Annual review 2011

The Health Foundation
Inspiring Improvement

A story of people doing extraordinary things

About us

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK.

We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people to make lasting improvements to health services. Working at every level of the system, we aim to develop the technical skills, leadership, capacity and knowledge, and build the will for change, to secure lasting improvements to healthcare.

We achieve this by:

— identifying evidence for change and best practice, through commissioning and synthesising research and evaluation

— creating opportunities to innovate and test ideas in practice

— demonstrate improvement in practice by working with partners and health services to implement large-scale improvement programmes

— encouraging and inspiring transformation by sharing the evidence for change and supporting health services to put it into action.

Our people

We have a team of 65 people working in our London office. We are led by our Chief Executive, Stephen Thornton, and our team of directors, overseen by our board of governors.

Thank you

Our work would not happen without the dedication, imagination and effort of the many individuals and organisations we work with and support to put improvement into practice. We would also like to thank our staff, our board of governors, our research and evaluation providers and all our delivery partners.

Contents

In 2011, the story of healthcare has been one of turmoil and uncertainty. Financial constraints and changing needs and expectations mean that changes to the way healthcare is provided are unavoidable. But, in the face of heated debate around NHS reform, it's all too easy to overlook the fundamental challenge: delivering safe and effective care and continuously improving.

Introduction

At the Health Foundation, we work with many remarkable people and organisations, including clinicians, academics, managers, patient groups and others, to respond to this challenge. The vast majority of our work takes place within healthcare systems to improve quality and safety. As an independent charity, we can offer constructive challenges, practical solutions and critical analysis to influence the policy agenda.

We focus on making improvements happen in practice. We also connect practice with policy, advocating practical approaches and using evidence of 'what works' to make the case for change. We have been working for some time on changing the relationship between patients and clinicians, promoting shared decision making and supporting patients to manage their own conditions. In 2011, we successfully lobbied for the Health and Social Care Bill to create a separate duty for commissioners to promote the involvement of each patient in their own care.

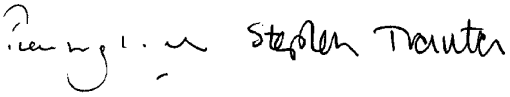
We have continued to work on patient safety, which will be one of our top priorities for 2012. Amid ongoing health service restructuring, the Health Foundation is one of the few remaining organisations actively promoting patient safety in England. We are determined to make sure that it stays high on the agenda for politicians and practitioners alike. Through improvement programmes such as Safer Clinical Systems, we are helping people build better, safer healthcare systems. We will also be developing and launching a major resource for safety-minded practitioners to connect them with the best knowledge, experts and peers, and galvanise and support action on patient safety.

Another important area for us in 2011 was our work to achieve wider change by developing future leaders of high-quality healthcare. Through our Quality Improvement Fellowship and GenerationQ programmes, fellows develop their leadership skills and understanding of quality improvement tools and techniques, which they then implement locally to improve service delivery. Many of our fellows take forward their work on improving quality at regional or national level and through their professional bodies.

Our new Improvement Science Fellowship programme, launched in 2011, also gives leaders in the field the opportunity to develop their skills and knowledge. These fellows are supported to develop leading-edge approaches to the emerging academic disciplines of improvement science and quality improvement. As well as running research programmes, they will be promoting improvement science, both nationally and internationally.

We are committed to reacting swiftly to the constantly shifting healthcare landscape. However, this does mean that things don't always go as planned. For example, the amount of work needed to respond to the issues raised by the Health and Social Care Bill attracted efforts away from other areas where we had hoped to influence policy. And sometimes, our research told us that we had more to do before getting new programmes up and running.

Whatever the outcome, we always seek to learn from what we do – not only through our research, evaluation and experience on the ground, but also from our stakeholders. In 2011 we surveyed a selection of these stakeholders, including award holders and a wider group of people interested in our work, and asked them to tell us what they thought of the Health Foundation and how we could improve. The message that came back was that they liked what we do, but they wanted to hear more about it and see our learning turn into widespread and sustained action. We are responding to this feedback, developing our business model and increasing our active communications. In 2012 we will be doing more than ever to capture and share our learning and tell the story of the extraordinary things people are doing to improve healthcare.



Sir Alan Langlands, Chair, the Health Foundation and Stephen Thornton, Chief Executive, the Health Foundation

The story of 2011

We work with people and organisations in the UK health services to continuously improve the quality of healthcare in the UK. In 2011 we worked on more than 30 improvement programmes, ran over 30 research and evaluation projects and funded more than 250 organisations and individuals to lead and deliver work to make healthcare safe, effective, person-centred, timely, efficient and equitable.

There are four 'pillars' to our approach, describing the four key aspects of what we do:

- **We *identify* to prove that change is necessary.**
- **We *innovate* to test new ideas in practice.**
- **We *demonstrate* to turn what works into accepted practice.**
- **We *encourage* to inspire and create advocates at all levels.**

In 2011 we had six strategic priorities that led our work:

- **inspiring improvement through changing relationships between people and health services**
- **inspiring improvement through healthcare professionals**
- **inspiring improvement in patient safety**
- **inspiring improvement by organising for quality**
- **inspiring improvement through use of knowledge**
- **inspiring improvement through value for money.**

In this annual review, we report our achievements against these strategic priorities. First, we provide a short overview of our work in 2011, followed by more detail about what we have been doing within each strategic priority.

An overview of 2011

Our improvement programmes

Every year our improvement programmes support a large number of organisations and individuals to deliver quality improvement projects within healthcare systems across the UK. For more information visit: ***www.health.org.uk/programmes***

In 2011, some of our main improvement programmes were:

- *Closing the Gap through Changing Relationships* – **7** projects in which teams work to transform the dynamic between people who use health services and those who provide them.
- *Closing the Gap through Clinical Communities* – **11** projects led by clinicians who are influential leaders in their clinical networks. The projects aim to improve the quality and safety of care in different clinical areas.
- *Co-creating Health* – Working with **8** NHS organisations to embed self-management support within mainstream health services across the UK.
- *Engaging with Quality in Primary Care* – **9** projects working to improve quality in primary care, addressing specific health issues, conditions and challenges. These ranged from the management of back pain to tackling domestic violence and reducing health inequalities.
- *Flow, Cost, Quality* – Working with **2** NHS hospital trusts to explore the relationship between patient flow, costs and outcomes.
- *Hospital Pathways programme* (delivered in partnership with the King's Fund) – **5** projects to demonstrate how the health service can achieve its aim of putting the patient at the centre of everything we do.
- *MAGIC (Making Good Decisions in Collaboration)* – Working with **2** NHS organisations to design and test interventions that encourage the use of shared decision making.
- *Safer Clinical Systems* – **8** projects to proactively identify potential safety breaches and so build better, safer healthcare systems.
- *Safer Patients Network* – **18** NHS organisations were network members, with access to expertise within and outside the network. They also took part in innovation and capability building programmes.
- *Shine 2010* – **18** projects to stimulate thinking, activity and the development of innovative approaches to improving healthcare quality.
- *Shine 2011* – **14** projects to find new approaches to delivering healthcare that reduce the need for acute hospital care while improving quality and saving money.

In addition, during 2011 our leadership development programmes supported individuals to develop their skills and knowledge.

- *Clinician Scientist Fellowships* – We continued to support **11** Clinician Scientist fellows.
- *GenerationQ* – The first **18** fellows continued their work with the programme, and the second cohort of **18** fellows started.
- *Improvement Science Fellowships* – We launched this new programme and appointed **4** fellows.
- *Quality Improvement Fellowships* – We supported **4** Quality Improvement fellows, bringing the total number of fellows to **26**.

For more information about the work that we are doing within healthcare systems to improve quality and safety, see our interactive map:

www.health.org.uk/map

Each improvement programme will generally involve a number of individual projects. For example, in 2011 the following projects ran as part of Closing the Gap through Clinical Communities.

- Abdominal aortic aneurysm, improving outcomes for patients, Vascular Society of Great Britain and Ireland
- Delivering better care for infants with brain injury, Cambridge University Hospitals NHS Foundation Trust and East of England Perinatal Network
- Enhancing care for people with chronic kidney disease, Kidney Research UK and East Midlands Renal Network
- FallsSafe – Action on inpatient falls, Royal College of Physicians
- Headsmart – Be brain tumour aware, University of Nottingham
- Improving lung cancer outcomes project, Royal College of Physicians
- Improving quality and safety in primary care, Forth Valley Health Board
- Improving quality and safety in primary care, NHS Quality Improvement Scotland
- Improving the quality of cardiovascular care by ambulance services, East Midlands Ambulance Service NHS Trust
- Optimising care pathways for acute stroke and transient ischaemic attack, Warwickshire Primary Care Trust
- PREVENT – Preventing blood-borne viruses through clinical networks, Central North West London NHS Trust
- Using quality networks to improve mental health services, Royal College of Psychiatrists

Our research

Research is central to the work of the Health Foundation and evidence is at the heart of everything we do. Our research, both primary and secondary, explores what works to improve the quality of care.

In 2011 we worked on **9** pieces of primary research and **9** secondary research projects. We also ran a monthly research scanning service, which we will be making available on our website in 2012, and produced **10** evidence scans that provided a rapid collation of available empirical research about particular topics. For more information visit: ***www.health.org.uk/research***

Our research work in 2011 included:

- *Does clinical coordination improve quality and save money?* This two-volume research report, published in June 2011, examines the evidence for how better coordination could improve patients' care and lead to less waste of healthcare resources.
- *Helping people help themselves.* This May 2011 report reviews the published evidence on the effectiveness of supported self-management.
- *Lining up.* A University of Leicester research team is examining the behavioural and cultural factors that affect the success of safety interventions designed to reduce central venous catheter blood stream infections. The findings will be available in 2012.
- *Measurement of patient safety.* This research was commissioned in October 2011 and will be conducted throughout 2012. It aims to produce a clear picture of current and best practice in measuring safety. The findings will contribute to the understanding and development of more effective measures of patient safety.
- *Spotlight on dementia care.* This improvement report, published in October 2011, brings together data, research and good practice guidance for dementia services, together with an assessment of the current quality gap. It identifies a 'road map' for the components of high quality dementia care.
- *The IRIS case study.* This case study explores the successful implementation of a primary care domestic violence referral service. It was published in February 2011.
- *Value for money in healthcare.* Research teams from Imperial College and the London School of Economics and Political Science (LSE) are each undertaking three-year research projects, started in 2010, exploring how healthcare resources are being spent in the UK and whether this provides value.

In addition to the Health Foundation's own research publications, each year a number of articles arising from research we have funded are published in academic peer-reviewed journals. In 2011, articles included:

Dixon-Woods, M, *et al.* 'Explaining Michigan: Developing an Ex Post Theory of a Quality Improvement Program.' *Milbank Quarterly*, June 2011.

Feder, G, *et al*, 'Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial'. *The Lancet*, November 2011.

Shebl, N, *et al.* 'Failure Mode and Effects Analysis: views of hospital staff in the UK.' *Journal of Health Service Research and Policy*, published online October 2011.

Our evaluations

It is vital for us to make sure we understand what works, and what doesn't, to improve the quality of healthcare. To help us do this, we commission independent academic research teams or consultants to assess the effectiveness of our improvement programmes.

We evaluate our programmes to provide sound evidence of the impact they have had, and to better understand how the impacts have been achieved – or have not. We use evaluation findings to inform healthcare providers, commissioners, policy makers and others about what has been learned from the programmes, as well as to develop and improve our own work. For more information visit: ***www.health.org.uk/evaluation***

In 2011, we worked on **11** large-scale programme evaluations. These included:

- *Closing the Gap through Changing Relationships*
  This evaluation will run until the end of 2012. It is investigating the experiences of those involved in the process of changing the relationship between patients and clinicians. It will also investigate the barriers to, and promoters of, successfully changing this relationship.

- *Engaging with Quality in Primary Care*
  This evaluation ran from 2007 to 2011 and the evaluation report will be published in 2012. It assesses the impact of the nine projects that took part in the programme and also explores the quality improvement approaches and evaluation methods used.

- *MaiKhanda*
  The five-year evaluation of our MaiKhanda programme was completed in 2011. It showed that the programme averted more than 1,000 newborn deaths, and was highly cost-effective according to World Health Organization criteria.

- *Safer Clinical Systems*
  This evaluation was commissioned in 2011 and will run until 2014. It will look at how effectively the systematic proactive approach used by the programme enables organisations to create safe and reliable systems.

A recent review of Health Foundation evaluations identified 10 challenges that consistently emerge when trying to improve quality in healthcare:

- Convincing people that there is a problem
- Convincing people that the solution chosen is the right one
- Data collection and monitoring systems
- Excess ambitions
- The organisational context, culture and capacities
- Tribalism and lack of staff engagement
- Leadership
- Balancing carrots and sticks – harnessing commitment through incentives and potential sanctions
- Securing sustainability
- Considering the side effects of change

A report describing these challenges, and ways to overcome them, will be published in 2012.

Inspiring improvement through changing relationships between people and health services

Evidence shows that involving patients in their care leads to increased satisfaction for patients and clinicians, improved patient experience and can result in more effective use of resources. The principle of 'no decision about me, without me' underpins the government's vision for healthcare. However, genuine patient involvement in their own care requires a fundamental cultural shift in the relationship between patients and clinicians.

We have conducted research and designed and delivered programmes that promote these new relationships. We support approaches such as shared decision making and supported self-management that equip patients to play a more active role in their own care.

We have used what we've learned to make the case for involving patients in their care, working with policy makers, clinicians, senior managers, the royal colleges and others. We have successfully influenced government policy and will continue to play a leading role in pushing this agenda forwards.

In 2011

— We continued to demonstrate that by changing the relationship between people and their health services we can improve the quality of care in practice. We continued to build and share the evidence of what works in changing relationships through our programmes, evaluations and research and development activity.

— We spent a significant amount of time and effort working to influence the Health and Social Care Bill, and had some notable success, as outlined below. However, prioritising this influencing work meant that we could not deliver other changing relationships activities, such as our planned engagement programme.

1

What we've been doing

Influencing the agenda

As part of our work to make shared decision making the norm, in 2011 we set out to influence the NHS Future Forum. The NHS Future Forum's report to the government on choice and competition highlighted our work and recommended a more sophisticated approach to the choice agenda, with an emphasis on patients having genuine involvement in their care as opposed to just choice of provider.

Building on this we worked in partnership with the charity National Voices to successfully lobby for the Health and Social Care Bill to create a separate duty for commissioners to promote involvement of each patient in their own care. We will continue to campaign for an NHS in which 'no decision about me, without me' is a central part of people's everyday experience.

www.health.org.uk/areas-of-work/influencing-policy

Showcasing best practice on personal budgets

After we published a research-based case study called *The personal touch: the Dutch experience of personal health budgets*, the Department of Health asked us to host a seminar to share our findings. The event provided an opportunity for those who took part in the research to share learning with individuals leading the English personal health budget pilot programme.

Our analysis of the Dutch experience highlighted that personal health budgets led to significant improvements in the patient experience, although there was less evidence of improvements in clinical outcomes. It advised the government to be wary of the programme having a negative impact on other aspects of quality – especially effectiveness and equity.

www.health.org.uk/phbcasestudy

Providing the tools for change

Self-management has been shown to be effective for patients with long-term conditions. To help clinicians support patients in this approach, in November 2011 we launched and promoted a self-management support online resource centre. The site provides information and practical tools that healthcare providers can adopt and adapt locally.

The site provides templates and tools that will help practitioners during consultations, along with advice and materials for running patient workshops. There are also key facts and figures to use in making the case for self-management support and case studies of how the approach is already being successfully implemented in key areas such as depression and diabetes. The site has proved extremely popular – by the end the year almost 4,000 people had visited, with a total of 14,715 page views.

www.health.org.uk/sms

Making decisions together

Shared decision making offers a host of benefits to patients and healthcare providers alike. Many patients want to play an active role in decisions about their health and care, and clinicians are often keen to offer patient-centred care. Meanwhile, a commitment to 'no decision about me, without me' continues to be a key theme of the coalition government's vision for the NHS. But this widespread desire to actively involve patients does not always translate into change on the ground.

A common problem is the lack of clarity about what is required for a decision to be truly 'shared'. Whilst some clinicians believe that they are already offering shared decision making, many of the clinicians who took part in our work realised that this was not the case.

To tackle this problem, the Health Foundation developed MAGIC (Making Good Decisions in Collaboration). The programme, working with sites located across Cardiff and Newcastle, is designed to develop and test practical solutions to support shared decision making. Decision aids such as 'pros and cons tables' or option grids help patients make decisions, and help clinicians systematically embed shared decision making into their clinical practice.

'If you've got an informal consultation, you might miss something out', explains one nurse who took part in the programme. 'With this approach, you can be sure that you've gone over everything because it's all set out, step by step.'

In a health service that has traditionally done things 'for' rather than 'with' patients, this kind of change requires a cultural shift. So the clinicians and senior academics who lead the MAGIC team also focus on changing professional attitudes and inspiring staff to work more closely with patients – not least, by demonstrating the benefits of shared decision making. A key focus is on supporting teams to adopt this new approach without the need for any additional funding, time or other resources.

Clinicians attend extended skills workshops, which promote the benefits of shared decision making and offer practical tools and techniques for going about it. Many have made significant changes as a result. One participant explained, 'I thought I knew a lot about the best ways to communicate, but this has made me completely rethink'.

In December 2011, an assessment found that patients in one of the participating services felt more knowledgeable about their conditions, more confident in asking questions, more satisfied with the service, and less anxious about care options. The clinicians who took part described the programme as a key quality improvement tool, and said that it had given them new skills and increased their personal satisfaction by making consultations more interesting and challenging.

Going forwards, MAGIC will be working to spread and sustain good practice. The programme will work with new clinical teams to support them in a consultancy model, providing training and developing additional decision aids. It will also look at how to engage senior leaders and help commissioners access better data about patient needs and preferences.

Find out more about MAGIC at:
www.health.org.uk/magic

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Inspiring improvement through healthcare professionals

Most healthcare takes place at the interface between the professional and the patient. As both healthcare and society develop, so too do the roles of health professionals. Doctors are expected to manage an increasing range of tensions: having responsibility to the individual but also to the wider population; improving quality of services while providing high-quality day-to-day care; meeting growing demands from patients to be fully involved as an equal partner in their care.

We work with clinicians, professional bodies and educationalists to support, develop and promote new ways of working.

Our awards, programmes and professional networks create the space for clinicians to think differently about what it means to be a healthcare professional and to get involved in improving quality. We also connect with policy makers, senior managers and professional leaders to advocate the importance of evolving professional roles alongside external levers for change.

In 2011

— We began working with clinicians, educators, patients and others to develop a deeper understanding of what it means to be a health professional in a modern healthcare system. This work will continue into 2012 with a project to open up a debate about how doctors' relationships with patients are changing.

— We continued to run our Closing the Gap through Clinical Communities programme, which supports clinician-led projects to improve the quality and safety of care in different clinical areas. We also continued our work with the medical royal colleges.

2

What we've been doing

Forging new roles for clinicians

As part of our work to examine evolving clinical roles, we organised a study tour to Sweden to look at how medical professionals work there. The tour group, of medical students, junior doctors and managers, came away feeling inspired to find new ways to make their services more patient centred.

'I'm ashamed to admit that in a lot of cases, hospitals and doctors work the way they do because history dictates, and because it suits us', wrote group member, specialist registrar Dr Bethan Graf, reflecting on her experience. As a result of the tour, Bethan is planning to implement innovative ways of running clinics, by phone, email or online.

In 2012 we will work to open up a debate about the challenges and anxieties doctors face as they adapt to changing relationships with patients, and how they might be supported.

The future of generalism

In 2011 the Health Foundation and the Royal College of General Practitioners (RCGP) set up an independent commission, chaired by Baroness Finlay, to examine the state of medical generalism. The commission concluded that more of the most talented doctors must be encouraged to make careers as generalists rather than specialists.

The commission report, *Guiding patients through complexity: modern medical generalism*, highlights the essential role of generalism in providing high-quality, sustainable healthcare, both now and in the future. It emphasises that developing the role of the generalist alongside specialists is vital if health services are to provide person-centred care and effective support for people with co-morbidities.

The RCGP is using the report as the basis of a major consultation.

www.health.org.uk/publications/generalism-report

Clinicians leading improvement

In 2011 we continued our Closing the Gap through Clinical Communities programme. Eleven teams are working to improve the quality and safety of care in their clinical areas, bridging the gap between current and best practice. One project developed care bundles for ambulance services to ensure that every patient presenting with heart attack or stroke received optimal pre-hospital care. Another used clinical networks and service user partnerships to reduce incidence of blood-borne viruses among people with drug and alcohol problems.

The programme is being evaluated, and we will share our learning from it over the coming year.

www.health.org.uk/ctgclincomm

When quality improvement is applied with rigour and care, it can result in measurable changes to services.

Engaging with young clinicians

Engaging with the clinicians of the future is vital if we are to develop and embed new ways of working. But few medical students have had the opportunity to run their own improvement project and see quality improvement in action. We funded Learning to Make a Difference – a programme led by the Royal College of Physicians of London and the Joint Royal Colleges of Physicians Training Board – to give foundation medics a better understanding of quality improvement methods and how these tools can benefit services.

Dr Sam Alimam was one participant. Her project set out to reduce adverse events resulting from prescribing warfarin. 'We learned the principles of quality improvement – it was a new concept – and how to initiate a quality improvement project', she explains. 'We encountered a lot of resistance, but we learned how to deal with that and change mentalities. And we learned that actually, small changes – if done correctly – can lead to big outcomes.'

Learning to Make a Difference worked on the basis that often the best way to understand a principle is from the inside: in this case, by being directly involved in developing and delivering quality improvement projects. Through the programme, foundation doctors were offered a quality improvement option as an alternative to the mandatory clinical audit element of their training.

The course was designed to teach students how to make change happen, and to think practically about how to improve the systems they work in. Projects focused on topics such as reducing healthcare-associated pneumonia and introducing databases to improve information management.

Another participant was Dr Alev Önen. 'We've really implemented a change in working practice within the unit', she says. Alev's project team developed checklists for consultants and foundation year medical students to reduce the number of critical omissions and errors in an acute medical admissions unit. The team developed stickers to help ensure consistent recording by doctors.

'The stickers are still being used nine months later', says Alev, 'and we've just heard that one of the hospitals in our trust is adopting the idea too, so it is spreading'. The project created a significant improvement in documentation at a cost of just £75 per year plus slightly more time taken for recording.

Sam and Alev are just two of the many students who were enthused as they saw their idea taking shape and the positive outcomes that they produced. Perhaps, most importantly, they discovered that when quality improvement is applied with rigour and care, it can result in measurable changes to services.

'Quality improvement projects give a framework and an aspiration for trying to make a difference', explains Alev. 'We've learned, as junior doctors, we can be empowered to make an impact on patient care. And personally, I know we've all learned skills that we can take on with us into future careers and further quality improvement projects.'

This story draws on videos presented at the end of the Learning to Make a Difference project. More information, tools and video case studies are available at: https://sites.google.com/site/lmdproject2010/

Inspiring improvement in patient safety

Most people who use the NHS are treated without incident, but around one in 10 patients admitted to hospital will experience some form of harm during their stay. There is growing awareness of the importance of patient safety, and pockets of excellence are emerging around the UK. But there is still not a reliable, sustainable improvement across the NHS.

Research shows that when patient safety breaks down, it is usually caused by clinical processes and systems rather than individuals. We help healthcare organisations run projects to redesign unreliable processes and to develop a proactive organisational culture that underpins patient safety with strong leadership, accountability, enthusiasm and long-term commitment.

Our programmes have shown that change is possible, but it requires time and determination. Amid ongoing health service restructuring, the Health Foundation is now one of the few organisations actively promoting this critical agenda.

In 2011

— We continued to promote patient safety work through our Safer Patients Network, and worked as a strategic partner to deliver the Patient Safety Congress 2011. We recruited eight organisations to take part in the second phase of our Safer Clinical Systems improvement programme.

— We have shared our learning from patient safety throughout 2011, with increasing numbers of award holders publishing their work and presenting nationally and internationally. Due to capacity constraints, we did not fully implement a coordinated communications strategy for this area. However, in 2012, we are committed to capturing and communicating learning from our patient safety work, and making sure that it stays high on the healthcare agenda.

3

What we've been doing

Learning from our Safer Patients Initiative

We published the findings from an independent evaluation of our Safer Patients Initiative in a 2011 learning report. The initiative – the UK's first major safety improvement programme – aimed to improve patient safety in the participating organisations, increase awareness of avoidable harm, raise the profile of patient safety and provide the foundations for a wider safety movement.

While there were improvements in patient safety reported at clinical team level, the evaluation found that over the 18 months of the programme there was not the organisational impact hoped for. This highlighted the scale of the resources needed to make organisation-wide change and the need to make changes at every level of the system, from policy to deep engagement with professionals. It also showed the time needed to deliver and embed improvements. Much of this learning has subsequently been applied in initiatives built on the Safer Patients approach in Wales, Scotland and the South West of England, where tangible impact at organisation level is now emerging.

www.health.org.uk/publications/safer-patients-initiative

Playing a national role in patient safety

We played a key role in the 2011 Patient Safety Congress – the UK's largest patient safety event – by becoming a strategic partner for the event. More than 700 national and international healthcare leaders and frontline staff came together to share innovative approaches to improving quality and safety, including several of our award holders, who presented their work.

The event also enabled us to take forward our work to build a network of people and organisations to test and develop new approaches in patient safety and an evidence base for safer care. We will be continuing to work as a strategic partner for the 2012 congress.

www.patientsafetycongress.co.uk

Targeting specific areas of harm

We worked to reduce the incidence of harm in healthcare by using new care bundles – packages of several interventions that combine to improve care. Through our FallSafe programme, units are working towards reducing injurious falls by 20–30%. The emerging benefits include improved multidisciplinary working.

We are also funding two mentor schemes that are helping reduce harm. NHS Tayside is mentoring three sites to prevent peripheral vascular catheter infection, using a care bundle approach. Two of the sites are sustaining 90% compliance with the bundle and are measuring an overall decline in infection. Meanwhile, Cardiff and Vale University Health Board is mentoring five sites to reduce pressure ulcers. Several are noticing clear improvements – for example, by December 2011 the site in Galloway had registered no reddened skin among patients for more than 133 days.

Ensuring safety through accurate patient data

For NHS Lothian, reliable electronic patient records are essential for high quality, safe care. As Simon Watson, Associate Medical Director for Patient Safety, says, 'Every day, life-and-death decisions are made based on what's in that record. Patients don't always know all their information – so if the details aren't accurate it could be very serious'.

Spurred on by concerns about missing patient records in outpatient consultations, NHS Lothian successfully applied to join the Health Foundation's Safer Clinical Systems programme to support Health Records staff improve their information system. Their aim was to make sure that the right information was available at the right place, at the right time – every time.

The project was led by Simon and Val Baker, Director of Clinical Information, and involved a number of the Health Board's administrative staff. It began with a detailed analysis of the current situation, which revealed an unexpected priority: the need to streamline the Health Board's many duplicate records – a legacy of the old multi-trust structure. But as staff began merging the duplicate files, a more serious issue became apparent. Some people's records were accidentally being merged with records of others patients who had similar names or other details. And if two patients' details were blended, it was almost impossible to separate them out again.

To get to the root of the problem, the NHS Lothian team and the Health Foundation's Human Factors experts conducted a detailed analysis of the merging process. They found that many errors crept in when records were merged by clinical, rather than administrative, staff. Then they physically observed the administrators as they worked, in order to identify any distractions, software glitches or other factors in the working environment that could lead to errors.

Once the causes became clear, the changes themselves were relatively simple – for example, ensuring that records were now created or merged by administrative rather than clinical staff wherever possible. The team also designed a system to give managers real-time feedback on staff accuracy, and record accuracy swiftly rose – from almost 75 to 95%.

'The project helped make sure we didn't dive into finding the solution before we were clear about the problem', Simon explains. 'The Health Foundation's team of experts challenged our beliefs and understanding of the problem, helped us assess and find evidence and, ultimately, helped us think differently. But the hard work was done by Health Records and eHealth colleagues so we were thrilled when their success was recognised and they were named as a finalist in the 2011 HSJ Patient Safety Awards.'

Following the success of this project, NHS Lothian are now working on a new project to improve the way patient data is shared at handover.

Find out more about Safer Clinical Systems at: www.health.org.uk/scs

Once the causes became clear, the changes themselves were relatively simple.

Inspiring improvement by organising for quality

The NHS is under pressure to improve quality and save money on a large scale. But the health system – and efforts to improve it – are often constrained by practical and cultural barriers between and within teams and organisations. Work to improve quality and safety in healthcare often falls short of its potential as it struggles to spread beyond isolated pockets of enthusiasm.

We are exploring what it takes to deliver improvement more systematically through whole organisations and healthcare systems. We are building an influential cohort of leaders with the skills to make a real difference to the quality of the healthcare systems they work in.

We are enhancing the evidence based on the context needed to support organisation-wide improvement. We are also supporting improvement efforts that span traditional boundaries to provide inspiring examples of how health services can reliably achieve large-scale improvement.

In 2011

— Our GenerationQ and Quality Improvement Fellowship leadership programmes proved highly popular, and received a record number of applications, as did our Shared Purpose programme, which focuses on how corporate and support functions contribute to the delivery of high-quality care.

— At the NHS Confederation conference we presented our research into the role of boards in delivering high-quality care. We also reviewed the evidence on context – the organisational factors that enhance or inhibit improvement. We recognise the importance of building our understanding in this area before we increase our work aimed at organisation-level interventions to improve quality.

4

What we've been doing

Breaking down boundaries

With a growing awareness of the importance of care pathways and systems across organisational boundaries, we have been expanding our work in this area. In 2011 both the Hospital Pathways programme (delivered in partnership with the King's Fund) and our Flow, Cost, Quality programme delivered impressive results for patients. For example, Northumbria Healthcare Foundation NHS Trust implemented a hip fracture project as part of the Hospital Pathways programme. After nine months, 90% of cases achieved Best Practice Tariff for fragility hip fractures awarded by the Department of Health, compared to 2% in April 2010.

In 2011 we also launched the pilot phase of our networking programme, which aims to match promising and innovative healthcare networks with the expertise they need to grow and achieve their full potential.

Counting the cost of poor coordination

In June 2011 we published *Does clinical coordination improve quality and save money?* This report examines the link between care coordination and quality outcomes, and asks which approaches are most effective at improving care, and whether they can also reduce costs.

It summarises the key evidence and grades the strength of each source, to clarify which approaches are the most robustly evaluated. The report concludes that improving the way care is coordinated can reduce costs, and should be a major consideration for how to improve quality while saving money. This makes the case for further investment in initiatives to improve coordination.

www.health.org.uk/clin-coord

Understanding context

In September 2011 our workshop, 'The importance of context in quality improvement', brought together several leading researchers in the field. They were joined by policy makers, health service leaders and other academics. They discussed various topics including the problems of defining and measuring context, how context alters as interventions are applied, and the need to classify interventions and establish which contextual factors influence each of them the most.

We have used the discussions at the workshop to shape our future work. In 2012 we will share our learning from our research into context and how it affects the success of improvement interventions.

Fellows develop the understanding, values and experience needed to confidently lead processes that result in better care for patients.

Q is for quality

'In my experience, most people join the health service because they're passionate about delivering care', says Suzie Bailey, Service Improvement Director at Sheffield Teaching Hospitals NHS Foundation Trust. 'Engaging them in improving what they do for patients isn't difficult. What is difficult is the behavioural change that actually makes the improvements happen.'

Wanting to encourage this change within her own trust, in 2011 Suzie joined the latest cohort of fellows on the Health Foundation's GenerationQ leadership programme.

GenerationQ sets out to develop a new generation of skilled, effective leaders of quality improvement in healthcare by combining practical quality improvement techniques with the development of personal effectiveness.

After a lower than expected response to a call for applications in the spring of 2011, GenerationQ was re-launched in the summer and received an extremely positive response, with a large number of high-quality applications. After a very rigorous selection process, the calibre of candidates meant that we agreed to fund two new cohorts – one, which Suzie is part of, starting in November 2011, the other in June 2012.

'I've come up from ground level – working initially in a junior administrative role, then as a service manager, heading up a range of clinical specialties, and now working as a senior manager', explains Suzie. 'Already the programme is giving me the opportunity to reflect on what I'm good at, and how I can be better – both professionally, leading quality improvement, but also using the team around me more effectively.'

The academic component of the programme is important to her too: 'It's making me look at the evidence for what I'm doing, as opposed to just going on gut feeling or on my experience as a manager. So it's bringing that rigour into my working life.'

The programme content is also rigorously evidence based. It was developed with Ashridge Consulting and Unipart Expert Practices, drawing on learning from the Health Foundation's work on leadership. It introduces innovative approaches to leadership development and sets explicit improvement leadership competencies, against which fellows are assessed throughout the programme.

A key aspect of GenerationQ is that it benefits the fellows' organisations as well as the fellows themselves. Fellows need to demonstrate that they are putting what they have learned into practice, including delivering an assessed improvement project in their organisation.

GenerationQ fellows include GPs, hospital consultants and heads of commissioning consortia, as well as senior managers. Like the first cohort of fellows, who are currently coming to the end of the programme, Suzie will be developing the understanding, values and experience she needs to confidently lead processes that result in better quality care for patients.

'From a personal point of view, GenerationQ is an opportunity to build on what I'm good at, stretch myself to develop further knowledge and give me a legitimacy for quality improvement', says Suzie. 'It's reignited my passion for why I came into the health service in the first place.'

Find out more about GenerationQ at:
www.health.org.uk/generationq

Inspiring improvement through use of knowledge

Our work supports many inspiring initiatives, often starting with simple ideas, that create far-reaching improvements in healthcare. We want to see a growing appetite for innovation, inspiring staff at every level of the system to improve delivery within their services and to strive for excellence.

To increase recognition and investment in these methods, we are working with leading thinkers to build the credibility of improvement science as applied academic disciplines. This approach to development, evaluation and dissemination will help ensure a more consistent and rigorous approach to health improvement, and will help strengthen the growing evidence base.

We bring together the current leaders in the field to accelerate the exchange of ideas and find practical ways to apply the new knowledge, in order to make concrete improvements to healthcare. These leaders are empowering healthcare professionals around the world to deliver services of the highest possible quality.

In 2011

— We helped to define and build the science of improvement by launching our Improvement Science Fellowship programme, working with the newly established Improvement Science Development Group and partnering with the BMJ Group as co-owners of the re-launched academic journal *BMJ Quality & Safety*.

— We continued to generate and promote new knowledge and evidence from research on improvement science and improving quality. This included producing a number of publications and holding the International Quality Improvement Exchange on innovation in healthcare. We commissioned an evidence review of knowledge mobilisation approaches, but decided not to publish it, as it revealed little in the way of innovative best practice.

5

What we've been doing

Bringing together leading thinkers

To help develop improvement science, we established the Health Foundation Improvement Science Development Group – a network of experts from six countries, chaired by Professor Paul Batalden, Emeritus Professor of Pediatrics at the US Dartmouth Medical School. In 2011, members attended two face-to-face meetings, with some joining by video conferencing, to develop an ambitious work programme designed to foster the collaborative development of improvement science.

The development group is also a valuable resource for our new Improvement Science Fellows. The Health Foundation is funding four fellowships to give established academics the time and resources they need to refine their research and think about improvement science, and to champion this approach among healthcare colleagues and health service researchers.

www.health.org.uk/areas-of-work/improvement-science

Presenting the evidence

One of the challenges of quality improvement is the need to sift through an ever-increasing body of evidence to find out what works. In 2011 we published a series of evidence scans summarising the evidence on particular aspects of healthcare and improvement. The scans help people working in quality improvement by providing a snapshot of the latest empirical research in a specific area. Published scans included *Competition in healthcare, Involving junior doctors in quality improvement* and *Levels of harm in primary care*.

In 2012 we will be launching a monthly research scan on our website. This scan will bring together the latest empirical improvement science research to help those working in healthcare improvement access relevant research evidence.

Raising the profile of improvement science

In 2011 we partnered with the BMJ Group as co-owners of the re-launched *BMJ Quality & Safety*, to raise the profile of improvement sciences among academics and health service professionals. The international peer-reviewed journal provides news, opinion, debate and research for academics, clinicians and healthcare managers. It encourages innovation and creative thinking to improve the quality of healthcare and the science of improvement.

The most popular article in 2011 was Perla, Provost and Murray's report of their original research 'The run chart: a simple analytical tool for learning from variation in healthcare processes', which was accessed more than 8,000 times during the year.

http://qualitysafety.bmj.com

Leading the way in improvement science

In these challenging times, the emerging disciplines of improvement science have the potential to answer some important questions for any healthcare system. In 2011, we recruited four post-doctoral fellows to a new programme designed to propel improvement science into the limelight, strengthen the evidence base, and act as champions for this developing field. The fellows receive a salary and costs to carry out research over three years.

One of the fellows is Davina Allen, a professor at Cardiff University with a background in nursing and sociology. Davina is looking at the various interfaces between teams in a patient journey to encourage better communication and more effective coordination of care. Another fellow is Tim Draycott, a consultant obstetrician at North Bristol NHS trust. Tim is identifying what makes some teams more receptive to new ways of working than others. He will then develop a technique to help organisations become more likely to adopt good practice.

'What makes this programme different from an ordinary research grant is the professional development that is built into it and the active encouragement we're given to expand our networks and share our learning', says Davina.

'It's more than just undertaking research', explains Tim. 'It's also about developing ourselves as researchers, and having the time, space and external expertise to do that.'

The fellows get together every few months for several days and also have access to the Health Foundation Improvement Science Development Group (see box).

'It's been fantastic to have some dedicated time to explore areas outside my normal discipline', says Tim, 'and especially to meet with the other improvement fellows, who all work in areas outside my expertise'.

Fellows are also expected to expand their networks and share their learning with colleagues from a wide range of disciplines, from psychology and sociology to mathematics and business studies. 'As a medic, you lead a very cloistered life', says Tim. 'But through the fellowship, I've been working with the business school at Bristol to understand organisational culture. It's allowed me to look outside of medicine, take what's relevant, and bring it back with me.'

Davina agrees: 'Academic research has grappled with this kind of service improvement in the past, but improvement science brings together people from a whole range of disciplines, and provides a language to describe this shared purpose. The time is right to bring science to bear on improvement processes that are going on at grassroots level. It's a breath of fresh air.'

The Improvement Science Development Group

Formerly known as the Improvement Science Network, the development group is a new virtual forum of international experts from disciplines within the field of improvement science. It contributes to the development of improvement science as an umbrella discipline, bringing together theory and methodologies from a range of disciplines through the sharing of ideas and knowledge.

The emerging disciplines of improvement science have the potential to answer some important questions for any healthcare system.

Inspiring improvement through value for money

Poor quality healthcare is common and costly. Research has shown that improving quality can also save money. Cost improvements are a key focus for healthcare organisations in the current financial climate, and in the context of the projected increase in healthcare demand in the UK over the coming decades.

We believe that there are many opportunities to make health systems more efficient. Tackling under-coordination alone could save 5% of total healthcare costs, and inefficiencies such as multiple requests for scans and tests can be prevented through better continuity of care and clinical coordination.

We are working to help services think about how to minimise waste and reduce costs while maintaining, or improving, quality. And through our research and improvement programmes, we are helping build up the evidence that shows which improvements can save money. With our expertise, we are helping services work smarter, not harder.

In 2011

— We continued to work with healthcare services, researchers and project teams to explore ways of maintaining or improving quality while reducing waste and costs. Our publication *Could quality be cheaper?* highlighted learning from our Shine 2010 programme. We also ran the Shine 2011 programme, which tested new approaches to reducing the need for acute hospital care while improving quality and saving money.

— We appointed a technical provider to develop a tool to help healthcare organisations and communities prioritise the use of resources when commissioning services. During 2012 we will promote this tool, and the research evidence that underpins it.

6

What we've been doing

Winning awards for quality

One of the Health Foundation's award-winning projects this year was a team from University Hospital Southampton NHS Foundation Trust. The team won the *Health Service Journal* Acute and Primary Care Innovation Award for its work on chronic obstructive pulmonary disease (COPD). The project addressed the growing number of emergency admissions and difficulties with management and diagnosis. The team's educational tool for GP surgeries resulted in a 50% increase in diagnosis of COPD in primary care, and reduced the rate of unplanned hospital admissions by one-fifth.

This was one of four national awards won by Health Foundation projects for their work to reduce costs while improving quality.

www.health.org.uk/news-austerity-innovation

Supporting effective commissioning

Allocating resources to where they can do the greatest good is a critical process for commissioners. Much research has been done in this area, but it can be hard to translate into daily practice. In 2011, we began work with PricewaterhouseCooper to develop a practical tool to help commissioners target funds effectively. It draws on research carried out by a Health Foundation-funded team at the London School of Economics.

The tool will include a training module, with an accompanying data analysis toolkit, to help commissioners analyse value for money. It is designed to enable new clinical commissioning groups in England, and health boards elsewhere in the UK, to effectively involve patients and the community in setting local priorities.

www.health.org.uk/news-star-vfm

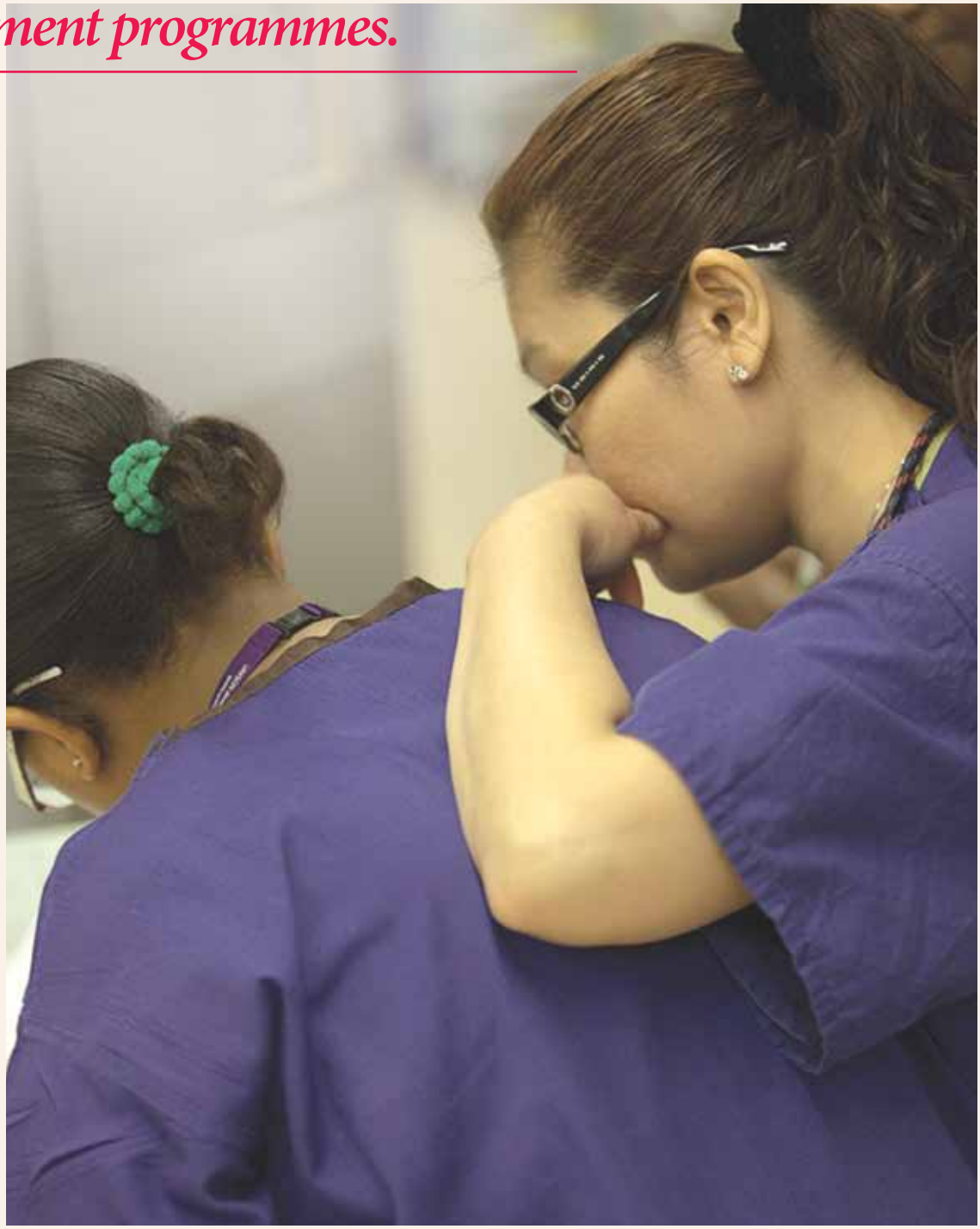
Getting out of hospital

Our research report *Getting out of hospital* reviewed the evidence underpinning the policy drive to transfer acute inpatient and day-case services from hospitals into the community, and examined its effectiveness for improving quality of care and saving money.

The evidence showed that, under the right conditions, community-based services can provide quality of care that is as good as that in hospital, and sometimes at lower cost. However, it argued that promoting early discharge from hospital would lead to cost savings only if it was associated with active reductions or decommissioning of hospital-based services. The report highlighted the lack of robust data, and the Health Foundation is seeking to tackle this issue by supporting research into value for money in healthcare.

www.health.org.uk/publications/getting-out-of-hospital

We had been researching the link between quality improvement and cost savings for some time, generating learning from our improvement programmes.



Does quality improvement cut costs?

Of the many challenges facing the healthcare system at present, two may appear to be at odds with each other: improving quality and making year-on-year savings. The government's drive for quality improvement, set out in the Health and Social Care Bill, has been widely welcomed. But how does it sit with the Nicholson challenge? Is it possible to make 4% a year efficiency gains without making cuts to services, and can NHS teams really improve quality while saving money?

Those were the questions the Health Foundation sought to answer in its submission to the Health Select Committee's 2011 inquiry into public expenditure. A key area of focus was whether health and social care bodies were doing more with the same level of resource, or whether they had reduced the quality of services to make ends meet.

We had been researching the link between quality improvement and cost savings for some time, and had generated a great deal of learning from running and evaluating our improvement programmes. In 2010 our first round of Shine projects began exploring and testing clinical-level initiatives that could improve quality while saving money. Sixteen of the 18 Shine projects produced significant quality improvements for a modest investment. The findings demonstrated improvements in areas such as productivity, time saving and better demand management.

Some also used robust cost measures to demonstrate clear savings. Our 2011 publication *Could quality be cheaper?* describes three of the most successful Shine projects. One project, at the University Hospital of Wales, identified savings of £651 per hysteroscopy if procedures were moved from theatre with general anaesthetic to outpatients with local anaesthetic, using reusable equipment.

However, it was often less straightforward to substantiate savings that directly released costs, such as a reduction in workforce or resources needed. This is partly because it is extremely difficult to accurately demonstrate savings, as consultant anaesthetist Dr Alwyn Kotzé, project lead of Airedale General Hospital's Shine project, explains: 'Most hospitals have a silo structure financially: drugs don't come out of the same budget as length of stay, nurses' salaries and blood products, so it can be quite difficult to quantify savings.'

Our submission to the Health Select Committee concluded that the government must be realistic about how services will need to change to meet the Nicholson challenge, and that while scaling up small-scale quality improvement programmes can make some contribution, it is unlikely to result in the scale of savings needed across the whole health system.

The final Health Select Committee report reflected our position, stating that fundamental changes are needed in the way that the NHS delivers care if the Nicholson challenge is to be met. It argued for better integration between health and social care, but found that many short-term savings will not deliver savings in the longer term.

Improving maternal and newborn health in Malawi

MaiKhanda is a landmark programme funded by the Health Foundation that addresses maternal and newborn health in Malawi. Working in three districts in central Malawi, MaiKhanda combined two large-scale interventions:

- A community mobilisation intervention, using a participatory action group cycle focused on women's groups that had shown some promising evidence from international studies. The programme mobilised 879 communities.

- A quality improvement intervention to identify and implement local strategies, working first in nine hospitals that provide comprehensive emergency obstetric care, and later in 29 health centres that provide some elements of basic emergency obstetric care.

In 2011, University College London completed their independent five-year evaluation of the programme. The results were striking.

Where the programme undertook community mobilisation alone, it achieved a 16% reduction in perinatal mortality. Where community mobilisation was combined with work in health centres, it achieved a 22% reduction in neonatal mortality. In the second half of the programme, the intervention was strengthened, and the evaluation reveals an impressive 30% reduction in neonatal mortality in the final 15 months.

The evaluation also tested a new method for collecting data: a community-based population mortality surveillance system, using local village leaders as 'key informants'. This low-cost system used a combination of government health surveillance assistants, volunteer key informants in villages, and just a handful of staff to collate the data. The effectiveness of this approach is of enormous significance for governments in sub-Saharan Africa,where real-time information about population mortality is seldom achieved.

Transposing quality improvement techniques from high-income countries to resource-poor settings such as rural Malawi is not straightforward. Limitations in resources, supervision systems, staff morale and motivation can all interfere with and limit impact. For long-term sustainability, interventions in healthcare facilities need to extend beyond clinical micro-systems and engage in system-wide improvements.

But the evaluation makes an important contribution to the debate about whether the greatest reductions in maternal and newborn mortality in low-income countries is best achieved by educating and empowering communities, or by improving healthcare systems. The evidence clearly points to the answer: by doing both at the same time and addressing the linkages between them, more can be achieved.

Policy makers are starting to think about the need for an integrated approach to developing the full range of evidence-based interventions to reduce maternal and newborn mortality in low-income countries. The results and learning from MaiKhanda will strengthen the evidence for working both with healthcare facilities and with the communities they serve, in the drive to improve maternal and newborn health.

In 2012 we will be publishing a learning report about our work in Malawi, along with the full evaluation of the MaiKhanda programme. We will also be continuing to support the programme.

www.health.org.uk/maikhanda

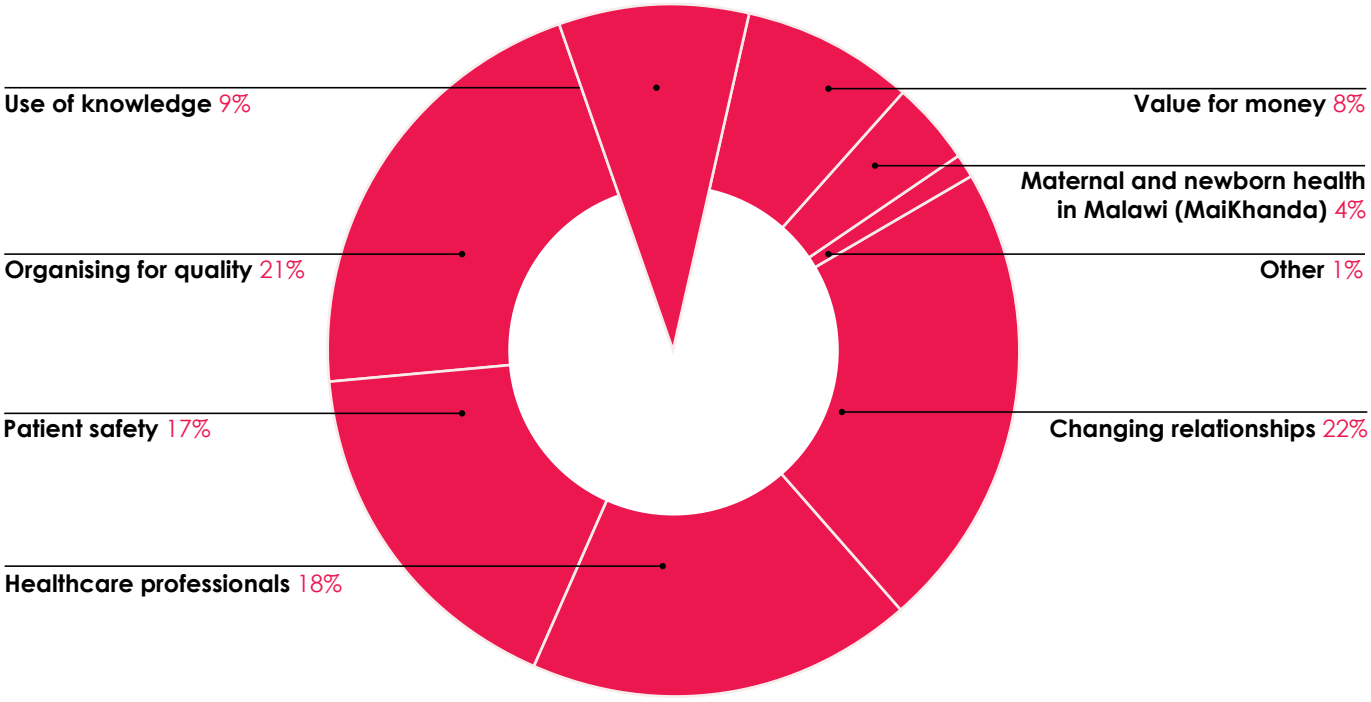
2011 Financial summary

Our endowment

The Health Foundation is funded by a significant endowment, established as a result of the sale of the PPP Healthcare group of companies to Guardian Royal Exchange (GRE) Insurance in 1998.

Over the past three years (2009–2011), our endowment has enabled us to spend over £65 million to continuously improve the quality of healthcare in the UK.

The decrease in expenditure from 2010 to 2011 predominantly relates to the postponement of the Shared Purpose programme (approximately £4m) to 2012.



Area of work	2011* £000	2010 £000	2009 £000	TOTAL £000
Changing relationships	2,737	8,823	3,188	14,748
Healthcare professionals	1,985	2,697	7,541	12,223
Patient safety	3,902	3,855	3,841	11,598
Organising for quality	5,638	5,090	3,197	13,925
Use of knowledge	2,269	2,438	1,314	6,021
Value for money	888	2,002	2,074	4,964
Maternal and newborn health in Malawi (MaiKhanda)	994	246	1,398	2,638
Other	212	172	140	524
	18,625	**25,323**	**22,692**	**66,640**

* 2011 figures are from management information. The costs of each strategic priority for prior years have been adjusted from those shown in the Financial Statements, to aid comparison with the current year's priorities. The overall costs for each year are the same.

Our plans for 2012

Against the current backdrop of economic constraint and major organisational change, the UK health service will continue to face major challenges in 2012. The Health Foundation will work to help people and organisations improve healthcare quality while cutting costs. We will support networks and organisation-wide transformational change alongside individual quality improvement projects.

In the coming year, to make sure that what we do has the greatest possible impact, we will be consolidating our work to focus on a smaller number of high-impact activities, while communicating our learning more vigorously. Our three main priority areas for 2012 are: shared decision making and supported self-management; patient safety; and engaging with senior leaders to understand the challenges of service reconfiguration.

At the same time, we will be putting stronger emphasis on achieving value for money in everything we do, to make sure that our work continues to reflect the challenges facing those working on the frontline of healthcare delivery.

Shared decision making and supported self-management

We will be capitalising on the considerable momentum built in 2011 to promote understanding and debate around shared decision making and supported self-management. With this in mind, we will investigate the changing clinician–patient relationship and the challenges this presents for doctors and will use our findings to drive a wide debate. We will also place a stronger emphasis on our work to improve education and training, which we believe is critical to the future of healthcare.

Meanwhile, we will continue to make the case for shared decision making and supported self-management, drawing on ongoing learning from our improvement programmes and research evidence. In order to help a wider range of people to understand and implement these approaches, we will be developing and promoting web-based resources, encouraging our fellows to act as champions and increasing our use of events and the media.

Patient safety

We will give a major boost to our longstanding promotion of patient safety. Our groundbreaking work shows that improvements are achievable. But patient safety is at risk of slipping down the agenda – particularly in the light of ongoing health service restructuring in England.

We will assess the external policy context and develop a high-profile influencing programme to keep patient safety in the spotlight. We will spearhead action on this issue through a range of activities, including a major demonstration programme, a new ambitious online and offline resource for safety-minded practitioners, a campaign aimed at junior doctors and commissioned research. We will also work to influence the new architecture to support patient safety at the NHS Commissioning Board.

Engaging with leaders

Given the increasing emphasis on service reconfiguration in local health economies, we will be actively engaging with senior leaders to understand the organisational and system challenges they are facing. This work will lay the foundation for a flagship improvement programme working with the whole health economy, which we plan to launch in 2013.

Other work

In addition to these three key areas of focus, we will continue and build on the following strands of work. We will:

- continue to take the lead in promoting the academic disciplines of improvement science, working closely with *BMJ Quality & Safety* and appointing further Improvement Science Fellows and a first cohort of PhD students
- increase our work to build the will and momentum for improving quality, reaching a wider number and range of frontline staff to help us better understand their needs and to provide a source of ideas and innovation
- invest in networks, including launching our new patient safety network and engaging with a number of existing and emerging networks through our network support programme
- build stronger relationships with the people we support, and will develop a community of improvement leaders through our leadership and improvement programmes
- embed the successes of our six-year investment in Malawi by implementing a final three-year exit strategy.

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