeds City.

Table 1: Collected data responses

DATA COLLECTION TOOL	TARGETED PARTICIPANTS	ACTUAL RESPONSES	RESPONSE RATE
Questionnaires	Monitoring &Evaluation practitioners, Managers, Nurses, Psychologists, Care workers	18	60%
Interviews	General Practitioners, Care home managers, supported living managers and key workers	9	75%
Focus Groups	Therapists, General Practitioners	4 Focus group discussions of (5 participants each)	100%

The table above summarizes data responses from all the National Health Service staff that participated in the study. The results showed that 18 (60%) were from questionnaires which comprised of monitoring and evaluation practitioners, managers, nurses, psychologists and care workers. It was followed by 9 (75%) response rate from interviews which included General practitioners, Care home managers, supported living managers and key workers. Lastly,4 (100%) response rate from focus group discussions from therapists and general practitioners. Efforts such as follow-up emails, reminders and scheduling flexibility were employed to maximize the response rate and reduce non-response bias. This diversity provides a broad perspective on hospital M&E practices. The highest response rate was observed in focus group discussions, where all 4 targeted participants (100%) including therapists and general practitioners—participated fully, suggesting a high level of interest or commitment among these roles. Interviews achieved a 75% response rate (9 participants), drawing input from general practitioners, care home managers, supported living managers, and key workers, further enriching the data with insights from frontline and managerial staff. To enhance participation and mitigate non-response bias, deliberate strategies such as follow-up emails, reminders, and scheduling flexibility were implemented (Creswell & Poth, 2018), which are essential practices in qualitative research to ensure representativeness and credibility of findings (Patton, 2015). Overall, the high response rates across different methods indicate a robust dataset and suggest that the findings are well-grounded in the experiences of a diverse cross-section of National Health Service staff.

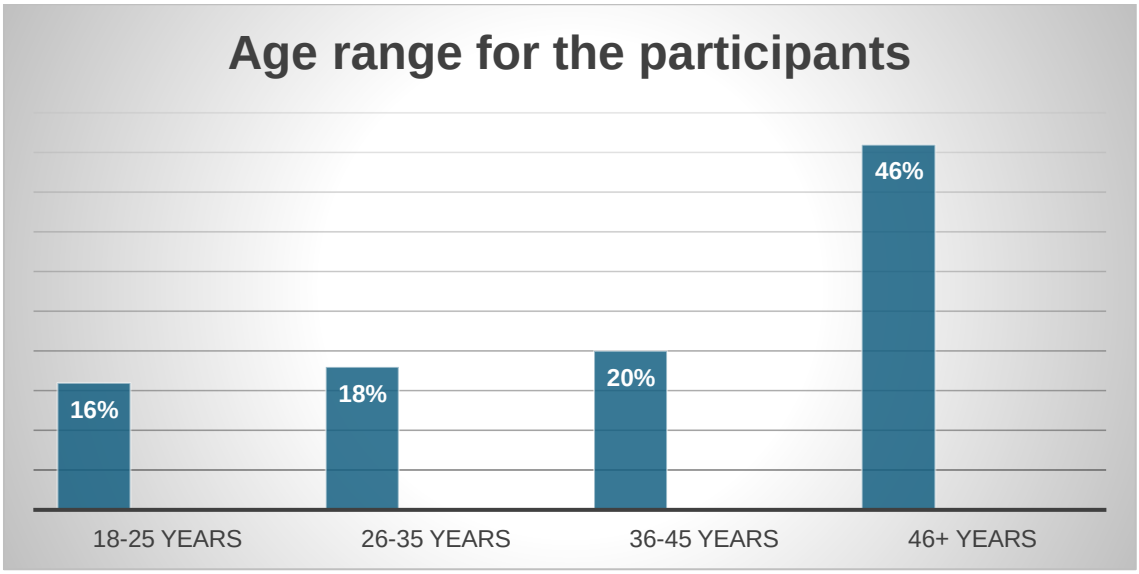
Figure 2 : Gender Distribution of survey respondents



ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue I January 2026

The figure above shows the gender of the respondents who participated in the research. Out of the forty-seven (47) respondents that participated in the study, of which 30 % were male and 70% were female. This gender distribution reflects the diversity of NHS staff involved in service delivery and M&E practices. Understanding the gender distribution of participants provides context for the perspectives shared in this study. It helps ensure that the findings reflect a balanced representation of staff . This reflects broader national and global trends in healthcare, where women often make up the majority of frontline and caregiving roles (World Health Organization, 2019). The predominance of female respondents in this study aligns with the typical staffing patterns observed in the NHS, especially in nursing, care work, and allied health professions. Understanding this distribution is crucial, as gender can influence perceptions, experiences, and engagement with M&E systems, potentially affecting how feedback is interpreted and acted upon (Newman, 2014). Including both male and female voices ensures a more comprehensive understanding of M&E practices and supports gender-sensitive policy development in health systems. Thus, this gender breakdown not only reinforces the representativeness of the study sample but also contributes to the reliability and relevance of the findings in reflecting the realities of NHS service delivery and evaluation processes.

Figure 1 : Age range



The figure above presents the age distribution of the respondents who participated in the study. The results showed that 46% of the participants were aged 46 years and above. It was followed by 20% of the participants who were aged between 36-45 years.Then,18% of the participants were aged between 26-35 years old.Lastly,16% of the participants were aged between 18-25 years. The predominance of older respondents is valuable, as they are more likely to have extensive experience with Monitoring and Evaluation (M&E) systems and a deeper understanding of long-term healthcare delivery practices (Friedman, 2020). Moreover, including younger staff offers emerging perspectives that may reflect new training approaches and digital adaptation in M&E. The variation in age enhances the richness of the data by incorporating intergenerational perspectives, which is crucial in a sector where workforce age diversity influences both service provision and adaptability to system reforms (WHO, 2020). This balanced mix ensures the findings consider both the institutional memory of seasoned staff and the innovation potential of newer entrants.

Table 1 : Professional roles distribution of participants

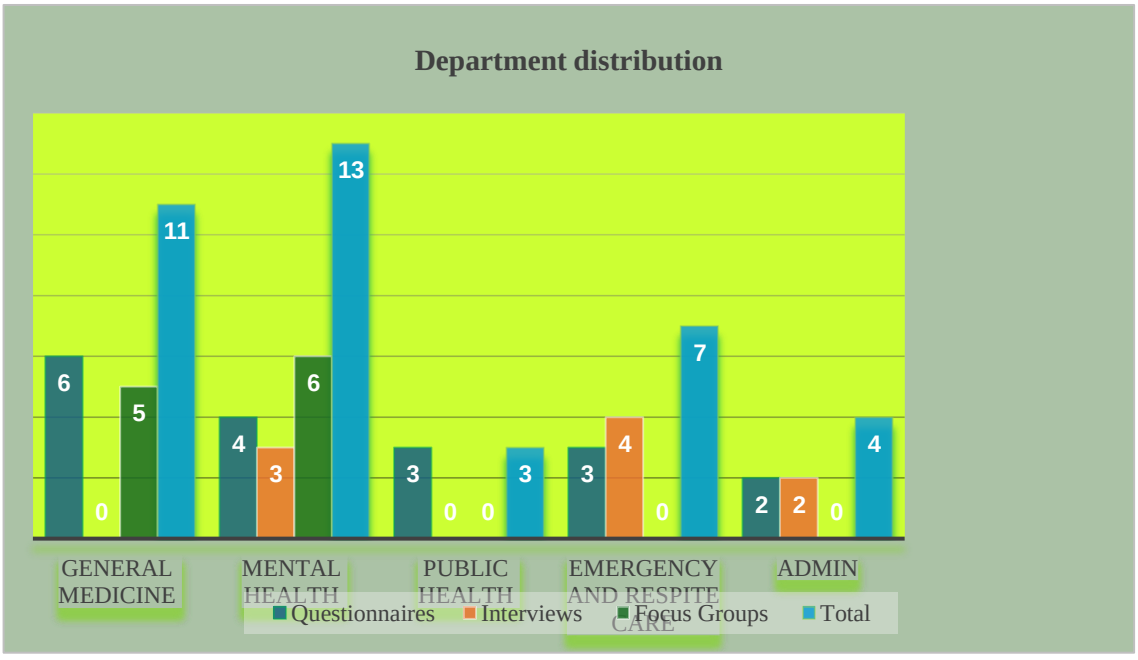
Role in National Health Service	Frequency	Percentage
General practitioners	8	17%
Therapists	12	25%
Care workers	11	23%

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue I January 2026

Psychologists	3	6%
Health Service Managers	4	9%
Administration staff	11	23%
M&E Officers	4	9%
TOTAL	47	100%

The table above shows the professional roles of the respondents. The results showed that the therapists, care workers and administration staff (25% and 23% respectively).It was followed by general practitioners, health service managers, Monitoring & Evaluation officers who had 17% and 9% respectively. Lastly, psychologists were 6% psychologists. This variety ensured diverse perspectives on M&E implementation and its impact on health service quality delivery within the National Health Service. This variety is crucial for capturing a comprehensive understanding of how M&E practices are implemented and perceived across different levels of service delivery. Frontline staff such as therapists and care workers offer practical insights into the day-to-day implications of M&E, while administrative personnel and managers contribute perspectives on system oversight, planning, and policy implementation (Patton, 2015). The inclusion of general practitioners and psychologists further enriches the data by adding clinical and mental health viewpoints, which are vital components of holistic healthcare quality. Such multidisciplinary engagement aligns with best practices in health system evaluations, which emphasize the need for input from varied stakeholders to ensure that M&E systems are both contextually relevant and operationally effective (Creswell & Poth, 2018). This professional diversity enhances the credibility and applicability of the findings, making them reflective of the complex, collaborative nature of healthcare delivery in the NHS.

Figure 5: Departmental Representation



Out of the 47 total participants (18 from questionnaires, 9 interviews, and 20 focus group members), representation was drawn from five key NHS service areas: general medicine (including general practitioners), mental health (psychologists, therapists), public health (managers with M&E roles), emergency and respite care (care/support workers), and administration (line managers, administrative officers). Several participants, especially in care and clinical settings, also served as Monitoring and Evaluation practitioners.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue I January 2026

Figure 6: Responses to whether the participants received formal training on Monitoring and Evaluation.

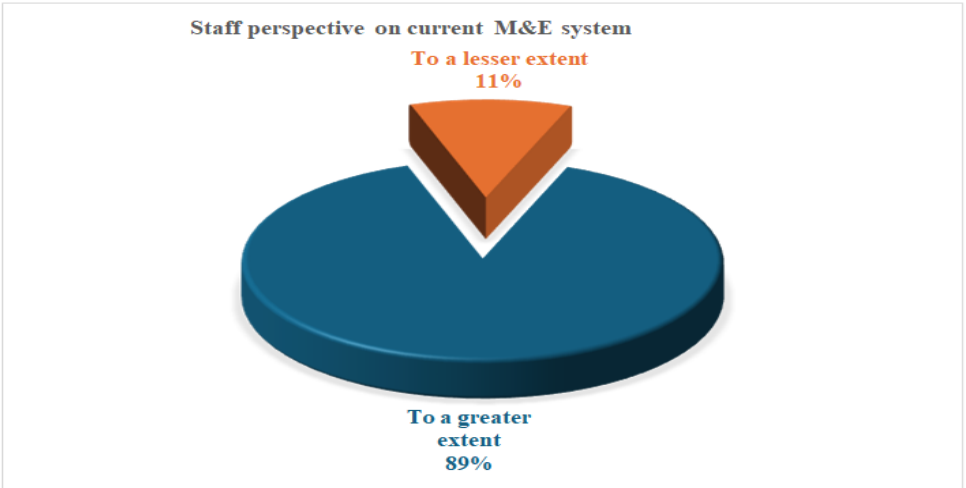
The figure above shows whether the respondents were formally trained on monitoring and evaluation or not. The results showed that 50% of the respondents indicated that they had received formal M&E training, while 50% reported that they had not.

Table 7: Staff perceptions on the role of monitoring and evaluation

Variable	Frequency	Percentage
Yes, Monitoring and Evaluation is important	42	89%
No, monitoring and evaluation is not important	5	11%
Total	47	100%

The table shows staff perceptions on the role of monitoring and evaluation in the National Health Service. The results showed that 89% of the participants indicated that monitoring & Evaluation is very important whilst 11% of the participants indicated that monitoring and evaluation is less important.

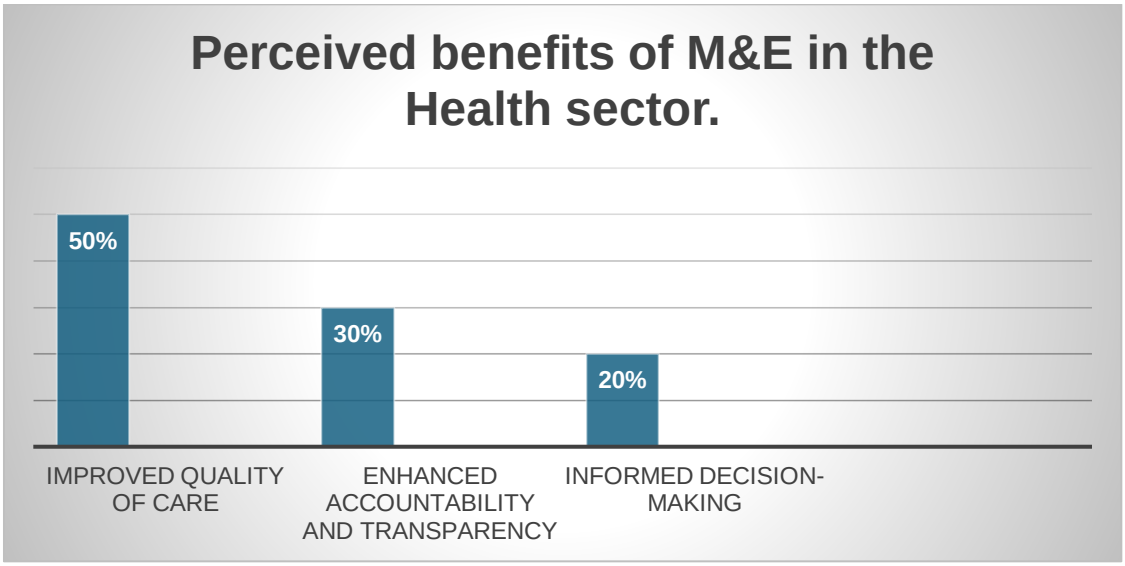
Figure 8: Staff perspectives on current M&E Systems



ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue I January 2026

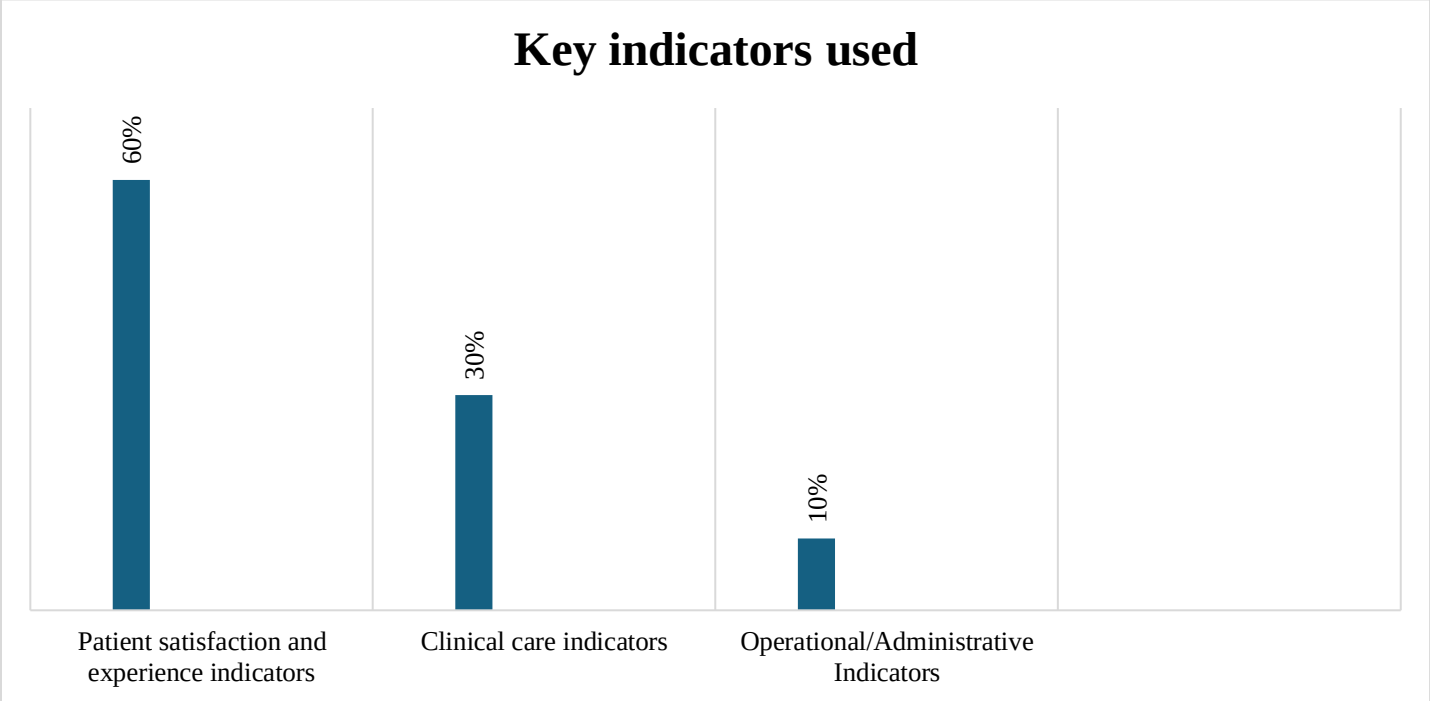
The figure above shows staff perspectives on current monitoring and evaluation systems. The results showed that 89% of the participants indicated that M&E contributes to a greater extent on improving quality health care whilst 11% of the participants indicated that it contributes to a less extent on improving quality health care.

Figure 9: Perceived Impacts in M&E.



The above figure shows the benefits of monitoring and evaluation in the health sector. The results showed that 50% of the respondents indicated that monitoring and evaluation improved quality health care. It was followed by 30% of the respondents who indicated that monitoring and evaluation enhanced accountability and transparency in the health sector. Lastly, 20% of the respondents indicated that monitoring and evaluation informed decision and allocation of resources in the health sector.

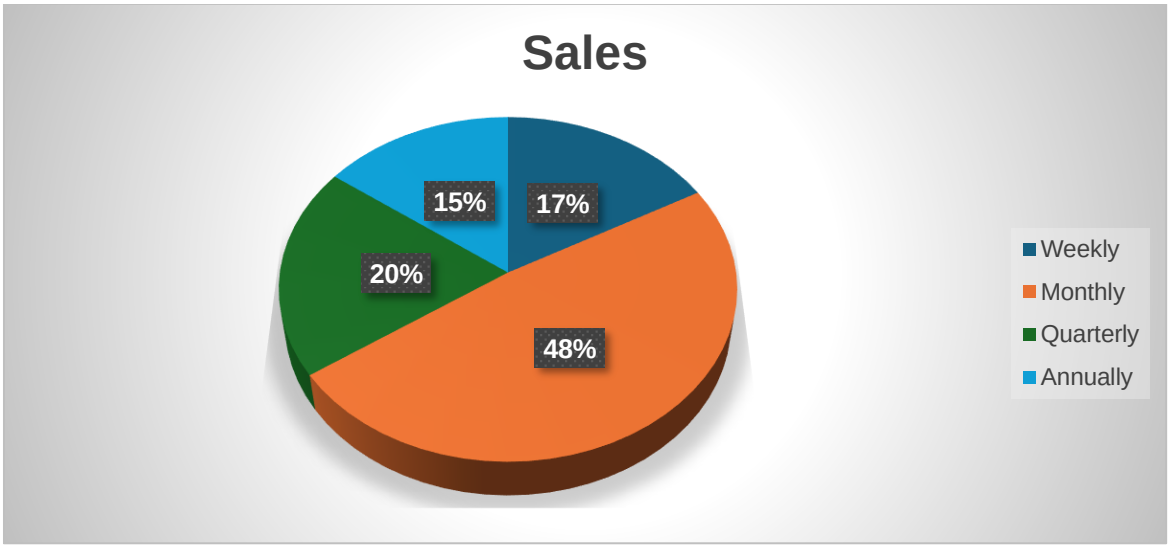
Figure 10: Distribution of Key Indicators.



The bar graph above illustrates the main indicators used by respondents in the National Health Service to evaluate healthcare quality. The majority (60%) identified patient satisfaction and experience indicators as the primary metric. It was followed by clinical care indicators (30%). Lastly, 10% of the respondents indicated that operational and administrative indicators were used in the health care sector.

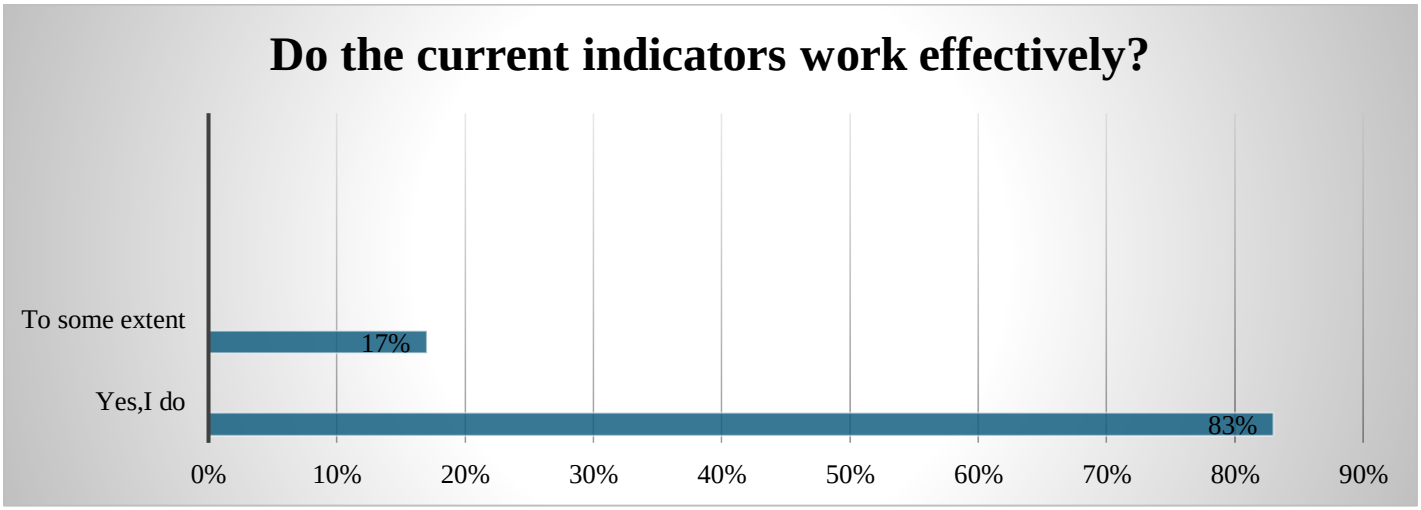
ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue I January 2026

Figure 11: Data collection frequency



The figure above illustrates how frequently data is collected and analyzed for Monitoring and Evaluation (M&E) purposes across departments within the National Health Service. The results showed that 48% of the respondents indicated that data is collected monthly, highlighting a regular rhythm of review that aligns with standard National Health Service reporting cycles. It was followed by 20% who indicated that data is collected quarterly.Then,17% of the respondents indicated that data is weekly.Lastly,15% of the respondents indicated that data is collected annually. This variation suggests a need for standardization across departments to ensure consistency in how M&E is conducted and utilized for quality improvement (Cousins & Whitmore, 2011).

Figure 12:Do you believe the current indicators used within NHS accurately measure healthcare service quality?



The figure above shows whether the current indicators work effectively. The results showed that 83% of the respondents agreed that the current indicators work effectively whilst 17% of the respondents indicated that the current indicators work to some extent.

Figure 13: What are the biggest challenges in implementing M&E frameworks within the NHS?

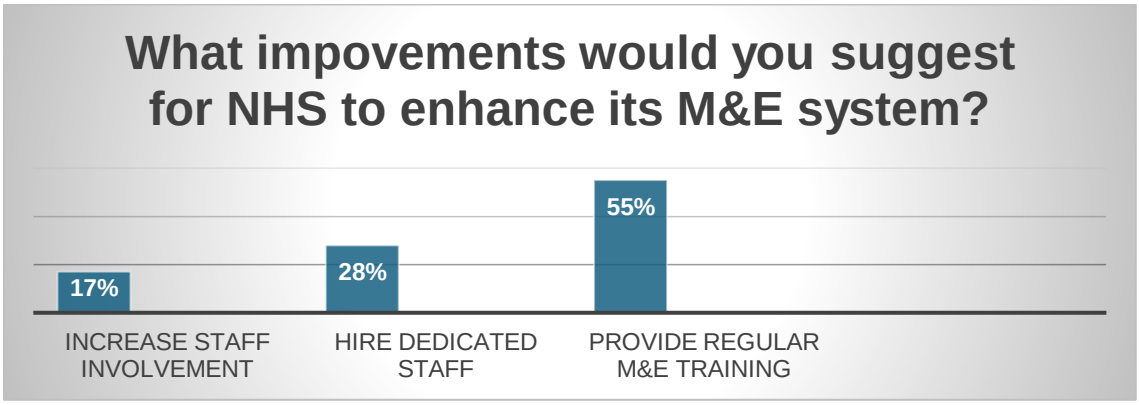
CHALLENGE	PERCENTAGE OF RESPONSES	INTENSITY
High workload and time constraints	46%	High impact
Shortage of staff & limited funding for M&E activities	31%	Moderate-High

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue I January 2026

Lack of dedicated M&E personnel	22%	Moderate
Lack of training on M&E tools and indicators	Remaining % (~0.5%)	Low

The above figure shows the challenges faced in implementing monitoring and evaluation within the National Health Service. The results showed that 46% of the respondents indicated that high workloads and time constraints acted as barriers to monitoring and evaluation implementation. It was followed by 31% of the respondents who indicated that there was a shortage of staff and limited funding for monitoring and evaluation activities. Then, 22% of the respondents indicated lack of dedicated monitoring and evaluation personnel .Lastly ,5% of the respondents indicated that lack of monitoring and evaluation tools and indicators as a challenge.

Figure 14: What improvements would you suggest for the NHS to enhance its M&E system?



The figures above show what improvements that were suggested to the NHS to enhance its monitoring and evaluation system. The results showed that (55%) of the respondents highlighted the need for regular M&E training. It was followed by 28% of the respondents who recommended hiring monitoring and evaluation staff .Lastly,17% of the respondents recommended increasing staff involvement in monitoring and evaluation of health issues. These insights collectively highlight both capacity-building and participatory reform as key directions for improvement.

CONCLUSION

This study set out to explore the role of Monitoring and Evaluation (M&E) in ensuring quality healthcare delivery within NHS Leeds, using a mixed-methods case study approach. The findings from this study offer a comprehensive overview of staff perspectives on Monitoring and Evaluation (M&E) practices within the National Health Service (NHS), highlighting both strengths and areas for improvement. High participation rates across data collection methods and a diverse respondent profile including gender, age, and professional roles ensure broad representation and reliable insights. Many respondents viewed M&E as vital to improving healthcare quality, enhancing accountability, and informing decision-making, with patient satisfaction and clinical care indicators being the most used metrics. However, challenges such as high workloads, limited staffing, and inconsistent data collection practices were identified as key barriers to effective implementation. The split in formal M&E training among staff further underscores the need for targeted capacity-building initiatives. Suggestions for improvement focused on regular M&E training, recruitment of dedicated personnel, and increased staff involvement, emphasizing the importance of both technical and participatory reforms. Overall, these findings affirm the value of M&E in the National Health Service and call for strategic investments to optimize its impact on healthcare delivery.

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