The Health Foundation
Inspiring Improvement

Our Impact

2003 –2009

Identify Innovate Demonstrate Encourage

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Foreword

This report is intended to offer an honest and comprehensive appraisal of our work over the last seven years.

Independent foundations are in a unique position to lead social change but they must think strategically about how they can create the most value for society with the resources they have. Impact-driven foundations are concerned with policy development, strategic communications, partnerships, evaluation and research, as well as the awarding of grants.

In 2007, we committed ourselves to a rigorous assessment of the impact of our work, defining impact assessment as:

'a methodology to assess changes resulting from the presence, investments and activities of the Health Foundation on key decision makers, service providers and patients.'

We wanted to understand fully the extent to which the Health Foundation has succeeded in creating change in healthcare systems by contributing to new practices, influencing healthcare policy, building partnerships and advancing the science of improvement.

We did this so that others and we can learn from our experiences. Impact assessment is therefore an important part of the Health Foundation's long-term strategic planning and development process. At the same time, there is an expectation that charitable organisations should be transparent and accountable, and The Charities Act (2006) places a strong emphasis on all charities satisfying the public benefit test.

In undertaking this assessment we drew on a large programme of independent evaluation of our major initiatives, as well as award holder reports, information from technical providers and the tacit knowledge and experience of our colleagues and award holders. Assessment of organisational impact is an emerging field and we hope that this report makes a useful contribution to it.

Dr Dale Webb
Director of Evaluation & Strategy

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
- demonstrating 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.

About this report

THE INTRODUCTION

presents the history of the organisation, the fundamental principles of our approach, and an overview of the programmes we have run in the past seven years.

CHAPTER 2

sets out the rationale for assessing our impact, and explains our methods for impact assessment and the challenges we faced.

CHAPTERS 3–7

comprise the main findings of the impact assessment. Each of these chapters measures impact against a different strategic aim (for a list of the strategic priorities, see p 9-11). These chapters follow a standard format, describing the main work activities within the strategic area and then presenting their impact under the four headings set out in the measurement framework (see p 98-99):

- building the will for quality
- identifying and testing interventions to improve care
- developing skills to ensure reliable delivery of care
- ensuring sustainability and spread.

CHAPTER 8

presents findings of the impact of our influencing work. As this is a cross-cutting theme it does not relate to any one strategic aim, and so follows a separate format.

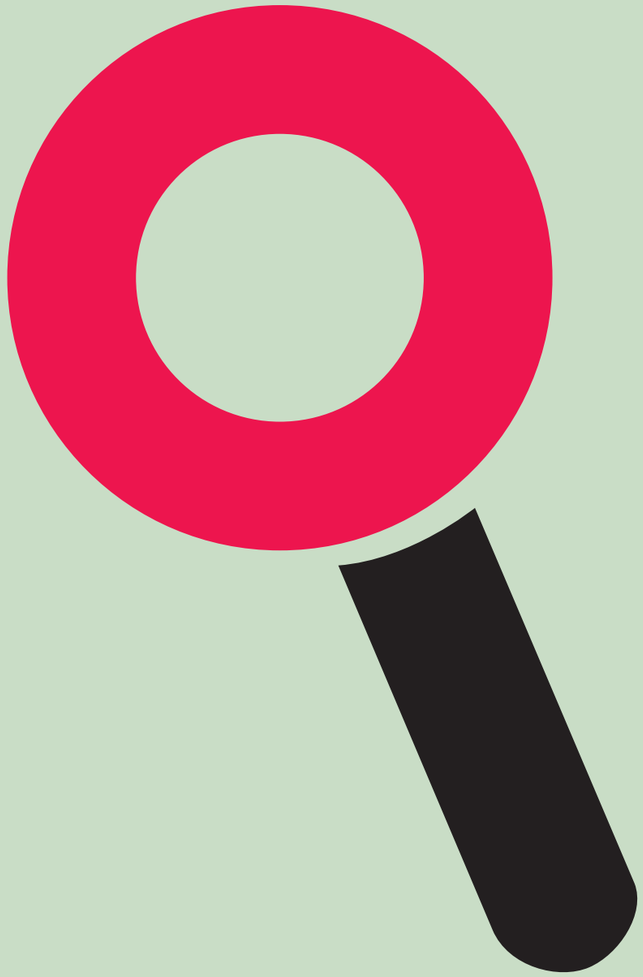
CHAPTER 9

sets out the conclusions to the report.

FINALLY,

the measurement framework is presented in the Appendix, on p 98-99.

Executive Summary



Introduction

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK. Over the past seven years, we have carried out a wide range of work with individuals, teams, organisations and wider systems, to make lasting improvements to health services.

This summary sets out the impact of our work from 2003 to 2009 – the period since we were established as the Health Foundation.

THE CHALLENGE OF ASSESSING OUR WORK

Assessing our work over a seven-year period was a challenge. During that time our organisation, aims and work programmes have evolved and refined in response to what we have learned. There have also been changes in the wider environment of healthcare policy and practice.

At the same time, our mission is ambitious. We work at many levels and in different systems. We seek to make improvements in local care as well as having an impact on national policy. Our approach involves testing new ways of working to improve quality to offer workable models, including developing rigorous evidence, embedding our methods, and engaging senior decision-makers.

All this means it is sometimes difficult to pinpoint and attribute the impact of some of our work. However, we want to be honest and acknowledge where things have not worked as well as highlighting our successes. We believe that only by reviewing our impact can we learn from experience and make sure our work delivers as well as it can to support our aims.

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Our impact

This main section of the summary sets out our impact on:

- influencing policy and practice
- our five strategic priorities, detailing each in turn
- improving maternal and neonatal health in Malawi, through our MaiKhanda project.

OUR IMPACT ON INFLUENCING POLICY AND PRACTICE 2003–2009

Our overarching aim is to improve the quality of healthcare. To do this, we draw on our learning to influence the views and decisions of those who shape health policy at national, regional and local level. We work with national policy makers, professional bodies and patient organisations.

- Our approach to improving patient safety has been adopted in all four UK countries, and many organisations have used the model we developed.
- Our work on safety is influential at national level, and was cited by the Health Select Committee in 2009.
- We have attracted a strong reputation for high-quality research.
- We influenced the report of *Next Stage Review*, led by Lord Darzi, through being single minded about ensuring that quality was on the agenda.
- The responses by four strategic health authorities to the *Next Stage Review* said that our work had helped guide their own plans.
- We have influenced regulators and arms-length bodies to strengthen their commitments to improve the quality of care.
- Our work has led several royal colleges to develop strategies for quality improvement, and to support training to ensure that professionals embed these approaches in their daily practice.

Our overarching aim is to improve the quality of healthcare.

Our strategic priorities

(It is important to note that because the programmes supporting some strategic priorities are more mature than others, the scale of the impact varies.)

Strategic priority 1:

Improving the quality of care by transforming the dynamic between people who use services and those who provide them

Our programme Co-creating Health forms part of our work to develop long-term, fundamental changes in relationships between people and health services. It has run since 2007, and will continue until 2012.

- Pilot sites are now using their own resources to run further courses within their organisations.
- Additional NHS organisations are trialling the approach, so the programme is being spread across the wider healthcare system.
- The programme has yet to finish or to impact significantly on interactions between healthcare providers and service users.
- There is some early evidence that outcomes such as patient activation, quality of life and self-management ability have improved.

Strategic priority 2:

Engaging with clinical communities to improve healthcare quality and value

We have run programmes to engage clinical communities in quality improvement since 2004. An independent evaluation described clinical engagement as one of the most 'visible and measurable achievements' of the programme.

- A great many clinicians have been mobilised to take part in quality improvement, and Engaging with Quality project teams have published more than 40 articles in peer-reviewed journals.
- Our programmes have directly influenced the quality strategies of several royal colleges. For instance, the Royal College of Physicians accepted our suggestion that it should put a quality strategy in place.
- Our work has also influenced *Tomorrow's Doctors* – the General Medical Council guidance that influences what will be taught to medical students for the next five-to-ten years.
- Five of our Engaging with Quality Initiative projects have led to policy changes far beyond their original award-holding sites. For instance, Assessing and Improving the Quality of Services for Patients with Inflammatory Bowel Disease (IBD) was a catalyst for the development of the National Service Standards for IBD in 2009.

Our impact through these programmes on patient outcomes were described by participating hospitals as 'small, patchy, but real', reflecting the complexity of drawing conclusions about the impact of interventions on clinical outcomes. However, some projects have had notable impacts on patient outcomes. For example:

- the Prescribing Observatory for Mental Health achieved statistically significant results
- data from two rounds of the Bowel Cancer Project showed small improvements in four of the five proxy measures used.

Strategic priority 3:
Transforming organisations to deliver safer patient care

This workstream began in 2004, when the Safer Patients Initiative was launched. This programme filled a gap. It raised awareness of harm arising from routine aspects of care, and created new standards of care and a belief that improvement was possible.

- The experiences of the hospitals reveal that the Safer Patients Initiative had real traction. It provided, for the first time in the UK, a practical approach to routine measurement of patient safety and real-time data.
- One of the programme's key impacts was that it established and embedded new data systems to measure patient safety. However, this impact was not consistent across all components of the intervention.
- The hospitals observed improvements in outcomes related to patient safety. The number of sites that achieved positive outcome measures ranged from the four sites that succeeded in reducing unadjusted mortality and adverse event rates to the 18 that reduced the MRSA rate in critical care.
- In 2004, the fledgling Safer Patients Initiative filled a void, offering an approach that for the first time in the UK provided routine measurement of patient safety and real-time data on performance. While participating hospitals identified successes in the specific wards and units targeted by the programme, the work largely remained project-based rather than becoming embedded in mainstream structures.
- As a result, we are now promoting the spread of the Safer Patients Initiative work, through our Safer Patient Network.

Strategic priority 4:
Developing leaders to improve health and healthcare

Our leadership programme began in 2002. Since then it has built a positive profile and caught the attention of policy-makers. We have had considerable success in influencing relationships. For instance:

- we sit on the Royal College of Physicians Future Doctors Working Group
- we were invited to be the keynote speaker on leadership in nursing at the 2009 Nursing Times Nursing Summit
- in partnership with the London Deanery, BAMMbino and the National Leadership Council we designed, facilitated and sponsored the first national Medical Leadership Fellowship Event.

We have moved from a focus on developing individuals to exploring the relationship between leadership and quality. For instance, Leaders for Change carried out improvement projects that had the following impact on patient experiences:

- the introduction of a one-stop, same-day service for one-day and short-stay surgical patients led to a faster service for patients and cost savings
- changes to a local diabetes service to make it more accessible to young adults led to a 50% reduction in the 'did not attend' rate
- introduction of a rapid assessment service to an acute orthopaedic service helped reduced waiting times from 16 weeks to six.

Strategic priority 5:
Building and promoting knowledge on how to improve care

To support our programming approach, we have invested in evaluation and research. Our aim is to generate robust evidence, and to use that evidence to inform policy and practice and contribute to wider debates and knowledge.

- Between 2003 and 2009, our award holders published more than 400 articles in nearly 200 journals.
- Some of our evaluation and research has already had a direct impact at policy level.
- Our research and evaluation programmes have contributed to the development of ideas and methods about quality improvement and how to assess it.
- We have built strong relationships with leading scholars and practitioners nationally and internationally.

Our research and evaluation programmes have contributed to the development of ideas and methods about quality improvement and how to assess it.

Improving maternal and neonatal health in Malawi

MaiKhanda, our programme in Malawi, aims to reduce maternal and neonatal deaths. Since its inception in 2006 it has achieved much, although we still have some way to go before reaching its ambitious goals:

- MaiKhanda has started to embed new skills to ensure reliable delivery of care.
- A team of Malawian staff has been developed to provide training, and local health centres are now using data more effectively.
- MaiKhanda has provided skills training to 1,800 community-based key informants, who collect data for a population-based mortality surveillance system.
- Interim data suggest some lowering of the case fatality rate for mothers in participating hospitals, although not for neonates. So far there has been no discernible effect on maternal and neonatal mortality.

MaiKhanda has started to embed new skills to ensure reliable delivery of care.

Conclusions

We at the Health Foundation are proud of what we have achieved. We are gaining a growing reputation among clinical, managerial, policy and academic communities as an independent organisation that inspires improvement. We have played a key role in the drive to put quality on the management agenda of the NHS, and to make a stronger connection between policy and practice.

Our approach focuses on encouraging an optimistic and positive attitude to change. At the same time, we do not shy away from highlighting problems with current practice – because only then can we press for change.

Our programmes of work have ambitious aims. In some instances, those aims have not been realised, but in others they have been met and even surpassed.

Difficult times lie ahead for the NHS, and it will become more important than ever to help the NHS maintain a focus on quality of care while reducing costs. In highlighting the challenges facing the health service, we want to make sure we are ideally placed to harness new ideas, so that we can provide positive solutions.

We will continue to support new developments and to evaluate our work and its impact so that we learn from our experience and can use our learning and successes to help the health service move forward to a higher quality and cost effective future.

Difficult times lie ahead for the NHS, and it will become more important than ever to help the NHS maintain a focus on quality of care while reducing costs.

Glossary of programmes

Building Relationships with Professional Communities awards – a programme of small awards for selected royal colleges to help them develop their expertise in the science of improvement.

Clinician Scientist Fellowships – a leadership programme that supports medical professionals to pursue academic research seeking to improve patient care.

Closing the Gap through Clinical Communities – a programme to improve the quality of care delivered to patients, by bridging the gap between known best practice and the routine delivery of care. In 2010/11 the programme is focusing on supporting clinicians with a track record as influential leaders in their clinical networks to lead on a range of quality improvement projects.

Closing the Gap: Changing Relationships – a programme to improve the quality of care delivered to patients, by bridging the gap between known best practice and the routine delivery of care. In 2011/12 the programme focuses on changing relationships between people and health services.

Co-creating Health – an improvement programme working to implement self-management support for people with long-term conditions.

Engaging with Quality Initiative – an improvement programme designed to improve quality to best-practice standards, based on the principles of quality measurement, clinician leadership and patient reported experience and outcomes.

Engaging with Quality in Primary Care – an improvement programme following the same principles as the Engaging with Quality Initiative (see above), but focusing on primary care.

Flow, Safety, Cost – an innovative three-year improvement programme designed to understand the relationship between patient flow, cost and safety.

Harkness Fellows – a leadership programme that offers experienced practitioners a chance to work in the US to study health policy.

Improving Patient Safety in Mental Health – a programme aiming to improve the reliability of care in order to reduce harm and raise safety awareness throughout organisations (began in May 2009).

Improving Quality and Safety in Primary Care – an improvement programme working with GP practices to develop their skills and put in place processes for flagging up risk and preventing harm.

International Quality Improvement Exchange – a network providing an informal opportunity for high-level leaders from eight European countries to discuss with peers how to improve the quality of healthcare.

IRIS - this project, part of Engaging with Quality Primary Care, aims to tackle the 'mismatch' between the large public health problem presented by domestic violence and the poor response from the NHS in general, and from primary care in particular.

Leaders for Change – our leadership programme that equips health professionals working in service improvement with the skills and knowledge to lead change.

Leadership Fellows – a leadership programme that developed individuals with the potential to become the future leaders of high-quality healthcare.

Leading Practice Through Research – a leadership programme that enabled mid-career professionals to undertake research to improve the quality of patient care or the health of the population.

MaiKhanda – an improvement programme working to improve the quality of healthcare for babies and mothers in Malawi.

MAGIC – a programme designed to test improved shared decision making between clinicians and patients, also known as Shared Decision Making (see below).

National Audit of Bowel Cancer Care part of Engaging with Quality programme) – an improvement project to identify what produces better outcomes in the management of colorectal cancer and then produce guidelines for improvements.

Quest for Quality and Improved Performance (QQUIP) – a research programme that provided a source of independent commentary and data about the quality and performance of healthcare provision.

Quality Improvement Fellows – a leadership programme that develops the improvement skills of clinically-qualified senior healthcare professionals.

PEARLS – this project aimed to improve clinical care by implementing best practice in the management of perineal trauma.

POMH – the Prescribing Observatory for Mental Health (POMH-UK) was set up in March 2005 to monitor and improve pharmacotherapy in specialist mental health services. Part of the Engaging with Quality Initiative.

Safer Clinical Systems – an innovative programme aiming to increase reliability in systems of care, in order to reduce failures in systems that harm patients.

Safer Patients Initiative – an improvement programme to find practical ways of improving hospital safety and to demonstrate what can be achieved through an organisation-wide approach to patient safety.

Safer Patients Network – a network of healthcare organisations working to find ways of building improvement skills and making healthcare safer for patients.

Shared Decision Making – an improvement programme explores how shared decision making can be embedded into clinical practice as a core part of mainstream health services (also known as MAGIC, see above).

Shared Leadership For Change – a leadership programme that offers leadership for multidisciplinary teams working across organisational boundaries to provide high-quality care.

Shared Leadership to improve healthcare for BME groups – a leadership programme that helped multi-organisational teams to improve the quality of health services for BME groups.

Strengthening impact programme – a programme that extends support for projects that have the potential to achieve measurable and sustainable improvements in the quality of healthcare.

01 Introduction

This report explores the impact of the Health Foundation's work from 2003 to 2009. It looks at how our work has resulted in changes for key decision makers, service providers and patients. It draws on a wide range of sources, including the findings of independent evaluation, research, data and learning generated by the organisations and individuals we have worked with, and the views of internal and external stakeholders.

Between 2003 and 2009, we spent around £25m each year on activities framed around five strategic priorities.

Strategic priorities 2003–09*

- Transforming the dynamic between those who use services and those who provide them
- Engaging with clinical communities to improve healthcare quality and value
- Transforming organisational approaches to patient safety
- Developing leaders to improve health and healthcare services
- Building and promoting knowledge on how to improve care

This paper sets out to show how far we achieved those aims, through a wide range of innovative programmes.

*As part of our 2010 Strategic review these priorities have been updated. See our website for more details www.health.org.uk

About the Health Foundation

The Health Foundation is a young organisation working in a relatively new field.

It was originally established in 1998, as the PPP Healthcare Medical Trust. At that time our activities were predominantly focused on clinical research, but the organisation recognised a need to support leaders and others who could make a real difference to the quality of patient care.

In 2003, we identified a primary aim of improving health and the quality of healthcare in the UK, and we rebranded ourselves as the Health Foundation.

OUR HISTORY

Today our focus is on inspiring improvement. We are here to inspire new approaches 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
- demonstrating 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.

AN EVOLVING ORGANISATION

Since its inception, the Health Foundation has undergone continuous, incremental yet profound change in order to develop and implement its mission.

Over the past seven years our understanding of improvement has developed considerably, and this in turn has informed our view of how best to contribute to the field. As a result, our mission and strategy has grown, the range of programmes we support has become more coherent and comprehensive, and our staff capability and capacity has matured. In short, we have undertaken a significant journey – and one that continues.

Our understanding of improvement has developed considerably, and this in turn has informed our view of how best to contribute to the field.

When it comes to assessing corporate impact, this evolution of strategy and focus raise a number of challenges – not least, the task of determining the basis for judging effectiveness and impact. Even within individual programmes of work, the aims may shift from one phase or cohort to the next. This means there is no steady state, and there are few fixed targets against which to make assessments. What is more, the nature of the work often involves complex interventions that in themselves are challenging to evaluate – not least, because the best approaches to evaluation are still hotly debated in the literature.

The Health Foundation continues to evolve as an organisation. Our approach and strategic priorities set out on page 16 were revised in 2010 as part of our rebranding and strategic review (for more information, go to www.health.org.uk). However, because this document seeks to show how programmes have fared in terms of the strategic priorities at the time, it is constructed around those original aims.

We now go on to look at how we work and how this approach is put into action, through the four critical functions of our work.

How we work

This section explains the theory of change that underpins all our activities, before setting out our approach, our impact framework and our major programmes of work.

OUR THEORY OF CHANGE

The Foundation's theory of change sets out the reasoning behind our contribution to healthcare. It pinpoints the nature of the problem we are trying to address, identifies potential solutions, and describes the focus of our activities.

What are the challenges to high quality healthcare?

The UK healthcare system is large, increasingly complex, dynamic and costly. These characteristics create significant barriers to ensuring that high quality care is consistently achieved everywhere. The Institute of Medicine sets out six domains of quality, arguing that healthcare should be: safe, timely, effective, patient-centred, efficient and equitable[1]. In the UK, deficiencies have been identified within each of these domains.

The factors that underlie these deficiencies include:

- the belief that the most important investment for improving quality is to develop new cures
- the frequent failure to translate quickly research findings into practice, or to implement tried-and-tested interventions
- clinical autonomy, which can result in tolerance of behaviours that add to waste, inefficiencies and a lack of accountability to managers and peers
- the many operational deficits, which mean that staff constantly have to recover from latent errors within the system
- the fact that clinicians only see a snapshot of the patient's care, even though the quality of care is determined by many different process steps provided by many different people
- the external environment, including methods of financing, performance assessment, regulation and organisational structures, which can have unintended consequences on the quality of care
- weak workforce design and planning, including the development of team working.

Potential solutions

There are many potential solutions for a healthcare system. We place particular emphasis on those that we believe have the greatest potential to make lasting and widespread change, they are described below.

- **A sustained focus on continuous improvement in the quality of health services**
  In addition to the more commonly identified solutions (identifying new cures, demonstrating the clinical effectiveness of new interventions and addressing the underlying determinants of health), better health outcomes can be achieved by improving the quality of care. However, until relatively recently this area has been neglected, and health systems need to focus on closing the gap between best and current practice. To achieve this, leaders need to know about leadership for improvement and be competent in this field.
- **Emphasising the importance of internal (intrinsic) motivators, alongside external (extrinsic) ones**
  The drive to improve quality is often focused on forcing external drivers to change (for example, through regulation, economic incentives and performance management). In fact, internal drivers of behavioural change (such as professionalism, skills development, organisational development and leadership) can be stronger motivators. Both are needed, but there needs to be an emphasis on finding ways to support and channel the motivations of professionals for greater health gain. Good leadership is critical to achieving the right blend of drivers – and, in particular, appealing to the internal motivators of staff and peers.

- **Acting at each level of the healthcare system and ensure all levels are aligned for quality**
  To achieve high-quality care for every patient every time, there is a need to work across the whole healthcare system and make sure the different parts of the system relate to each other in support of quality – for example, in:
  - one-to-one interactions between a patient and a clinician
  - the clinical micro system
  - delivery systems
  - interventions designed to achieve change at the national level.
- **Redefining the nature of the relationship between patients and those who provide care**
  One critical determinant of quality of care is the interaction between patients and their clinical team. To achieve the best outcomes, patients need to be equipped to play an active role in their care, and for their care to be personalised. This demands a different approach to how clinicians and the wider healthcare system engage with patients and local communities.

The way we work

The way we work is based on Porter and Kramer's proposition that foundations should use all of their resources to achieve the greatest impact (Porter and Kramer)[2].

This idea has driven the organisation ever since which consists of four critical functions – research and development, improvement programmes, evaluation and strategy, and communication and public affairs.

- Research and development ensures that new areas of work are underpinned by the knowledge base of what works when it comes to improving quality, and generates evidence for use by healthcare decision makers.
- Award programmes test ideas to improve care – first as localised innovations, then at scale, and finally in moving towards system-wide sustainability and spread. Our leadership programmes aim to develop the capacity for leadership for improvement. Our networking approach recognises that in order to achieve this shift we need to provide an environment that nurtures those who lead improvement work, and allows them time and space to learn together.
- Evaluation and strategy generates convincing evidence from our major activities about improvements in care and contributes to ongoing learning from individual programmes and to the science of improvement. We use this to assess organisational impact and feed into our strategic planning.
- Communications and public affairs establishes our unique contribution and profile, and uses the learning generated through our programmes to influence policy and practice, reaching the diverse range of audiences in health services.

Having looked at our theory of change, the impact and the way the organisation works, we now consider how these translate into our work on the ground, through our major programmes of work.

Our major programmes of work

In the early years of the Health Foundation, translating our programming concepts and theory of change into practice was a major challenge. It required much greater internal capability and technical skills than the organisation's activities had done up until 2003 – for example, programme design skills, evaluation expertise, and the ability to broker knowledge from a diverse range of experts, practitioners, policy makers and clinicians. The timeline of key pieces of work is set out on the following page.

PROGRAMME TIMELINE

2003 With the support of key external experts and organisations, we embark on the development of our first major demonstration project: the Safer Patients Initiative. The programme is designed to test ways of improving safety on an organisation-wide basis, as well as to provide the Foundation with the opportunity to model new ways of working. A second wave is launched in 2006. Today 15 of the 24 participating trusts continue to work with us, through our Safer Patients Network.

We also launch a suite of leadership programmes to equip healthcare leaders with personal development opportunities and the know-how to lead and support improvement work. The Clinician Scientist Fellowship programme, which pre-dates our focus on improving the quality of healthcare, funds individual clinicians to undertake academic research of direct patient benefit, and supports fellows to develop as leaders in their field.

2005 We launch the first of our Engaging with Quality programmes (designed to tap into the enthusiasm of clinical leaders operating in professional bodies and in multi-professional networks) and a major research programme – the Quest for Quality and Improved Performance – aiming to provide independent commentary on the quality and performance of healthcare in the UK.

2006 We start an ambitious programme of work in Malawi, to reduce maternal and neonatal deaths in three districts. The programme, entitled MaiKhanda, works with 11 hospitals, 32 health centres and 800 community-based women's groups. Mortality is measured using a population-based surveillance system involving 1,800 community informants.

2007 We launch Co-creating Health – a programme that aims to transform care for people with long-term conditions, working with eight organisations that are seeking to embed self-management in mainstream services, supporting patients to play an active role in their health.

2008 We embark on the pilot phase of our Safer Clinical Systems programme. Five sites work to identify and test a range of interventions to improve patient safety from a systems perspective, building an evidence base to support their work.

Meanwhile, we broaden out our safety work, working with four strategic health authorities to support the development of their patient safety infrastructure. We establish innovative communities to test out the approaches used in the Safer Patients Initiative in new clinical services and settings.

2009 We launch Closing the Gap (an annual programme that focuses on bridging the gap between known best practice and the routine delivery of care) and Shine (a small-scale programme to test innovative interventions that deliver high-quality care). We also develop a new research and development strategy to strengthen the evidence base on how to improve care and to promote the use of best practice by decision makers at all levels of the healthcare system.

For the first time in our history we now have award programmes at all stages of their lifecycle, from early conceptualisation through to design, development, full implementation and evaluation. Critically, we have also begun to address the issue of how best to achieve sustainability and the spread of our work. Going forward, a much greater concentration of our work will be on developing ways to sustain and spread our work and promote its uptake.

02
Assessing our impact

In 2007, we committed ourselves to a rigorous assessment of the impact of our work. We defined impact assessment as: 'a methodology to assess changes resulting from the presence, investments and activities of the Health Foundation on key decision makers, service providers and patients'[3].

We wanted to carry out an analysis of the consequences – intended and unintended – of our activities so that we, and others, could learn from our experiences. We also wanted to make sure we understood fully the extent to which we had succeeded in effecting change in healthcare systems by contributing to new practices, influencing public policy, building partnerships and advancing research and evaluation.

As a charitable foundation, we are required to report publicly on our activities and performance. The Charities Act (2006) set out that all charities must satisfy the Public Benefit Test, which means they must prove that their purpose is beneficial to the community. Meanwhile, the introduction of accounting standards (SORP) and the Standard Information Return (which the largest charities have to complete in addition to the standard return to the Charity Commission) go further to ensure that charities are transparent and accountable.

Independent charitable foundations are in a unique position to lead social change, but they must think strategically about how they can create the most value for society with the resources they have. Impact assessment is therefore an important part of the Health Foundation's long-term strategic planning process.

FIGURE 1:
The Health Foundation's strategic planning process

Our approach to impact assessment

This impact assessment was based on our theory of change (see p 20) and our measurement framework (see p 98). This framework incorporates the following:

- building the will for quality
- identifying and testing interventions to improve care
- developing skills to ensure reliable delivery of care
- sustaining and spreading our work.

These categories are broken down into specific measures.

The framework was developed through consultation with Health Foundation staff and partners, and was intended to be sufficiently broad to work across all our programmes. We used it to underpin our data extraction and synthesis, and to inform the analysis presented in chapters 3–7.

Our approach to data collection was very broad, drawing on a large programme of:

- independent evaluation of our major programmes
- programme and project reports
- information from technical providers
- knowledge and experiences from the Health Foundation and our programmes and project individuals and teams.

We extracted data from all relevant sources, using the measurement framework, and wrote interim reports on the work that had taken place within each of our strategic aims. We reviewed these reports during 2008 and 2009, to ensure accuracy, comprehensiveness and balance, and updated them in preparing this final report.

We were clear that our impact assessment needed to be scientifically as rigorous as possible. However, impact assessment is still evolving, and organisations are generally 'in the foothills' when it comes to work of this sort. This led to a number of challenges as well as opportunities.

Challenges in assessing our work

There is extensive literature on the challenge of evaluating complex programmes, and attributing impact to a programme is seldom straightforward. Our interventions tend to be complex. For example, within a single programme the organisational arrangements for individual projects may vary in terms of size, region, political complexity and current performance. Also, the programmes themselves are diverse, each one encouraging different innovations and solutions to different healthcare problems. These different solutions are then often tested in different types of community. As a result, the business of drawing on this wide range of approaches to identify learning points that can inform healthcare policy and practice is a complex task.

Despite the well-documented challenges of assessing complex programmes, we wanted to trace a causal pathway as far as was reasonable, acknowledging that the type and standard of evidence was likely to vary. We understood that the further we looked from the specific locus of a programme the harder it would be to establish a firm causal connection, and the more we would need to rely on anecdotal sources of evidence.

For this reason we have referred to these sources as 'causal contributions' rather than the more usual term 'causal attribution'. This acknowledges that a given outcome is not necessarily directly due to a specific factor in question, because it not always possible to disentangle the numerous policy, environmental, cultural and organisational factors that may have some influence on the areas in which we work.

From the outset we were aware that some impacts would be difficult to measure or inappropriate to report – particularly those that relied on our relationships with senior decision makers – and that our impact will only truly be known in the longer term. Indeed, very few of our programmes had even completed by the time of the assessment.

A final complexity was the significant evolution of the Health Foundation's organisational mission and strategic focus during this period, which meant that we were measuring the impact of a moving target.

Despite all these challenges, everyone involved was clear about the importance of attempting, to the best of our ability, to carry out a rigorous exercise to glean lessons learned and points of good practice that could be used to develop our work further and to be shared with others working in the important field of healthcare improvement.

The basis for the measurement framework

Our measurement framework aligns with the following specific activities, which we believe enable the solutions described on page 21. The measurement framework can be found in the Appendix (page 98).

Building will and focusing attention:

- aligning agendas and winning the hearts and minds of people (with a variety of interests) through good communications
- exposing the frequency, severity and personal impact of poor care at local and national levels, and showcasing the best performance to make it clear that poor care is avoidable and demoralising
- assessing the impact of factors that shape environmental performance and advocating for barriers to be removed
- making clear the evidence base for what works and what is uncertain, both for clinical and continuous quality improvement interventions, and finding effective actions that can be taken or promoted by those wanting to make change.

Developing skills to identify what works and ensure reliable delivery:

- building levels of quality improvement skills, nationally, regionally and locally
- reinforcing positive behaviours rather than using blame, to enable greater interaction on quality issues, and focusing on improvement in the best, and the majority, rather than solely on poor performers
- advocating for personal and collective responsibility as well as personal accountability.

Identifying and testing interventions to improve the quality of care:

- designing interventions that take into account the heterogeneity in service organisations in terms of their capacity, capability, leadership and culture
- using study variations to find best practice, best people and best organisations, and learning from system failures
- releasing capacity by removing barriers and ensuring best fit between roles and competencies, supported by the right equipment, and simplifying care processes and improving patient flow.

Taking actions that create new routines as a result of spread:

- supporting those delivering health services to reflect on and make changes in how their services are delivered along the care pathway, bearing in mind that patients see things that others do not
- recognising the organisational and human factors at play – for example, varying resources, the need for teamwork in a sector with unstable and unformed teams, and the need for processes to ensure patients' desires are taken into account
- exchanging knowledge across other sectors and countries, to seek out effective methods and practices.

03
Transforming relationships between people and health services

This chapter focuses on the first of our five strategic aims: 'improving the quality of care by transforming the dynamic between people who use services and those who provide them'.

Our aims were to:

- support healthcare systems to test and refine interventions that support patients to play an active role in managing their health and healthcare
- promote the development of skills in partnership working with patients as a core element of the education and training of healthcare professionals
- convince healthcare policy makers and practitioners to adopt proven strategies and interventions for supporting patients to make an active contribution to improve health and healthcare
- explore and evaluate approaches to involving patients in quality improvement activities and their relationship to improved health and healthcare outcomes.

Our work in this area

In the Health Foundation's 2005–09 Strategic Plan this aim was originally worded 'to support patients to make an active contribution to improving health and healthcare outcomes'. Despite being the youngest of the five areas of our work, the work in this aim has evolved significantly.

The programmes of work that are most likely to result in improvement are those that engage patients and clinicians alike.

Our starting position acknowledged that the programmes of work that are most likely to result in improvement are those that engage patients and clinicians alike. The team leading this work spent the early years building in-house knowledge by commissioning significant pieces of research and establishing relationships with organisations and experts within the field. We compiled comprehensive summaries of the evidence, original research comprising interviews with 3,000 British people living with long-term conditions, and a survey of our Healthcare Leaders' Panel, in order to assess how we could work to best effect in this area.

MAIKHANDA

MaiKhanda was a six-year programme launched in 2006, dedicated to improving the quality of healthcare for babies and mothers in three districts of Malawi. It involved forming an international consortium of leading experts to work alongside local healthcare professionals and the Malawi government. We are working in partnership with two organisations – the Institute of Healthcare Improvement and Women and Children First – to plan and carry out the work.

MaiKhanda has taken a two-pronged approach:

- supporting government efforts to improve care inside hospitals
- providing support directly to village communities, by empowering and educating local people to improve care for pregnant women and newborn babies.

The programme works with 11 hospitals, 32 health centres and 800 community-based women's groups. Mortality is measured using a population-based surveillance system that records all pregnancies, births and deaths covering 10% of the rural population of Kasungu, Lilongwe and Salima each month, using a system involving 1,800 village-based volunteers and 250 government health workers.

The success of this programme could make a substantial contribution to the region achieving one of the United Nations Millennium Development Goals: to reduce the under-five mortality rate by two-thirds between 1990 and 2015 across the globe[4].

CO-CREATING HEALTH

Co-creating Health is an improvement programme, launched in 2007, with the aim of embedding self-management support in to mainstream health services to improve the quality of life of patients with long-term conditions. It will run until 2012. It is underpinned by the philosophy that patients are experts on themselves and on their social circumstances, attitudes to illness and risk, values and preferences – and that they therefore should be active partners in ways to improve the quality of health services.

The eight sites working on Co-creating Health are local health economies involving primary and secondary care. They are working across four long-term conditions to integrate three workstreams:

- an advanced development programme (ADP) for clinicians
- a self-management support programme (SMP) for people living with long-term conditions
- a service improvement programme focusing on system changes.

In phase one, each workstream was delivered by one of three technical partners (the Expert Patients Programme Community Interest Group, Finnamore and Client Focused Evaluation Programme). The evaluation, led by Professor Louise Wallace at Coventry University, will compare the effects of the programme against control sites, and is due to report in 2011.

The first phase of the programme ended in August 2010, but the programme was extended for two years in order to:

- increase the level of integration between the three components of the programme – for example, to increase the number of ADP-trained clinicians engaged in developing organisational policy to support self-management
- define meaningful outcomes in order to measure the impact of the three specific self-management tools
- increase the numbers of people with long-term conditions completing self-management support courses, providing long-term follow-up data.

CLOSING THE GAP: CHANGING RELATIONSHIPS

Closing the Gap is an annual programme dedicated to bridging the gap between best practice and routine delivery of care. It aims to support demonstrable improvements, build the knowledge and skills of the workforce, and create approaches to transform the quality of healthcare in the UK. Each year, the programme has a distinct focus.

Over 2011/12 Closing the Gap: Changing Relationships, aims to change the relationship between people and health services, with funding of up to £400,000 for each of the eight selected projects. The Health Foundation has selected teams to be part of Closing the Gap: Changing Relationships, which will be launched in April 2011.

MAGIC: SHARED DECISION MAKING

This programme explores how shared decision making can be embedded into clinical practice as a core part of mainstream health services. The programme is designing and testing interventions to encourage the use of shared decision making tools and techniques. It began in August 2010 and runs until January 2012.

It adopts the philosophy underpinning Co-creating Health: that patients are experts on themselves (see previous page). It focuses on how shared decision making can best be implemented within the clinician–patient encounter, and applies in any situation when there is more than one reasonable course of action. This applies to a broad range of patients – not only those with a long-term health condition.

We now present the impact of Co-creating Health, MaiKhanda and our wider influencing work in this area, set out under the four headings highlighted in the measurement framework (see p 98).

Our impact

BUILDING THE WILL FOR QUALITY

We have brought evidence about the importance of increasing the uptake of evidence-based patient engagement interventions to the attention of policy makers and other organisations.

We have good evidence that other organisations, such as Macmillan Cancer Support and the Scottish Long-term Conditions Collaborative, have drawn on our approach to self-management support through references to our work, using our definitions or adopting similar models and language to describe their aspirations to those of Co-creating Health. Meanwhile, organisations such as the British Thoracic Society and the British Lung Foundation have sought to draw on our knowledge and expertise. In 2007, Diabetes UK asked us to advise on the development of its Year of Care programme, and we later formed a partnership with the charity to support the programme.

We were also asked to contribute to a seminar led by the Department of Health to consider the policy implications of the evaluation of the Expert Patient Programme, and to an Oxford University Press book on self-management. In July 2006, the British Medical Association asked us to contribute to its published position statement on the Expert Patient Programme.

In addition, examples from our work in this area have been reflected in key Department of Health policy documents. We are not able to attribute this to our work in this area, but it is reasonable to conclude that our thinking has been with the policy tide, which has been flowing towards self-care and self-management support for people with long-term conditions since the publication of the White Paper[5]. Indeed, anecdotal evidence suggests that our research on care planning influenced the 2010 White Paper.

More recent examples include *The Next Stage Review*[6] (2008), *The Patients' Prospectus*[7] (2009) and *The NHS operating framework 2009–10*[8] for the NHS in England . In 2008, the Welsh Assembly Government requested our advice on its planned approach to review the range of support for self-care, to inform future policy development.

We have brought evidence about the importance of increasing the uptake of evidence-based patient engagement interventions to the attention of policy makers and other organisations.

Case study:

Engaging local communities and national policy

MaiKhanda is successfully building will by engaging local communities and the maternal and neonatal health policy community in Malawi. The commitment of local communities to engage was evident at a series of open days held in 2009. At one, 500 people from local communities attended, each of whom had prepared a song and dance or short play about maternal and neonatal health. The local member of parliament attended, as did Malawi's television station, the local health education unit and numerous non-governmental organisations.

MaiKhanda has forged major links with national policy – specifically, Malawi's national roadmap for maternal and neonatal health. The deputy director of the Ministry of Health has been committed to the programme since its inception, and is a member of the twice-yearly Partners Council. The district health officers, who report directly to the minister, attend learning sessions, and one has provided coaching visits to the health centres. In addition, the Ministry of Health's Health Management Information Systems staff have engaged in the collaborative learning events.

Malawi's former vice president has commended MaiKhanda's work after listening to:

- women's groups members explaining their work
- men talking about their involvement
- key informants explaining how they collect data and the use to which data are put
- the chiefs talking about the leadership and support that they give.

She took community teams with her to help sensitise other communities up and down the country that she visited as the national Goodwill Ambassador for Safe Motherhood.

DEVELOPING SKILLS TO IMPROVE QUALITY

It is too early to determine the impact of Co-creating Health and MaiKhanda on the skills of health professionals involved in them, but we have some interim evidence.

Co-creating Health has started to impact on the clinical consultation. Before-and-after measurements relating to a small cohort of those attending the Advanced Development Programme training suggest improvements in practising self-management support in the areas of patient centredness, sharing power and responsibility with the patient, and ensuring that the patient is comfortable with a jointly agreed management plan. These findings are also reflected in interviews and testimonies collected from Advanced Development Programme graduates.

The following testimony is particularly powerful, as it comes from one of the sites focusing on people with depression, where the nature of the condition makes self-management challenging:

My new skills enable me to develop a collaborative partnership, which empowers the service user to manage better on a day-to-day basis with their long-term illness. The skill that stands out in my mind, which I applied with greatest success, is setting the agenda. This has been revolutionary, in that it helps to frame the sessions and from this most service users were able to follow problems they were facing in a logical way, without jumping from one subject to another.

Advanced Development Programme graduate

However, the interim evaluation also states that we have yet to see conclusive impact of the three specific self-management tools used in Co-creating Health on the clinical consultation. There is no measurable change in the extent to which clinicians customise treatment recommendations in response to the patient's preferences and beliefs.

Some clinicians are concerned that the course does not foster their long-term motivation towards applying self-management support. Finally, at this interim stage there is a lack of evidence that patients apply the self-management tools within their clinical consultations.

Meanwhile, MaiKhanda is starting to embed new skills to ensure reliable delivery of care. Work at the hospitals and local health centres aims to build skills in data collection and measurement, plan-do-study-act (PDSA) cycles and skills to use tools such as maternal death reviews. The programme has developed a team of Malawian staff to provide training to health facilities and run collaborative learning events.

There are some encouraging signs. For example, before the programme none of the hospitals involved used maternal death reviews. Now, all of them do, and they make recommendations to improve obstetric care based on the reviews. Interim evaluation results show raised awareness of healthcare quality and some attempts at innovation.

Also, local health centres are engaging with data – sometimes for the first time. For example, at an open day in Kasungu, the first issue on which the manager of Kapelula Health Centre briefed the vice president was the use of data (which is now displayed in the outpatient area where the women attend the antenatal clinic). However, the support for health centres has been less intense than in the hospitals, and over a shorter period of time.

Within the community, MaiKhanda has provided skills training to 1,800 community-based key informants, who collect data for the population-based mortality surveillance system. Meanwhile, women's group members have developed PDSA skills, and can analyse their progress in implementing change strategies using simple evaluation techniques.

IDENTIFYING AND TESTING INTERVENTIONS TO IMPROVE CARE

It is too early to be able meaningfully to determine the impact of Co-creating Health on patient activation, self-efficacy and quality of life. This will be reported through the final evaluation in 2011.

Interim findings from an early longitudinal analysis of patient activation (which assesses patient knowledge, skill, and confidence for self-management, and compares scores before and six months after attending the Self-management Programme) show a significant improvement in patient activation that was consistent across all the conditions. Comparison against control sites has yet to be made.

There is a similar trend in other areas of the evaluation, including improved self-management ability and quality of life. One patient who has completed the Self-management Programme explained:

At first, I thought, what was this project about? What am I getting myself into? I chose to participate in the seven-week self-management of depression course, which I found invaluable. My confidence increased when I learnt the simple steps of planning and setting goals to motivate myself into resuming certain skills and hobbies again.

However, crucially, the self-management course provided me with the opportunity to find the appropriate peer support within my community [and] understand and recognise my triggers, and it demonstrated how I could relax and own my own problems. The specific course content enabled me to pace myself and manage a better quality of life for myself, which was a powerful tool and resource in terms of my recovery.

Self-management Programme graduate

For MaiKhanda, the randomised-controlled trial evaluation will report in 2011 on the main outcomes. Already, the method used to monitor mortality at population level (which is a more accurate method of estimating mortality than the 'sisterhood' method commonly used to measure maternal mortality in the developing world) has demonstrated that baseline maternal mortality was much lower than previous figures from the Ministry of Health and UNICEF.

So far, MaiKhanda has had no discernible effect of maternal and neonatal mortality at population level. However, in the hospitals where the programme is working – and where mostly complex deliveries take place – interim data suggest some lowering of the case fatality rate for mothers, though not for newborn babies. It is important to note that there has been an increase in deliveries at health centres across intervention and control areas, probably reflecting a change in the law that bans the use of traditional birth attendants supporting delivery at home.

SUSTAINING AND SPREADING IMPROVEMENT EFFORTS

Co-creating Health sites are starting to mobilise their own resources to run further Advanced Development Programme courses for clinicians working within the same long-term condition, and two sites are already spreading the programme to other areas of their organisation. There are early signs that a small number of sites are planning to use elements of it, or modified versions, for people with other long-term conditions.

Clinicians who have undergone the training programme are reported to be practicing their self-management support skills with people with any long-term condition, and some sites are considering spreading the model to services for other long-term conditions. The clinical lead at Guy's and St Thomas' NHS Trust has incorporated clinician skills to support self-management within the NHS London workforce development plan for long-term conditions.

We are also seeing encouraging signs of NHS organisations trialling a modification of the Co-creating Health approach. For example, we know that one of the Co-creating Health sites is resourcing a pilot that takes a whole-team approach to implementing the programme model. NHS Islington – involved in one of the sites working with people with diabetes – is hoping to embed the Co-creating Health self-management principles and practice within primary care.

Following the involvement of one of its sites within Co-creating Health, NHS East of England is now running a pilot designed to test the implementation of seven core principles of self-care with primary healthcare teams across the strategic health authority. The focus of this work is how to make the best use of limited consultation time, and is part of a national project funded by Skills for Health.

MaiKhanda has achieved some successes in attracting additional resources. For example, a Dutch entrepreneur has designed a new form of bicycle ambulance, and has donated some of these to women's groups participating in the programme that have expressed a need for one as part of their change strategy. Communities that have received bicycles have established committees to ensure that they are properly used and maintained. One community told us that its ambulance bicycle had been used on seven occasions in the first 10 days, reducing the journey time to access care from seven hours (on foot) to one hour.

MaiKhanda has also established a partnership with Care Malawi, which is providing advice in vegetable garden production and giving seeds to women's groups that want to set up a vegetable garden as part of their nutritional strategy for pregnant women.

Following the involvement of one of its sites within co-creating Health, NHS East of England is now running a pilot designed to test the implementation of seven core principles of self-care with primary healthcare teams across the strategic health authority. The focus of this work is how to make the best use of limited consultation time, and is part of a national project funded by Skills for Health.

Conclusions

We have carried out some important work in this area – not least, by influencing the quality improvement agenda among policy makers and key players in the field. It is early days to evaluate our two key programmes work in this area – Co-creating Health and MaiKhanda, and we are awaiting final evaluations.

However, Co-creating Health is already impacting on the quality of clinician–patient encounters, and both programmes are showing indications of spreading and sustaining improvement work.

The key challenge has been assessing impact given the multifaceted nature of the programmes. Co-creating Health and MaiKhanda are arguably the most complex and ambitious of the Health Foundation's demonstration projects. Both may be thought of as 'combination therapy' programmes, combining multiple strands and integrating a number of central concepts. Both have seen a number of successes, but the conceptual and operational challenges have been considerable, and have needed to be worked through as part of the implementation process.

Put another way, although these programmes ostensibly operate in a 'testing model', the reality is that to date they have operated mostly in an 'innovation model'. This distinction is crucial when considering their impact. Because it took some time to resolve the conceptual challenges and fine-tune the delivery mechanisms of Co-creating Health and MaiKhanda, they have only been implemented as they were originally envisaged in the past year or so. Nevertheless, both are showing promise.

04
Engaging with clinical communities to improve healthcare quality and value

This chapter focuses on the second of our five strategic priorities: 'engaging with clinical communities to improve healthcare quality and value'.

Our aims were to:

- work with clinical communities across services to demonstrate measurable improvements in healthcare quality and value
- convince decision makers and clinical teams to create sustainable systems that measure and use clinical quality and patient outcomes to improve care
- work with national professional communities to promote activities that will accelerate measurable improvements in healthcare quality and value
- promote quality and safety improvement, including working with patients, as a significant part of professional education and development.

Our work in this area

Evidence published in 2003[9] shaped the rationale for our work in this area. It proposed that clinicians were attentive to the issues but were insufficiently engaged with efforts to improve healthcare quality, and that there were significant barriers to getting them involved with improvement programmes. Barriers included a lack of time and resource, poor clinician–management relationships, and unclear roles, which affected communication between different clinical staff.

We have invested £11m to increase clinician engagement in quality improvement activities. Since 2004 we have run two major programmes:

- **The Engaging with Quality Initiative** – a programme designed to improve quality to best-practice standards, based on the principles of quality measurement, clinician leadership and patient reported experience and outcomes
- **Engaging with Quality in Primary Care** – a programme following the same principles as the Engaging with Quality Initiative, but focusing on primary care.

Other programmes in this area included:

- **Closing the Gap through Clinical Communities** – a programme designed to improve the quality of care delivered to patients, by bridging the gap between known best practice and the routine delivery of care
- **Strengthening Impact programme** – a programme that supports projects by current or past award holders that have the potential to achieve measurable and sustainable improvements in the quality of healthcare
- **Building Relationships with Professional Communities** – a programme of small awards for selected royal colleges to help them develop their expertise in the science of improvement.

Each of these is described opposite.

THE ENGAGING WITH QUALITY INITIATIVE

The Engaging with Quality Initiative, established in 2004, funded eight projects led by royal colleges to improve the quality of care in a range of conditions and diseases in acute and mental healthcare, including inflammatory bowel disease, chronic obstructive pulmonary disease and prescribing for serious mental illness. The multidisciplinary teams were led by clinicians, with members of the core project team drawn from a range of partner organisations. The funding given to teams ranged from £350k to £600k. Projects ran for three-to-four years, with one project finishing in 2009 and the remainder finished in 2010.

The programme was based on a dual premise. The first was that clinicians are scientists, and take measures of clinical quality seriously as long as they are authoritative and that professional bodies are considered authoritative sources of clinical standards and their measurement. The second was that clinicians are more likely to engage with quality improvement projects that are initiated and controlled by clinicians. Seven out of nine projects ran audits as a core improvement intervention, supplemented by a range of other improvement methods.

The Engaging with Quality Initiative also included a support programme and leadership development support for the teams running the projects. It was evaluated by a consortium consisting of RAND Europe and the Health Economics Research Group (HERG) at Brunel University.

ENGAGING WITH QUALITY IN PRIMARY CARE

This programme was launched in 2006, and was developed along the same lines as the Engaging with Quality Initiative, but with a focus on primary care. Nine awards were made, to award holders including primary care trusts, universities and not-for-profit organisations. Some projects looked at system-wide changes in practice, testing improvement methods in the management of one or more conditions, while others focused on specific diseases or conditions, such as chronic kidney disease, domestic violence and back pain.

The projects were based on partnerships between organisations and clinicians leading multidisciplinary teams with patients or patient organisations. The awards ran for three years from April 2007 to 2010, and ranged from £350k to £700k.

Like the Engaging with Quality Initiative, this programme included a development programme for participating project teams, and is being evaluated by the RAND–HERG consortium.

CLOSING THE GAP THROUGH CLINICAL COMMUNITIES

This programme, launched in 2008, aimed to improve the quality of care delivered to patients by bridging the gap between known best practice and the routine delivery of care. In September 2009, we made 11 awards, in clinical areas ranging from primary to tertiary care and populations ranging from neonates to the very old, with a total investment of £5m.

All these activities took place in the context of a policy landscape that was increasingly concerned with improving quality and the role of clinicians within this objective. Our work preceded important policy documents such as the White Paper: *Trust, assurance, safety* (2007) and *High quality care for all* (2008), as well as the National Clinical Audit Programme (2008).

Between 2004 and 2009, as our understanding of how best to work with clinical teams has increased, the design of these large-scale improvement awards has evolved. There is now a stronger focus on improvement interventions other than clinical audit, and greater challenge about the ways in which each intervention is implemented.

The learning and development support for the teams has become more sophisticated and tailored to the skills needs of project teams, and has increased in scale. These changes appear to be resulting in better engagement and greater understanding of improvement by the participating teams.

STRENGTHENING IMPACT PROGRAMME

This supports projects by current or past award holders that have the potential to achieve measurable and sustainable improvements in the quality of healthcare. Four awards have been granted to royal colleges. Three move forwards work undertaken in Engaging with Quality Initiative projects and one by Salford Hospitals NHS Foundation Trust on behalf of the North West Improvement Alliance. A further project was based on evidence from our research into stroke, and our investment in Quality Improvement Fellows (see p 71), run in partnership with the Royal College of Physicians and the Stroke Association.

BUILDING RELATIONSHIPS WITH PROFESSIONAL COMMUNITIES PROGRAMME

This programme with selected royal colleges is working and is designed to help them develop their expertise in the science of improvement. The largest award is to the Healthcare Quality Improvement Partnership (HQIP), for expertise in improvement methods for teams running national and local clinical audits. HQIP is a charity and company limited by guarantee, set up and controlled by the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices.

We now report on the impact of the Engaging with Quality Initiative, Engaging with Quality in Primary Care and our wider influencing work in this area, set out under the four headings highlighted in the measurement framework (see p 30).

Our impact

BUILDING THE WILL FOR QUALITY

Clinician engagement was one of the most 'visible and measurable achievements' of the Engaging with Quality Initiative[10]. All 18 project teams succeeded in attracting widespread participation in their audits. For example, the UK Inflammatory Bowel Disease Audit project, led by the Royal College of Physicians, ran the first UK-wide audit of inflammatory bowel disease (IBD). Three-quarters of the 238 hospitals targeted completed the audit.

One product of the project has been the development of IBD standards. At the launch of the standards, Richard Driscoll, Chief Executive of the National Association for Colitis and Crohn's Disease said:

'The IBD Audit Project in particular has been a real catalyst for the IBD Standards, and these would not have developed so effectively without the formal collaboration between organisations that the Health Foundation grant created.' [11]

Meanwhile, the independent evaluation of the Engaging with Quality Initiative concluded that: 'professionally-led [quality improvement] in acute care can successfully mobilise large numbers of clinicians across a wide range of organisational settings. In acute settings it also appears that this engagement has more to do with the professional identity of clinicians than with any pecuniary gain[10].

As one project wrote, 'The fact that the project was started by consultants helps it to appeal to other colleagues, in that the goals of the group are common to the profession as a whole – to improve patient outcomes – and that the markers of quality are based on the experience and knowledge of the profession[12].'

Engaging with Quality projects have published more than 40 articles in peer-reviewed journals, 30 articles in professional journals or royal college publications, and have given more than 100 conference presentations. Project champions (such as enthusiastic, senior, respected members of the profession) and incentives such as professional peer pressure (for example, comparative audit) played an important role in motivating clinicians to take part.

We have also had some success influencing the professional bodies. For example, we influenced the content of *Tomorrow's doctors*[13] – the General Medical Council guidance for what will be taught to medical students over the next five-to-ten years. This resulted in quality and safety having a considerably higher profile in the final report than in earlier drafts or previous editions.

In 2009, we part-funded a collaborative conference between the Royal College of Physicians and two of its US equivalents, which resulted in a 'call to action'. This call invited individual physicians, institutions, academic communities and medical societies to:

- embrace and improve the use of performance measurement
- recognise the importance of physician leadership as an essential ingredient in quality
- redouble efforts to create strong interdisciplinary teamwork
- work to ensure more active and effective engagement of patients and community.

Our strengthened relationships with the royal colleges, and our improved understanding of their internal processes, have also helped create opportunities for us to influence. For instance:

- as a result of contact with us, the Royal College of Physicians took on board our suggestion that its new unit should have a quality strategy
- the Royal College of Psychiatrists consulted with us during the review of its quality unit
- the Royal College of Obstetricians and Gynaecologists – with whom we had no previous relationship – turned to us to discuss how to evaluate their clinical dashboards.

Our interpretation is that without the Engaging with Quality Initiative these occurrences are unlikely to have taken place.

DEVELOPING SKILLS TO IMPROVE QUALITY

The work of this strategic aim has had some success in increasing the capacity for clinical quality measurement and improvement in the UK, by developing the infrastructure and skills within the royal colleges and other professional bodies. The Engaging with Quality Initiative evaluation explains: 'Senior figures within the royal colleges and professional bodies have been engaged from the outset, and we have seen that the profile of [quality improvement] has been raised within these organisations and their capacity to support [quality improvement] in more practical ways has been improved.'[10]

The Engaging with Quality Initiative increased the royal colleges' understanding of improvement methods (Royal College of Midwives), helped maintain their involvement (Royal College of Physicians in Glasgow and Edinburgh) and influenced the creation of a Clinical Standards Department (Royal College of Physicians). However, these achievements depended very much on those bodies' prior experience with delivering improvement interventions, as well as the constituencies to whom they are accountable.

Some of the work we funded has contributed to changes in clinician training. The Royal College of Midwives-led Perineal Assessment Repair Longitudinal Study (PEARLS) aimed to improve the standards of perineal care in the UK through education, training and supported practice. The project conducted surveys and a baseline audit in 20 maternity units before developing educational packages and running training sessions that were delivered by trained facilitators in each maternity unit. According to its own assessment, the project contributed to multidisciplinary training in perineal repair becoming a mandatory requirement of trusts.

Self-reported data from award holders indicate that the support programmes for the two Engaging with Quality programmes have improved leadership skills, such as practical and project management skills and ability to lead primary care clinicians[14]. We have learnt that the successful implementation of improvement efforts requires a combination of skills – clinical, project management, communication, financial, measurement and cost estimation[10].

In both programmes, service users were integral members of project teams, and this had positive impacts. In the project Implementing Evidence-based Primary Care for Back Pain[15] a service user contributed experience in quantitative research, with published work on spinal therapies, and expertise in organising patient-centred focus groups and feedback sessions. According to the evaluation, this 'at least facilitated the project and at best made a distinct and significant contribution to its success'.[10] In another project a service user[16] is actively driving the involvement of a primary care trust with patients and the public, and has helped shape the integration of the project with the trust's wider work.

IDENTIFYING AND TESTING INTERVENTIONS TO IMPROVE CARE

Among the projects funded through this strategic aim, some have achieved positive impacts on clinical outcomes. This success has been limited to date, but was described by the Engaging with Quality Initiative evaluation as 'small, patchy but real'[10]. This assessment reflects the complexity of drawing conclusions about the impact of interventions on clinical outcomes, the timeframe in which change is measured, and the challenge of unambiguously attributing changes to an improvements intervention. Four examples of projects that resulted in clinical outcomes now follow.

The Prescribing Observatory for Mental Health

This project achieved statistically significant improvements, including:

- a 3% reduction in the prescribing of more than one antipsychotic between 2006 and 2008
- a 7% increase in patients prescribed antipsychotics who have their blood pressure, body mass index, blood glucose or HbA1c and lipids measured at least once a year
- the prescription of more than one antipsychotic (-6%)
- the prescription of first- and second-generation antipsychotics in combination (-4%).

The project has achieved further improvements since Health Foundation funding finished. It sustains itself through subscriptions by mental health trusts. One of the subscribing sites has reported to us a continuing drop in rates of high-dose and combined antipsychotics prescribing since our funding ended.

National Bowel Cancer Audit project
Data from two rounds of audit (2006 and 2007) show small improvements in four of the five proxy measures of surgical outcomes that the project identified:

- 30-day mortality rates
- recording of circumferential margin involvement
- length of stay
- number of lymph nodes harvested.

No improvement was recorded in the abdomino-perineal excision of rectum rate.

It is important to note that the project acknowledges that it is: 'difficult to separate the improvements in care attributable to this project from those due to other ongoing programmes across the UK which aim to improve the access to services, diagnostic and treatment'.[12]

Identification and Referral to Improve Safety of Women Experiencing Domestic Violence Project (IRIS)

The project (part of the Engaging with Quality in Primary Care programme) ran a cluster randomised-controlled trial in 48 general practices, to test the effectiveness of an intervention to improve the identification and referral of women experiencing domestic violence. Advocate educators delivered domestic violence training sessions to clinical and administrative teams. To remind GPs to ask about possible abuse, screen prompts, triggered by specific read codes in the electronic medical record, were installed on their PCs. The practices also produced publicity materials and established a practice champion.

Outcomes were impressive, with a 21-fold increase in referral rates and a 3.5-fold increase in recorded identification in intervention practices. The project was cited as an example of best practice in the report of the Department of Health Taskforce on the Health aspects of violence against women and children and in *The way forward: the pan-London violence against women and girls strategy*.[17,18]

The Health Foundation is now funding a programme of work aiming to spread the model nationally.

Improving Management in Gastroenterology

This project developed patient-driven quality outcome guidelines for four gastrointestinal disorders: reflux disease, irritable bowel syndrome, inflammatory bowel disease and coeliac disease.

Decision-support information was incorporated in computer templates used by GP practices involved in the study, and each practice had a 'gastro-champ'. Data are still being analysed, but there are early indications of improvements in terms of more accurate and earlier diagnosis of certain conditions. Evidence from the project is being used to make a strong case for inclusion of gastroenterology in the Quality and Outcomes Framework.

SUSTAINING AND SPREADING IMPROVEMENT EFFORTS

Three of the eight Engaging with Quality Initiative projects have succeeded in obtaining ongoing financial support for audits or measurement systems. The most significant example in terms of long-term sustainable work is the Prescribing Observatory for Mental Health. This project has recruited half of all mental health trusts in the UK as members of its regular audit, and has successfully moved to an annual membership fee to ensure project sustainability. The subscribing trusts will participate in the audit. This will include comparison data that will aid continuous quality improvement.

In four of the projects, the approaches we funded are being sustained through follow-on programmes. Most notably, this includes the Psychiatric Liaison Accreditation Network, run by the Royal College of Psychiatrists, which is intended to improve the management of the mental health of patients in acute hospitals. This includes continuing use of the tools for improving the treatment of patients who self-harm, developed as part of the project of the same name. For example, the online questionnaire will be kept up to date.

Our work has also acted as a catalyst for changes in clinical practice outside the areas in which we have directly invested. For example, as a result of the work of the project Resources for Effective Sleep Treatment, the local PCT provided Lincolnshire GP practices with a local prescribing incentive for hypnotics from April 2009.

Our work through our award programmes has informed government policy. There is self-reported evidence from five Engaging with Quality Initiative projects that the approaches they developed and implemented as part of the programme have led to policy changes. These have resulted in the learning being spread – and sustained – far beyond the original award-holding sites, as follows:

- **Assessing and Improving the Quality of Services for Patients with Inflammatory Bowel Disease**
  This project was a catalyst for the development of the National Service Standards for IBD in February 2009. Together with the audit work, these standards are part of a package of tools that have created a self-sustaining momentum in the IBD community that will support quality improvement. The IBD Audit is also included in the Annual health check 2008/09 process. IBD is also cited in the recent Scottish Long-Term Conditions document, as a direct result of the project's work to build relationships with ministers in all four countries of the UK.
- **Improving the Assessment and Management of Perineal Trauma**
  Team members from this project, led by the Royal College of Midwives, were involved in developing the report *Safer childbirth* (2007), published jointly by four of the royal colleges. This document, which set minimum standards for the organisation and delivery of care in labour, recommended that all health professionals involved in the care of women in complicated labour must have training in perineal suturing.

- **Assessing and Improving the Quality and Management of Care for Patients with Epilepsy and for those with Community-Acquired Pneumonia**
  This project developed a secondary care bundle that will be introduced to all hospitals within Scotland, as part of the Scottish Antimicrobial Prescribing Group work plan, which has designated the care bundle best practice.
- **The Bowel Cancer Project**
  The Care Quality Commission has used core data developed from the bowel cancer project audit in its Annual health check 2008/09. The Prescribing Observatory of Mental Health project is also mentioned by the commission in its report *Talking about medicines: the management of medicines in trusts providing mental health services*[20], as well as in the national report *Risk, rights, recovery*.

Conclusions

Our work in this area has had some clear positive outcomes – not least, the re-launch of the NHS-funded National Clinical Audit and Patient Outcomes Programme, which was influenced by our work. However, this kind of project has still not yet become mainstream. National clinical audits are still focused more on measurement than on improvement, and clinical teams are still struggling to find resources to implement novel improvement ideas.

Although we have not seen the sea-change in measurable health outcomes that we might have hoped for, the wider benefits achieved by the Engaging with Quality Initiative have been considerable. The programme succeeded in:

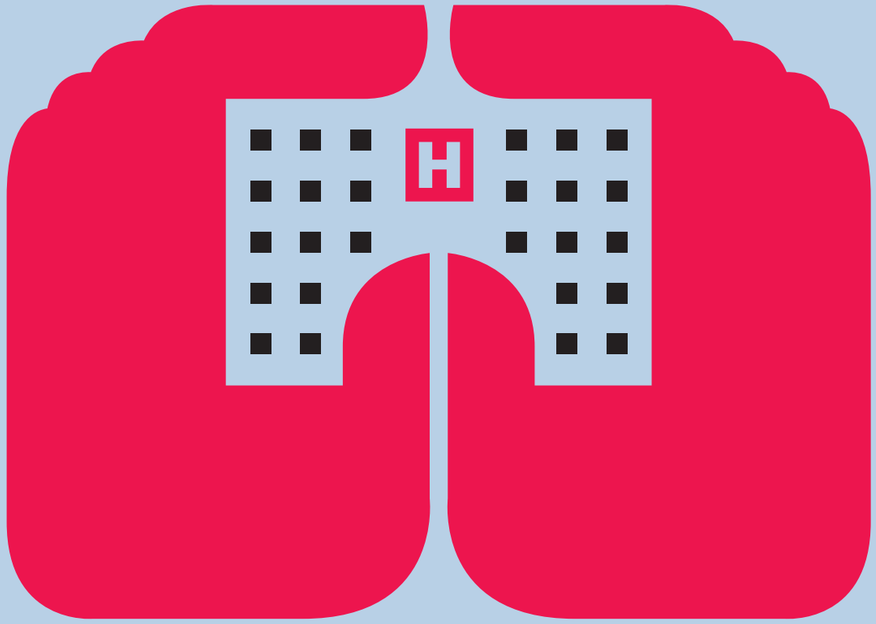
- engaging clinicians and service users in effective processes of change
- engaging policy makers and decision makers
- promoting the capacity of the healthcare system to deliver improvement
- contributing to the knowledge base about improving quality
- contributing to the design of evaluations of continuous quality improvement efforts.

Indeed, given the limited nature of the improvement interventions, it is extremely encouraging that the evaluation found improvements in structures, processes and cultures. With hindsight, the strong focus on clinical audit, coupled with limited change mechanisms, was unlikely to produce a step-change in outcomes.

Improving quality is part of clinicians' professional identity, and tapping into this can be a powerful motivator for change, both among those who are leading programmes to improve quality and among their peers. Clinician-led programmes to improve quality can produce benefits including greater standardisation of professional practice, more equitable care, greater quality control, and improved patient satisfaction. They can also have some positive impacts on patient outcomes, even within a comparatively short period of time. However, this is more likely to happen if teams have a shared understanding of the processes that are required to improve quality.

Crucially, programmes to improve quality need to be aligned with the mainstream allocation of resources in healthcare, supported through professional training, commissioning and regulation and integrated into the management of services.

05
Transforming organisations to deliver safer patient care



This chapter focuses on the third of our five strategic aims: 'transforming organisational approaches to deliver safer patient care'.

Our aims were to:

- transform organisational approaches to achieve measurable and sustained improvements in the safety of care for patients
- support the development of skills to spread effective methods for patient safety improvement within and beyond organisational boundaries
- support system-wide strategies to adopt and spread effective patient safety practices
- test and develop new methods for improving patient safety and improved reliability
- convince policy makers to embed safety as a critical system performance issue.

Our work in this area

The key programmes in this area were:

- **The Safer Patients Initiative** – a programme designed to prevent avoidable deaths, reduce adverse events and improve safety climate scores
- **Safer Clinical Systems** – a programme aiming to increase reliability in systems of care, in order to reduce failures in systems that harm patients
- **The Safer Patients Network** – a network of organisations working to find ways of building improvement skills and making healthcare safer for patients.

We now describe our work on each of these in turn.

SAFER PATIENTS INITIATIVE

In 2003/04, with the support of key external experts and organisations, we embarked on the development of this programme, which was our first major demonstration project. Its initial aims were:

- no avoidable deaths (a reduction in the Hospital Standardised Mortality Ratio)
- adverse event rates reduced 10 fold in each of the intervention areas
- improvement in safety climate scores (with demonstrated improvement across all 18 dimensions).

Phase 1 ran from 2004 to 2008. The programme brought four UK hospitals together to test ways of improving safety on an organisation-wide basis and developing their expertise in patient safety. The programme:

- concentrated on five clinical areas, each containing multiple interventions that, individually, had an established and accepted evidence base in the UK (for example, better management of patients in intensive care, infection control, preventative antibiotics for surgery and medicines safety)
- provided training in quality and safety improvement
- ensured that safety was a strategic priority, by making sure chief executives and senior executive teams were fully involved.

The four sites worked with the Health Foundation and safety experts from the Institute for Healthcare Improvement (IHI). The evaluation was undertaken by Professor Lilford at the University of Birmingham, who convened a multidisciplinary team of health service researchers to measure the impact of the programme.

The second phase was launched in 2006, and ended in 2008, working with a further 20 hospitals. Phase 2 hospitals worked in pairs to take forward safety improvements in their sites, building on the learning from Phase 1. They too had the support of the IHI. The sites tested ways of making care safer in three areas of their hospitals:

- on the wards
- before, during and after operations
- in critical care.

In each of these settings, staff looked at ways to improve infection control, the management of drugs and communication between staff teams and patients.

As with Phase 1, sites had the support of the IHI and the University of Birmingham carried out the evaluation.

SAFER CLINICAL SYSTEMS

Safer Clinical Systems aims to increase reliability in systems of care, thus reducing the number of failures in clinical systems that result in harm to patients. The pilot phase was launched in 2008, with five sites working to identify and test a range of interventions to improve patient safety from a systems perspective, building an evidence base to support their work. They are testing and developing interventions to:

- reduce variation in systems
- proactively search for risk
- control risk and ensure systems can cope with new threats, as well as recognised threats
- develop leadership skills and engage staff.

SAFER PATIENTS NETWORK

In June 2009 we launched the Safer Patients Network – an innovative, self-sustaining, member-driven group of 15 organisations that had been involved in the Safer Patients Initiative. The key goal is to develop and test ways of building improvement skills, making healthcare safer for patients.

By providing peer support and challenge, the network aims to increase the scale and pace of change in eliminating patient harm within and beyond their own organisations. Network members are supported by the Health Foundation alongside our partner the Institute for Healthcare Improvement, and the network is being independently evaluated by Cardiff University and York Health Economic Consortium.

OTHER PROGRAMMES IN THIS AREA

From 2008 we broadened out our safety work to include the following activities:

- **Flow, Safety, Cost** is a three-year programme designed to understand the relationship between patient flow, cost and quality. The participating organisations are South Warwickshire NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust. Kate Silvester, a systems and improvement expert engaged by the Foundation to work on this programme, provides dedicated clinical systems improvement expertise to support this programme.
- **Improving Patient Safety in Mental Health** aims to improve the reliability of care in order to reduce harm and raise safety awareness throughout organisations. It began in May 2009.
- **Improving Quality and Safety in Primary Care** offers GP practices the opportunity to develop their skills and put in place processes for flagging up risk and preventing harm. Through the programme, 80 general practice teams are identifying and reducing risk and harm to patients registered with their practice.

We are also working with four strategic health authorities in a range of capacities, to promote the wide uptake of safety interventions across the NHS in England, and with three trust boards to improve patient safety to pilot a board development programme during 2010.

We now report on the impact of our Safer Patients Initiative and our wider influencing work in this area, measured against the impact measurement framework (see p 98).

Our impact

BUILDING THE WILL FOR QUALITY

The Safer Patients Initiative has demonstrated that the principles and practices of patient safety can help motivate and inspire staff to achieve new performance benchmarks. It struck a match and ignited interest.

In 2004, when the project began, there was still little concerted activity to address patient safety at organisational level – even though the profile of patient safety had been raised through seminal publications including *An organisation with a memory*[21] and the Bristol inquiry[22]. The term 'patient safety' was not routinely used in management, and the focus was still more on risk management and assurance. Boards received little information beyond formal complaints on the safety of the care within their organisations.

Safety itself was largely subsumed within the clinical effectiveness agenda, and was considered to be the responsibility of individual clinicians, rather than a system responsibility. As such, national agencies focused on reporting patient safety incidents rather than active approaches to improve safety[21].

The Safer Patients Initiative raised awareness of harm arising from routine aspects of care, creating new standards of care and a belief that improvement was possible. It engaged senior managers, who became enthusiastic and shared an understanding of the programme and its underlying theory of change[26]. Their support and enthusiasm helped to make safety an organisational priority, as a result of the growing managerial recognition and focus on patient safety, as well as by promoting the systematic approach advocated for tackling safety issues[26].

Case-note reviews provided senior executives with insight into the shortcomings of care within their organisations, galvanised impetus to act, and provided managers with the language and territory with which to engage clinical staff. In short, the programme offered a set of defined interventions to address safety concerns and a set of methods to problem solve and improve, and encouraged multidisciplinary team working.

However, more could have been done to engage middle managers in the programme. This group did recognise that risks on the ward were not always managed well, so the challenge of engaging them was thought to be due to the day-to-day nature of their work, which often focused on managing highly complex clinical and organisational demands with limited resources[23,24].

Our work in patient safety has been influential at national level. Most prominently, the Safer Patients Initiative is cited in the 2009 parliamentary health select committee's report into safety[25], which recommends that NHS organisations glean information about actual harm done to patients from data sources such as case-note reviews (advocated by our programme). In its response to the committee's findings, the Labour government said:

Building the will and desire to lead change directly and at the right level, and providing these key staff with the skills to achieve positive change, are the hallmarks of projects like the Safer Patients Initiative and the Patient Safety First Campaign that are to be encouraged and promoted. Sustainable change in every healthcare organisation – not just some – is only possible if the principles and practices of programmes such as these are embraced[26].

Specific impacts on the patient safety agenda are set out in Table 1, opposite.

TABLE 1: IMPACTS ON THE PATIENT SAFETY AGENDA

Impact	Data source
The safety first report recognised the Health Foundation as playing significant part in safety improvements at a national level	Safety first: a report for patients, clinicians and healthcare managers. CMO, Liam Donaldson, December 2006
A report to the Welsh Assembly presented examples of good practice including Conwy and Denbighshire and the Safer Patients Initiative	Minimising healthcare associated infections in NHS trusts in Wales. Report by the Auditor General in Wales to the Welsh Assembly, November 2007
The Foundation's patient safety work was cited in the National Patient Safety Association report on actual signs of deterioration of patients	Recognising and responding appropriately to early signs of deterioration in hospitalised patients. NPSA, November 2007
The NHS Institute published a paper based on the round table, co-hosted by the Health Foundation, on mortality reduction	Reducing avoidable deaths – medical directors. NHS Institute for Innovation and Improvement, June 2007
A report by Northern Ireland's chief medical officer cites work with the Health Foundation as enabling Northern Ireland to adopt internationally recognised best practice in tackling healthcare-associated infections	C-difficile. Committee for Health, Social Services and Public Safety Report. Northern Ireland, February 2008
In a speech, the prime minister gave credit to our work and influence of the Safer Patients Initiative on the patient safety agenda	Speech by former Prime Minister Gordon Brown. Patient Safety Congress, 2008
Safer Patient Initiative projects feature prominently as examples of good practice in patient safety	Patient safety. House of Commons Health Committee, July 2009
The government response to the Health Select Committee report says 'In the Committee's views SPI, the Health Foundation's important work in applying carefully researched methodology for improving safety performance, were welcomed. We also value the contribution The Health Foundation is making as a member of the National Patient Safety Forum and the NQB, and in particular its major contribution with the NPSA and the NHS III in supporting the national programme for improving safety in England'	Patient safety. Department of Health, October 2009
A Scottish Government document says that Scottish Patient Safety Alliance will 'build upon the successes of the current SPI which is already improving safety standards in NHS Ayrshire and Arran, NHS Dumfries and Galloway and NHS Tayside'	Better health, better care: action plan. Scottish Government, December 2007
This Northern Ireland documents recommends that the country 'develop indicators for safe and effective care from existing experience and programmes of patient safety, specifically evidence built through trusts involved with SPI for systematic use across Northern Ireland'	Indicators of safe and effective care: a proposed approach for health and social care. Northern Ireland, May 2007

The experiences of the hospitals involved reveal that the Safer Patient Initiative worked well. It provided, for the first time in the UK, a practical approach to enable routine measurement of patient safety and real-time data: a quality of 'stickiness'. Statistical process control methods enabled the sites to collect and analyse their own local data to observe the impact of interventions on process and outcomes measures in real time. For the first time, sites could understand how they were doing and where their problems lay. Measurement made unreliable care and harm visible, and gave ward-level managers the information they needed to improve clinical practice.

In Phase 2, all 20 sites passed run chart rules[27] on at least half of the 43 process and outcome measures[28]. The programme developed award holders' knowledge on a range of improvement issues, established a 'learning by doing' ethos, and taught them how to use communication tools such as situation, background, assessment, recommendation (SBAR) and the Early Warning Score system, which, according to the independent evaluation:

… improved communication by creating a template that prompts the nurses to provide the relevant information in a format that appeals to the medical staff. It can also prompt staff to engage more in the process, as formalising the documentation has introduced a new element of accountability for both the nurses and the doctors.[29]

Independent research[30] found that the sites' experience of process measurement was very positive – it helped them understand cause and effect, engendered local ownership of data for improvement, and made current care reliability visible. However, there were a number of data quality issues, including technical difficulties with metric definition and implementation. Continuous process measurement and feedback to support iterative improvement work is ideal in theory, but harder to implement in practice, and a strong focus on the organisational capacity for continuous improvement is needed.

IDENTIFYING AND TESTING INTERVENTIONS TO IMPROVE CARE

Senior leaders reported that the greatest improvements in the Safer Patients Initiative had been the creation of routine monitoring of care processes, understanding of quality improvement and quality and safety awareness and knowledge[31]. Local implementation teams reported that the main impacts were on the cultural, interprofessional, strategic and organisational aspects of care delivery[32].

Some of the site-generated data are impressive. For example, in Phase 2, 18 sites achieved a 50% reduction of MRSA on intensive care units, 17 reduced central-line infection rates to zero, 10 reduced the ventilator-acquired pneumonia rate to zero, nine went more than 300 days without a central line infection, and seven reduced MRSA on general wards by 50%. However, only three sites showed improvement on more than three-quarters of the measures.

The greatest successes were generally reported by the sites in more defined clinical areas, such as intensive care, where arguably there was greater scope to address people and context issues, such as a stronger team culture. This contrasts with the work on medical wards where the diffusion of the Safer Patients Initiative was potentially undermined by the instability caused by rotating teams and frequent use of agency staff[23,26].

The goals for reduction in mortality and adverse events were purposefully set as ambitious stretch goals. This was as much to galvanise attention and effort as to be realisable targets. By the end of the programme, some sites were reporting significant progress or achievement against these goals. However, as we know that the penetration of the programme within the first 18 months was limited (see later), we are cautious about drawing conclusions on cause and effect.

The external evaluation found few differences in quality standards in Safer Patients Initiative sites compared with controls. This suggests that the programme did not have a strong additional effect from SPI on the measures chosen. The evaluators recognised that effects may have occurred in areas not specifically assessed by the study design, and may surface in the longer-term. They proposed that organisational patient safety interventions may need improved implementation, including more investment in making explicit their theories of change and greater recognition of the scale of resource, effort and support for organisational systems needed.

Our conclusion is that the Safer Patients Initiative has made a significant contribution to make to establishing new and important data-collection systems within defined clinical areas and impressive improvements in some clinical areas. However, any effect of the programme on clinical outcomes at an organisational level, over and above other programmes or improvements, was not substantial. In retrospect, however, this is not surprising given the scale at which it was operating.

SUSTAINING AND SPREADING IMPROVEMENT EFFORTS

It took much longer than expected to create a robust Safer Patients Initiative prototype from which to spread. Consequently, the programme did not achieve the organisation-wide impact that we had originally hoped for. The challenges in this area were due to the following factors.

- The participating organisations had no systems for safety measurement, and it took months to put these in place.
- In many cases baseline data were not available.
- In some organisations, trust mergers and leadership changes destabilised the programme.
- Hospitals' negative experience of using data for externally driven performance management meant that it took extraordinary time and effort to win their trust to be transparent with their data.
- Few organisations had systematic approaches to training staff skilled in quality improvement methods, so there was a need to train staff as the interventions were rolled out [33,34].

In addition, the number of people exposed to the approaches was limited, suggesting that the reach of the programme was too small to achieve a wider or deeper impact within the timescale.

In summary, the ambition of transforming organisations within a two-year programme was over-ambitious. As a result, the work remained largely a 'project', rather than being embedded in mainstream structures. Nevertheless, many successes were identified within the specific wards and units targeted by the programme, and today many sites have started to spread the approach. For example:

- NHS Tayside is one of four sites that have spread the Safer Patients Initiative approach to the maternity unit
- in Northern Ireland's South Eastern Trust, staff working within the general acute service have spread the medicines management approach to the psychiatry department
- Conwy and Denbighshire achieved whole trust hand-hygiene compliance[25]
- since February 2007, Luton and Dunstable Hospital has been holding quarterly spread events to share its learning and to advocate the Safer Patients Initiative.

New structures

More broadly, sites have now recognised a need to give departments or divisions more responsibility for implementing and monitoring safety. They have created new structures to support safety work, and all of the hospitals within Phase 1 have set up structures to ensure that measurement for improvement becomes embedded within routine processes. For example, since the introduction of the programme in Conwy and Denbighshire, safety briefings are held at the start of the theatre list each day, and a short time out occurs at the beginning of each operation.

Training

Hospitals involved in the Safer Patients Initiative have incorporated its methods into their local training programmes. NHS Tayside has established a patient safety training programme for doctors in the first and second year of their training, Luton and Dunstable NHS Trust has established training for all staff in using the communication tool SBAR, and in Conwy and Denbighshire the resuscitation team has incorporated SBAR into the training for all new medical staff. We have also seen considerable spread of the programme outside of the 24 hospitals involved in the programme.

National patient safety initiatives

Most notably, the four national patient safety initiatives have come about as a direct consequence of the Safer Patients Initiative. Three of these have been led by previous Health Foundation award holders: Jonathan Gray was Campaign Director for the 1,000 Lives Campaign in Wales (he has since moved to take up a senior post in New Zealand), Stephen Ramsden was Director of Patient Safety First in England, and Jason Leitch is the National Clinical Lead for Patient Safety at the Scottish Government.

The will to develop these national initiatives was built on the evidence derived from early successes of the Safer Patients Initiative, and the change package used is sourced from the programme itself. In December 2009, over 96% of acute and 62% of non-acute trusts had voluntarily signed up to Patient Safety First[35].

The programme has also had an international reach. The Danish patient safety campaign Operation Life was inspired in part by the Safer Patient Initiative, and a newly formed Danish safety collaborative of five hospitals is built directly on the approach.

Finally, we have been working with four SHAs to support the development of their patient safety infrastructure, to further test different improvement approaches, and to understand which measures are effective in spreading safety improvement across a SHA region.

NHS South West has launched an improvement programme based on the Phase 2 model, and NHS South Central, NHS North West and NHS North East are undertaking a range of programmes that have their roots in the Safer Patients Initiative. Members of the programme's sites are now helping as part of faculty for the NHS South West safety programme.

Conclusions

We are very proud of the many and varied achievements of the Safer Patients Initiative. The impact on frontline medical staff, leadership and improved and clinical outcomes within the timeframe of the programme was not as significant as we may have hoped. However, it is too early to judge the organisational, let alone the system-wide, impact of the programme.

One difficulty with the assessment was that while the interventions were applied at test sites, the outcomes measured by the evaluation were at organisational level. This does not negate the positive self-reported results of individual trusts, but it does challenge the wider aspiration that the intervention would have an additive effect that could be observed at organisational level.

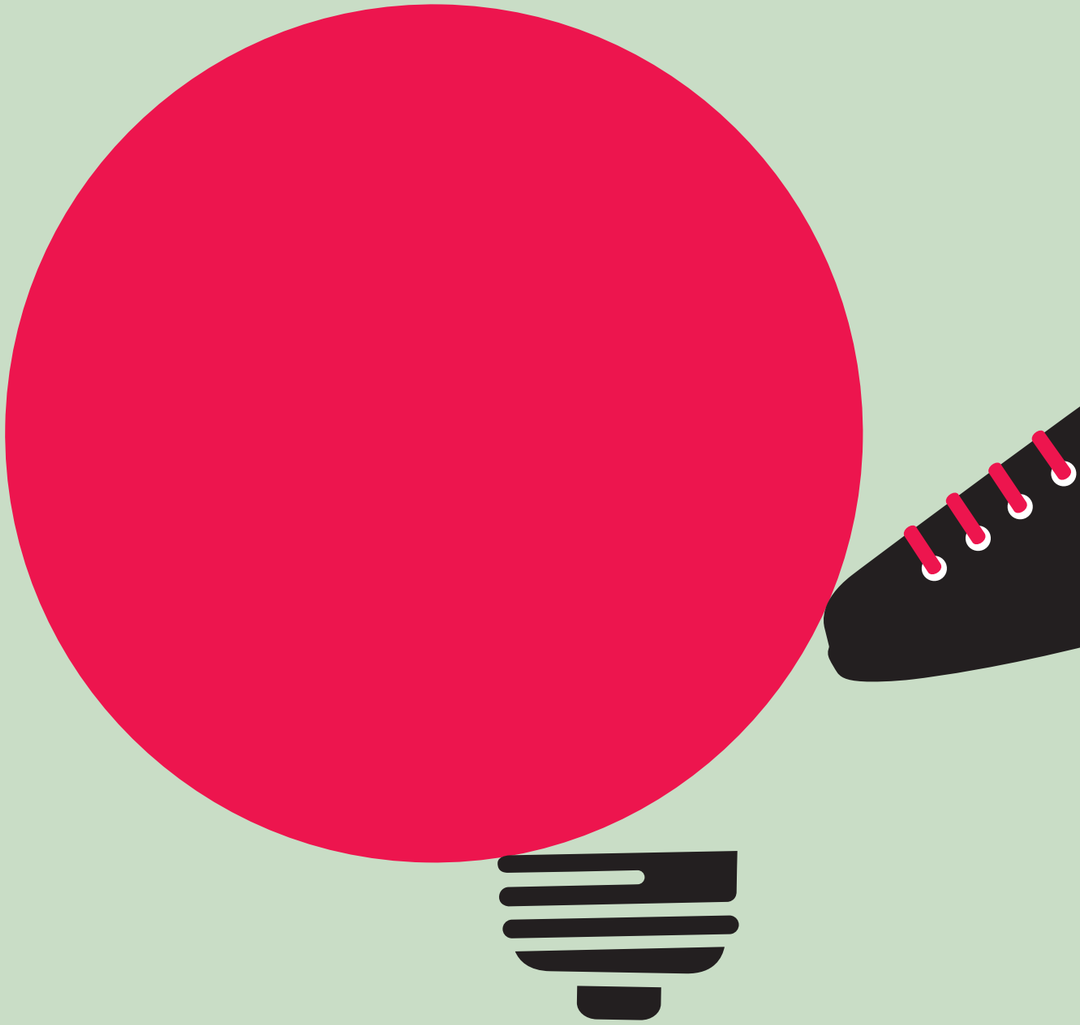
Improving and embedding patient safety in NHS organisations and across healthcare systems is a massive challenge, and requires a long-term programme. Nevertheless, the Safer Patients Initiative model has demonstrated great potential, and the approaches championed within the programme now shape the work of many hospitals and health systems across the UK.

06
Developing leaders to improve health and healthcare services

This chapter focuses on the fourth of our five strategic priorities: 'developing leaders to improve health and healthcare services'.

Our aims in this strategic priority were to:

- build will and focus attention on the role of good leadership in improving the quality of healthcare
- seek out and develop people with potential to lead quality improvement
- convince healthcare organisations to invest in leadership skills and team work explicitly linked to quality improvement
- explore and develop robust methods for cross-organisational learning to embed or promote clinical quality improvement
- develop strategies to embed improvement skills and attitudes into the core repertoire of the health workforce.



Our work in this area

Our active commitment to developing leaders began in April 2002, when our board identified the development of leadership in healthcare professionals as one of its four key strategic priorities. The board subsequently agreed that we should design a portfolio of award programmes aimed at developing the leadership potential of clinicians and managers, testing a range of different approaches and embodying various understandings of what it means to be a leader.

Our focus on leadership emerged from an understanding of the important contribution that effective leadership makes to improving healthcare. Alongside the knowledge that, within the NHS, there was limited access to innovative, high-quality leadership development opportunities.

The Clinician Scientist Fellowship programme started in 2000, pre-dating our focus on improving the quality of healthcare in the UK. This programme became the first of our suite of leadership offers, funding individual clinicians to undertake academic research that is of direct patient benefit and that supports fellows in developing as leaders in their academic field.

Since 2003 we have run a diverse portfolio of leadership programmes that have been evolutionary and experimental in nature. They have moved from a focus on developing individuals to exploring the relationship between leadership and improving quality. Our funding of more than £28m to date has supported 238 individuals and 12 teams. Nearly £15m of this represents our commitment to 24 Clinician Scientist Fellows.

The portfolio has consisted of up to eight different programmes at any one time, six of which have supported multiple cohorts of award holders.

Most of these programmes have supported individual leaders, clinicians, managers, policy makers and academics, while others have supported teams in shared leadership programmes in the areas of diabetes care and the health of black and minority ethnic (BME) communities.

In 2004, we commissioned two reports to inform the development of a programme of work in shared leadership. The first helped to confirm the idea that a shared leadership programme should form an experimental part of the programme. The second helped to shape the design of the leadership programme. Through case studies of clinical teams in the UK, the latter made a strong case for developing a shared leadership programme for clinical teams, providing evidence that effective teamwork can have a measurable impact on clinical care and organisational outcomes.

Two board decisions have been particularly influential in reshaping the Health Foundation's leadership programme. First, in June 2005 our board agreed that the Health Foundation's distinctive contribution to the field of leadership development should be 'leadership for quality improvement'. Second, in our 2008–12 strategic plan, the board supported a commitment to reshape our leadership programmes using learning about effectiveness gained through our work to date, and approved our intention to replace Leaders for Change and Leadership Fellows with a new programme.

We have now made awards to the final cohorts of Health Foundation Leadership Fellows, Leaders for Change, Harkness Fellows and Leading Practice through Research. New programmes were launched in 2010.

TABLE 2: THE HEALTH FOUNDATION'S LEADERSHIP PROGRAMMES 2003–09

Leadership scheme	Description	(no of cohorts, approx nos per cohort)	Duration
Clinician Scientist Fellowships	Supports medical professionals to pursue academic research seeking to improve patient care	(3 cohorts, 5 people)	5 years
Leading Practice Through Research	Enabled mid-career professionals to undertake research to improve the quality of patient care or the health of the population	(6 cohorts, 5 people)	variable
Leadership Fellows	Develops individuals with the potential to become the future leaders of high-quality healthcare	(5 cohorts, 16 people)	22 months
Leaders for Change	Equips health professionals working in service improvement with the skills and knowledge to lead change	(6 cohorts, 15 people)	One year
Harkness Fellows	Offers experienced practitioners a chance to work in the United States to study its health policy	(5 cohorts, 2 people)	18 months
Quality Improvement Fellows	Develops and equips clinically qualified senior NHS professionals with quality improvement tools and techniques	(5 cohorts to date, 3 people)	One year
Shared Leadership For Change	Offers leadership for multidisciplinary teams working across organisational boundaries to provide high-quality care	(One off; 6 teams)	18 months
Shared Leadership to improve healthcare for BME groups	Helped multi-organisational teams to improve the quality of health services for BME groups	(one off, 6 teams)	2 years

Our impact

BUILDING THE WILL FOR QUALITY

Our leadership programme has built a positive profile and caught the attention of policy makers. As early as 2005, Lord Warner (then Minister of State for Healthcare, Lords), and Earl Howe delivered speeches in parliament that described programmes within the leadership programme as 'vital' and 'innovative' work. Lord Warner praised the Health Foundation and its Harkness Fellows for 'promoting international collaboration and the exchange of ideas and experience', while Earl Howe told fellow peers that clinical academics were an essential cog in the functioning of the NHS, citing our Clinician Scientists Fellowship programme.

Other references to our work in the policy arena include the Scottish Diabetes Framework, updated in 2006, in which the Scottish government pledged to use learning from the Shared Leadership for Change diabetes team in Lothian to spread best practice across Scotland[36]. The following year, the Scottish government cited our research on leadership interventions aimed at members of BME groups[37] in its review of the appointment process for consultant recruitment[38]. The research made recommendations on tackling discrimination and increasing diversity in the NHS.

Other evidence of impact on influencing relationships includes the following achievements.

- We have membership of the Royal College of Physicians' Future Doctors Working Group.
- We were invited to be the keynote speaker on leadership in nursing at the *Nursing Times* Nursing Summit in January 2009.
- In partnership with the London Deanery, BAMMbino and the National Leadership Council, in November 2009 we designed, facilitated and sponsored the first national Medical Leadership Fellowship Event.
- We were invited to provide editorials on leadership in the RCN journal *Nursing Older People* (in spring 2008) and in *GMC Today* (in spring 2009).
- We were invited to give keynote sessions at the launch of the UK Academy of Nursing, Midwifery and Health Visiting Research.
- We published an article on policy development in NHS Scotland *Curam* magazine (in spring 2009).
- We have a quarterly opinion column in the *Nursing Times*.

DEVELOPING SKILLS TO IMPROVE QUALITY

The programmes within the leadership programme vary considerably in terms of the range of leadership and improvement skills that they address. None of them contains a formal skills curriculum or set of competencies, so our assessment of impact comes from self-reported post hoc data collected through the independent evaluation. This involved asking a sample of past and current award holders what benefits they had attained as a result of their award.

The evaluation reported improvements in:

- influencing skills
- management skills
- ability to lead change
- increased flexibility to adapt one's leadership approach to task
- an ability to build organisational leadership capacity
- an enhanced ability to interpret team dynamics
- greater tolerance of organisational ambiguity
- stronger ambitions concerning the degree of individual impact to improve services
- knowing how to facilitate effective corporate decision making and more active networking[39].

Award holders also reported that their understanding of the methods and approaches to improving quality had improved. A survey by the external evaluators, which covered 82 individuals participating in six of our leadership award programmes, showed average scores for each programme ranging from 6.9 to 9.7 (with 1 representing 'strongly disagree' and 10 representing 'strongly agree'). Given that some programmes did not have a strong or explicit focus on improvement methods, this is a surprisingly positive rating.

A separate independent evaluation of our Shared Leadership for Change awards reported that the programme delivered tangible results in terms of improvements in teams' skills and abilities. There were significant differences between comparator and award teams on approximately half the indices of teamwork development that were measured, in addition to self-reported improvements in skills and abilities[40]. All award-holding teams reported benefits such as:

- improved clinical leadership
- increased levels of activity and achievement – particularly in developing, agreeing and implementing strategy
- improvements in team processes to drive change
- a greater sense of team cohesion.

Several projects also reported improvements in cross-organisational working, due to improved relationships and influencing skills.

IDENTIFYING AND TESTING INTERVENTIONS TO IMPROVE CARE

Establishing the impact of our leadership awards on the quality of healthcare is challenging. Many benefits of more effective leadership are visible only in the medium-to-long term. We are not looking to demonstrate that the Foundation's programmes are the sole mechanism by which impact is achieved: more ingredients make a good leader than an excellent leadership programme, and more things make a good improvement intervention than an excellent leader. We are, however, seeking to demonstrate that our programmes play a significant role in achieving impact. We are looking for evidence of causal contribution.

While our leadership award programmes have increasingly focused on leadership for improvement, few of the programmes have been designed to impact directly on the quality of healthcare within the life of the award. Some, such as Leaders for Change, target service improvement managers, and aim to improve the effectiveness of service improvement by equipping people with new skills and resources. The improvement projects carried out by award holders on these programmes often operate closer to the patient, and are therefore more likely to have had some impact on patient experiences.

The evaluation surveyed 82 participants across the programmes and asked them to score the extent to which taking part helped them carry out real service improvements, on a scale of 1–10. The average score for this question was 8, suggesting that leadership skills are an important part of successful quality improvement[39].

Examples of positive impact from our leadership programmes

- The introduction of a one-stop same-day service for day and short-stay surgical patients. Consultation, tests, pre-assessment and surgical operation are all provided on the same day and no routine post-operative visit is scheduled unless it is essential. Savings to the hospital and the PCT are approximately £300 per patient.
- The redesign of a mental health service for older people, resulting in the development of city-wide memory services with improved access to diagnosis and an increase in the range of services offered to service users.
- Changes to a local diabetes service to make it more accessible to young adults, resulting in a 50% reduction in the 'did not attend' rate.
- The introduction of a rapid assessment service to an acute trust's orthopaedic service, leading to a reduction in waiting times from 16 to 6 weeks.
- The transfer of diabetes care from secondary to primary care, resulting in a reduction of waiting times from 12 months to no wait.
- The unexpected death of a child, used as motivation to review and strengthen clinical governance across a trust.
- The development of an 'information dashboard' displaying progress against agreed quality indicators for a genetics service.
- Use of dramatised patient experiences to improve personal skills, shared with five trusts following positive evaluation of impact.

Leading Practice through Research

We have evidence that several completed projects on our Leading Practice through Research programme have contributed to improving quality. In one example, programme participant Gary Parkes carried out a study to see how telling patients their lung age affects the rate at which they quit smoking. The study was published in the *British Medical Journal* in 2008 and was cited in the *European Respiratory Journal* and *The Lancet*, and won the Royal College of General Practitioners/Merck Sharp and Dohme Research Paper of the Year Award[41]. In April 2009, based on the new evidence from the study, the Cochrane Library of systematic review changed its conclusions about the use of biomedical markers in smoking cessation[42].

Gary reports that several PCTs have presented business cases to implement lung age testing as part of their smoking cessation strategies. The medical director of Newham PCT reports that the PCT easily exceeded smoking cessation targets for the past 12 months, and attributes its success to including lung-age testing as part of its community-based campaign. The Department of Health's chronic obstructive pulmonary disorder strategy document, launched in February 2010, proposes further research to expand the use of lung age to motivate smoking cessation[43].

Team-based leadership interventions

There are positive signs that our team-based leadership interventions are contributing to the improvement of services. In one example, as part of the Shared Leadership for Change: Diabetes programme, the Carmarthenshire Diabetes Network successfully moved routine diabetes care from secondary to primary care. The shift resulted in a dramatic reduction in waiting times for new secondary care appointments, from 12 months to no wait. Training within primary care enabled the discharge of more than 500 type 2 diabetes patients to primary care. As a result, 80% of local diabetes care is now delivered exclusively within primary care – well above the Welsh General Medical Services contract target of 60%.

The network believes that it would have achieved this improvement without the support of the Foundation, but describes the award as a catalyst that has enabled it to bring about these improvements more quickly.

In another example, as part of the Shared Leadership for Change: Health Inequalities programme, a project in Wakefield aimed to improve mental health outcomes for BME communities. The project evaluation found a 22% increase in the secondary care adult mental health services and a 29% increase in the number of BME people accessing substance misuse services. According to the project team, 'these massive achievements would not have been possible without shared leadership upwards and downwards'[44].

SUSTAINING AND SPREADING IMPROVEMENT EFFORTS

The leadership programme has yet to articulate fully a theory of change underpinning its work for sustainability and spread. A systematic approach to tracking our award holders in the longer term is not yet in place, but we are aware of a number of approaches that are sustained once our direct investment comes to an end.

There is also some evidence that our approaches to leadership development have influenced the design of development programmes run by others. In 2007, the NHS Institute launched a programme with similar features to Quality Improvement Fellows. The same year the National Institute for Health Research started to commission leadership development for medical and clinical researchers – a novel concept when we first introduced leadership development support into our Clinician Scientist Fellowships. We have also provided leadership development advice to others, including the NHS Institute, the Scottish Patient Safety Partnership and the Commonwealth Fund.

An initial evaluation of the Clinician Scientist Fellowship programme in 2005 showed that the first cohort had successfully attracted more than £4.2m in additional research funding[45].

Some of our past award holders – particularly Quality Improvement Fellows and Harkness Fellows – are now recognised as advocates, mentors and system leaders for improving quality. Table 3 shows examples of award holders who have taken on senior quality improvement roles following participation on one of the Foundation's leadership programmes.

Since 2003 the Health Foundation's suite of leadership award programmes has been designed to offer healthcare leaders personal development opportunities and increasingly, as the programmes have evolved the know-how to lead and support improvement work. This strategic aim is now in a state of transition, moving from a period of exploring the relationship between leadership and improvement to a new phase of testing emerging ideas about leading from improvement, through GenerationQ – a new programme launched in 2010.

We are now developing our approach to leadership and organisations, reflecting on our learning to date. We have traditionally framed our contribution to the leadership and quality arena as 'developing leaders to improve health and healthcare services', and have concentrated our investment principally in the development of individual leaders.

We are in the process of reviewing this focus so that in the future it encompasses improving the quality of care through developing individuals, teams and healthcare systems with adaptive capacity continuously to improve their care. This would more accurately reflect our growing understanding of which leadership and organisational transformation approaches are most effective in improving quality and guide our ongoing investment.

TABLE 3: EXAMPLES OF LEADERSHIP PROGRAMME PARTICIPANTS WHO HAVE TAKEN ON SENIOR QUALITY IMPROVEMENT ROLES

Pre-leadership programme	Post-leadership programme
Jason Leitch was a clinical academic oral surgery consultant at the Dental School in Glasgow before he was awarded a Quality Improvement Fellowship in 2005.	In March 2007, as a result of the successes of NHS Tayside through its involvement in the Safer Patients Programme, the Scottish Patient Safety Alliance was launched. Jason was asked to come on board as National Clinical Lead for Safety and Improvement.
Maxine Power was Associate Director of Quality Improvement at Salford Royal NHS Foundation Trust. She became a Quality Improvement Fellow in 2006. While she was in the United States on the programme she worked up a project brief to identify a core number of processes to improve outcomes for patients after stroke.	On return to the UK, Maxine became Director of the North West Improvement Alliance. She has recently been appointed to the post of National Improvement Adviser to the Quality Innovation, Productivity and Prevention programme. In 2008 the Health Foundation gave Maxine funding to implement the project she had designed as a Quality Improvement Fellow – Stroke 90:10.
Annette Bartley was a Modernisation Manager at Conwy and Denbighshire Trust. She became a Quality Improvement Fellow in 2006. Her project focused on developing one or more models of care at the bedside to make care safer and more personalised for patients, and more efficient and effective for staff.	On return to the UK, Annette took her study to the Welsh government and she was asked to pilot the model in her own organisation, Conwy and Denbighshire Trust and another in South Wales. Annette is now Director of the Safer Patients Network.
Derek Feeley travelled to the United States as a Harkness Fellow after being promoted to Director of Healthcare Policy and Strategy at the Scottish Executive's Health Department. His aim was to gain the skills he needed to fulfil this influential strategic influential role.	In addition to this role he now also sits on the national advisory board that shapes and drives the Scottish Patient Safety Programme.

Conclusions

Since 2003 the Health Foundation's suite of leadership award programmes has been designed to offer healthcare leaders personal development opportunities and increasingly, as the programmes have evolved the know-how to lead and support improvement work. This strategic aim is now in a state of transition, moving from a period of exploring the relationship between leadership and improvement to a new phase of testing emerging ideas about leading from improvement, through GenerationQ – a new programme launched in 2010.

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07
Building and promoting knowledge on how to improve care

This chapter focuses on the last of our five strategic aims: 'building and promoting knowledge on how to improve care'.

Our aims were to:

- seek intelligence about leading-edge practice and policy, to identify new areas for development
- produce coherent and accessible performance information
- generate convincing evidence about improvements in care
- stimulate debate about methods and work collaboratively both nationally and internationally
- frame a positive agenda for quality improvement.

Our work in this area

The Health Foundation has made a large investment in evaluation and a growing investment in research. Efforts to improve the quality of healthcare are seriously undermined by the shortage of good evidence that describes the nature of quality deficiencies, monitors progress in performance in the public domain, and describes intervention to improve quality. We developed this strategic aim in response to these gaps.

Although we funded health services and biomedical research before becoming the Health Foundation in July 2003, our new organisational mission signalled a fresh business model. Since then, evaluation and research have increasingly become core components of our approach.

In late 2003 we published the findings of a report commissioned with the Nuffield Trust from Dr Penny Dash entitled *Increasing the impact of health services research on service improvement and delivery*. We considered a range of ways to promote and support health services research, and agreed to fund the NHS Confederation for three years to establish and embed a Health Services Research Network.

In November 2003 the board approved an evaluation strategy with the following four aims:

- to generate robust evidence of the effectiveness of the Foundation's portfolio of programmes
- to use that evidence to inform policy and practice as well as make contributions to specific bodies of knowledge
- to contribute to debates in the UK and abroad about approaches to evaluating interventions to improve quality and build best practice models into our evaluation
- to strengthen our accountability function by demonstrating the benefits accrued through the investment of resource in our programming areas.

A research programme emerged in 2003 and 2004, and we started to commission specific research projects to inform specific programme development.

In September 2004 the board approved a new strategic aim: to build and make public the knowledge base for quality and performance improvement. This was part of a new strategic plan for the period 2005–09. Its aims were:

- to gather and use intelligence about emerging issues that impact on the quality of healthcare at levels in the system
- to develop public performance information about the state of quality of healthcare
- to develop public performance information about quality improvement activities, strategies and methods, including those of the Health Foundation.

At the same time, the board gave approval for a long-term strategic partnership to build capacity for healthcare performance monitoring in the UK, through a programme called the Quest for Quality and Improved Performance (QQUIP). Launched in 2005, this ambitious five-year programme was designed to:

- assess the performance of the healthcare system in the UK and where it needs the most improvement
- identify the most effective strategies to improve the quality of care
- assess the resource implications of strategies to improve the quality of care.

In 2005 the board gave approval for a second substantial five-year research programme, to be led by Imperial College, built around the core question *How do healthcare organisations become safe?* Also that year we developed the International Quality Improvement Exchange, to bring together leaders in healthcare from eight European countries to discuss issues of common interest with a view to accelerating quality improvement.

Two years later we developed a programme of context-setting research that was designed to strengthen the evidence base in areas of strategic importance to inform our work and shape future priorities.

In June 2009, the board received a mid-term review of the Quest for Quality and Improved Performance. It revealed that the programme had effectively shone a light onto the UK healthcare system's ability to monitor its performance, but that it had not succeeded in identifying or building capacity in this area. It was clear from the review that the programme aims were too ambitious – particularly its goal of building the capacity for commentary on healthcare system performance.

In 2009 we commissioned qualitative research to understand how our research and development programme was perceived by national policy and decision makers, academics, governmental and independent national bodies, senior clinicians and NHS managers to inform the development of our research work.

Our approach to research and development is becoming increasingly central to the overall work of the Health Foundation. Evidence is now at the heart of everything we do. In 2009, we launched a new strategy for research and development that aims to ensure that it makes a significant contribution to strengthening the evidence base. It places an even stronger emphasis on research aims. This is in order to ensure that the research has a greater impact on policy and practice, and that it encompasses a broad approach of systematic reviews, original research and case studies to explore what works to improve the quality of care.

The key programmes in this area were:

- **Quest for Quality and Improved Performance (QQUIP)** – a research programme that provided a source of independent commentary and data about the quality and performance of healthcare provision
- **International Quality Improvement Exchange** – a network providing an informal opportunity for high-level leaders from eight European countries to discuss with peers how to improve the quality of healthcare

We now present the impact of our research and development work, set out under the four headings highlighted in the measurement framework (see p 98).

Our impact

BUILDING THE WILL FOR QUALITY

According to independent research undertaken in 2009, our research is well respected but not widely known among key UK audiences[46]. It is seen as:

- **relevant** because it addresses different research questions, and from different angles, from government-funded research
- **timely** because our independence allows us to respond quickly to emerging issues and to be 'fleet of foot'
- **high quality** because we work with academic leaders in the field.

The products from our commissioned research are regarded as accessible, clearly written and presented in a user-friendly way.

Response to our research:

They can commission the research that can't or won't be commissioned by government, to challenge and question central tenets of government policy – and in a timely fashion.
(Academic)

My observation is that the standard of their work is very high [...] I think they have a good reputation.
(Clinician)

They seem to commission research in areas that are important for patient care and improving quality of the NHS. From what I've seen they get very good people to do it as well.
(Academic)

I think they are an easier read than our documents.
(Decision maker, governmental national body)

Elsewhere, our research has been cited as an authoritative commentary on health quality issues[47].

The work we have funded has made a contribution to the knowledge base about how to improve the quality of care. Between 2003 and 2009, our award holders published more than 400 articles in nearly 200 different journals. More than four-fifths (81%) were published in condition-specific journals (such as the *International Journal of Colorectal Disease* or the *European Journal of Cancer*), and 19% in journals specialising in quality improvement (such as *Quality in Primary Care, Quality and Safety in Health Care*) or general medical journals (such as the *British Medical Journal*).

All our research and evaluation reports are made freely available on our website, and each has been downloaded many times. For instance, in the three months following its publication in September 2009, the report *Measuring value for money in healthcare: concepts and tools* was downloaded more than 1,800 times.

Some of our research has already had a direct influence at policy level. For example, we funded Peter Smith (formerly of the Centre for Health Economics at the University of York and now at Imperial College) to undertake economic analysis of healthcare budgeting. This work has met with interest at policy level, as the case study below illustrates.

Case study:

Analysing programme budgeting data and informing the QALY threshold

In 2007 Professor Peter Smith and his team sought to examine the extent to which the NHS in England has been:

- securing good value for money
- developing a sound technical approach to measuring the efficiency of primary care trusts (PCTs) in England
- assessing whether its spending constitutes value for money for taxpayers and the government.

This team was the first to exploit English PCT programme budgeting data in order to compare costs and clinically meaningful outcome measures. Since 2003, each PCT has prepared data on expenditure on healthcare across 23 programmes of care. These programme budgeting data seek to allocate all items of NHS expenditure to disease categories. They can be analysed to estimate the cost of saving a life year in major programmes of care. Using programme budgeting data from 2006/07, this figure is around £9,974 for circulatory disease and £15,387 for cancer.

This study had major policy implications for examining NHS performance, and has also informed debates about the level at which the National Institute for Health and Clinical Excellence (NICE) 'cost per quality-adjusted life year (QALY)' threshold should be set.

Professor Smith has worked with NICE on its estimates for the QALY threshold of £30,000 and has informed its work on new interventions. In 2007, he twice gave evidence to the Health Select Committee on NICE, demonstrating how the analysis from his team gives a far sounder basis for setting the threshold than previous approaches. The committee was impressed with the analysis and endorsed further research of this kind in order to build a robust evidence base.

Source:
The Health Foundation (2010). Commissioning health: A comparison of English primary care trusts. London: the Health Foundation

Our research programme has also been used by the Irish government's Commission on Patient Safety and Quality[48], drawing on the reports *Regulation and quality improvement* [49] and *Patient-focused interventions*[50].

Some of our evaluation designs have encouraged evaluators to develop innovative, and sometimes groundbreaking, studies. These approaches have caught the attention of others. In a recent call for proposals, the National Institute of Health Research Service Delivery and Organisation cited our approach to commissioning and managing the Engaging with Quality Initiative evaluation with RAND Europe, and the importance of an emergent approach to the evaluation design of complex interventions[51].

In 2008 the RAND team published an article in *Implementation Science* in 2008 about this experience. They wrote:

The emergent approach we developed with the Health Foundation's agreement proved not only necessary but also, we would argue, essential if, through development and evaluation, change in clinicians' attitudes to clinical engagement in quality improvement are to be identified and encouraged… This developmental approach enhanced the capacities of all involved to reflect on the [Engaging with Quality Initiative] and to seek to use evidence better in engaging clinicians and delivering improvement for patients and for the healthcare system[52].

Developing skills to improve quality

Our work stream on knowledge does not directly engage with clinicians in the same way that out other programmes do. The learning from our work is used to inform development of skills and understanding.

IDENTIFYING AND TESTING INTERVENTIONS TO IMPROVE CARE

It can sometimes take 10–15 years for methodological or conceptual research to be translated into practical approaches to improve care. However, one of our projects, described in the case study opposite, was a good example of early translation of research into practice. The programme in question was an economic modelling project that was used successfully with NHS Isle of Wight to allocate resources more efficiently.

Case study:

Economic modelling

A team at the London School of Economics (LSE) carried out substantial original methodological research[53] to develop a new approach to setting priorities for populations. This involved developing a method to provide information on the scale of likely costs and benefits of any potential change for populations. This approach has since been endorsed by NICE as the preferred method for comparative assessment of treatments.

Next, the researchers developed the model into a usable methodology for commissioners, recognising that decision making was social as well as technical and needed to include factors such as reducing inequalities, feasibility, political acceptability, and national priorities. To do this, they worked with NHS Isle of Wight, which was looking to invest £2m over two years and had no discernible or transparent process to resource allocation.

The team ran stakeholder workshops through which 21 potential strategic programmes were identified. Participants reviewed these in a one-day 'decision conference' where they built a model of the costs and value to the trust of the 21 interventions. Each intervention was scored, and all the scores weighted to ensure they were comparable. The process led to consensus on the additional interventions in which to invest.

Many of the PCT's senior management praised this project for the transparent nature of the process and the ease with which it enabled the PCT to engage a wide range of people.

The methodology demonstrates visually the nature of the choices to be made and the scale of an intervention's potential impact. However, the major benefit was seen to be the engagement in the process.

Jenifer Smith, Director of Public Health and Chief Medical Adviser, NHS Isle of Wight, explained:

You're able to show the board that what you want to invest in could get 10% more benefit in terms of health outcome than doing it another way. The board doesn't always want to do that, but it's a very good way to understand the basis on which you're making decisions. It's quite hard for all of us to weigh up the differences between treating one or two very seriously ill people with the latest technology or treating very large numbers out in the community who may not be perceived to be as acutely in need of health services. This is a means of translating that into measurable benefits of some sort.

In 2009 the PCT received an Excellence in Commissioning award at the South Central Regional Health and Social Care Awards, in recognition of the fact that this approach supports the priority-setting and stakeholder engagement competences demanded by the world class commissioning framework.

The approach is now being trialled with NHS Sheffield, and is being used by the Department of Health in its development of the new mental health strategy New Horizons.

SUSTAINING AND SPREADING IMPROVEMENT EFFORTS

We have represented the Health Foundation's research and evaluation work on the boards of the Health Services Research Network, the UK Evaluation Society and the National Quality Indicators Committee. We also hosted an inaugural meeting of government and charity research commissioners. This led to a commitment from this group to create regular opportunities to share information and research plans.

Our research and evaluation programmes have contributed to the development of ideas and methods about improving and assessing quality, and we have built positive relationships with leading scholars and practitioners involved in efforts to improve quality nationally and internationally. This has enabled us to bring them together for debates on ideas and methods about quality improvement and its assessment. Examples include a symposium at the 2008 International Forum on Safety and Quality, organised jointly by the Health Foundation with the Institute for Healthcare Improvement and Dartmouth Medical School, which was attended by 400 delegates and a follow-up session at the 2009 International Forum on Quality and Safety in Healthcare.

Conclusion

The Health Foundation is continually evolving as an organisation and now has a better understanding of the challenges inherent in improving quality than ever before. We recognise the benefits of building a stronger evidence base to underpin improvement activity. We have an important contribution to make to this process, both by investing our own resources in an extensive and robust programme of evaluation, research and development, and by encouraging others to do so. Since 2009 we have started to position research and development more centrally within our work.

In focusing on what works, the Quest for Quality and Improved Performance programme did not systematically gather information about the barriers to the uptake of effective and safe healthcare. This knowledge is crucial to aid effective implementation. In future we need to focus not only on published peer-reviewed evidence but also on understanding how evidence is used in practice.

We have also begun to grapple with the question of which aspects of our large-scale demonstration projects we can confidently promote. We have discovered that the evaluation of complex improvement projects presents continuing challenges – not least, because the best approaches to evaluation are hotly debated in the literature. However, we continue to work to ensure that new evaluations are based on a clear statement of a programme's aims, underpinning theory, delivery mechanisms and intended outcomes, to ensure that they are answering the right questions in the right ways.

At this stage, we need to determine more clearly what it is that the Health Foundation wants the world of healthcare to do differently in relation to the knowledge base that underpins efforts to improve quality. As a result, we are reviewing this strategic aim in order to identify our clarion call and the programme of activities that will be required in support of our influencing objectives.

08
The impact of our corporate influencing work

We want the UK to have a healthcare system of the highest possible quality. To do this, we work with national policy makers, professional bodies and patient organisations, in order to:

- promote our learning as widely as possible
- remain at the forefront of thinking in our sector
- work towards ensuring that quality is forged into the national health agenda.

Through this, we encourage the sustained uptake of new daily practices across the NHS.

This chapter reports on the impact of our overarching influencing activities. This work draws on the learning generated across each of the individual strategic aims, in order to influence the views and decisions of those shaping health policy at national and regional level.

Our work and impact in this area

Our key work in this area focused on influence in the following areas:

- national policy
- individual decision makers
- regulators and arms-length bodies
- key political players.

Our work in each of these areas is described below.

INFLUENCING NATIONAL POLICY

A key achievement was that we succeeded in influencing the Next Stage Review[6] led by Lord Darzi, bringing our learning to bear on the process and directly influencing the direction of policy from the moment the review was published. The final report very much goes with the grain of our thinking, as we were single minded in ensuring that quality was on the agenda.

Since its publication we have worked to influence a number of the strands of work that are being developed by the Department of Health in England. This has culminated in the appointment of our Chief Executive, Stephen Thornton, to the National Quality Board. His intervention has led to a government review of methodologies for determining and interpreting hospital standardised mortality ratios. He also succeeded in focusing the board on encouraging greater alignment between the numerous national regulatory, management and oversight bodies in the NHS in England.

Following the Darzi review, each of the strategic health authorities responded, describing their visions for improving health and healthcare over the next decade. In their responses, four strategic health authorities (the NHS North West, NHS West Midlands, NHS South West and NHS East Midlands) made reference to the Foundation's work in guiding their own plans. For example, NHS East Midlands made the commitment that it would 'follow [the Health Foundation's] approach to embed a comprehensive approach to quality and safety', and framed its vision within our four key proposals to the review.

ENGAGING WITH DECISION MAKERS

Much of our influencing work takes place under the radar, and involves engaging directly with decision makers to make our case and present the evidence generated through our own work. As a recent comment from a senior policy maker at the English Department of Health attests:

'Reports produced by the Health Foundation come to us in the Department of Health without an attendant barrage of publicity. Others' reports by contrast come with all that baggage which we officials have to waste time on damage limitation, rebutting and responding to the media. That is wasted effort. With material from the Foundation, which is always of a high quality, we can get straight down to looking at what is being said and how we can build it into our thinking.'

We know from private feedback received from senior decision makers that their work has been underpinned by what they see as 'sound thinking from the Health Foundation on quality'.

Conclusion

INFLUENCING REGULATORS AND ARMS-LENGTH BODIES

We have successfully influenced regulators and other arms-length bodies. For example, Stephen Thornton's work on the board of Monitor, the independent regulator of NHS foundation trusts, has helped strengthen its commitment to improving quality. Monitor is currently out to consultation on proposals to enhance the assessment of quality governance in trusts applying for foundation status, and sets out a 'quality governance framework' for boards. These new proposals, when adopted, will provide boards of applicant trusts with an essential toolkit to assess how well their organisations manage and understand quality.

Through his role as a commissioner of the Care Quality Commission, Martin Marshall, our Clinical Director and Director of Research and Development, has been able to influence the policies and practices and of the main health and social care regulator as it develops its regulatory methodologies. He has ensured that the Commission's work is underpinned by a commitment to improvement as well as to standards, ensured that participation in clinical audit has remained as a registration criterion, and has actively encouraged a role for clinicians in shaping regulation alongside other levers for change.

INFLUENCING KEY POLITICAL PLAYERS

Meanwhile, Stephen Thornton maintained strong links with Conservative and Liberal Democrat health spokespeople while in opposition, which is proving critical for influencing the coalition government elected in May 2010.

Over the last seven years our corporate commitment to increasing our influencing role has shown clear, positive results. We have succeeded in engaging constructively with a range of key policy makers, and findings from our work are widely cited. Our programmes and research are recognised and respected by a wide range of professional, policy bodies and government. We have successfully raised our profile, and developed a reputation for leading edge thinking and sound evidence. As we look forward to the future, we continue to review and strengthen our wider influencing role.

09
Conclusions

We are proud of what the Health Foundation has achieved. We have galvanised action and results on the ground by focusing attention on the gaps between best and current practice. Sometimes we have catalysed change at a national level.

We have a growing reputation among clinical, managerial, policy and academic communities as an independent organisation that inspires improvement. We have been successful at identifying key topics of significance and putting our weight and influence behind them. Above all, we have made a major contribution to getting quality on the management agenda of the NHS, and to making a stronger connection between practice and policy.

Our work has tapped into the intrinsic motivations of health professionals. When clinicians are invited to take a lead role in selecting the clinical area and intervention of choice, they are able to mobilise large numbers of colleagues to become involved in improving quality. We believe that the best way to convince practitioners that improvement is possible is by celebrating success and encouraging an optimistic approach to change. At the same time, we never shy away from highlighting problems with current practice – because only then will we find the solutions.

Our programmes usually have ambitious aims. In some instances those aims have not been realised, but in many others they have been met – and even surpassed. We continue to fine-tune the balance between setting stretch goals and knowing what is likely to be achievable in a given timeframe. Because we work with innovative, and often emerging, improvement programmes, sometimes it is not possible to have a clear sense at the outset of what is achievable in a given context, and specific sets of resources and methods. Nevertheless, we think it is motivating to set stretching goals.

Difficult times lie ahead for the NHS. In the coming years it will be more crucial than ever to help the NHS maintain a focus on quality of care while still reducing costs. We are committed to supporting the service in its response to the financial crisis. This will involve a mix of work, including continuing to pursue our core agenda, being more active in spreading our general learning about how to improve quality and developing further our work to directly address productivity. In highlighting the challenges facing the health service, we want to ensure that we are well placed to harness new ideas to tackle them.

We will continue to support new developments and to evaluate our work and its impact so that we learn from our experience and can use our learning and successes to help the health service move forward to a higher quality and cost effective future.

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Appendix: Measurement framework

Building the will for quality

We have established strong influencing relationships with policy and academic organisations, and have access to and are invited to contribute to key working groups and processes.

Our outputs or investments are cited in relevant health policy sources, peer-reviewed publications, conferences or the media.

Our approaches to improving the quality of care are reflected in other organisations' documentation.

Senior leaders in the service, professional bodies and patient organisations value our support.

Our investments have helped individuals to make improving the quality of care a priority in their organisations and professional bodies.

Developing skills to ensure reliable delivery of care

Individuals we have invested in have developed, and are demonstrating, leadership in line with our understanding of leadership and its relationship to improvement.

Individuals we have invested in have demonstrated competence in their use of methods to improve the quality of care.

Individuals we have invested in are recognised by their peers as exceptional leaders for improving quality.

Individuals we have invested in have used methods to embed patient perspectives in approaches to improve the quality of care.

Identifying and testing interventions to improve care

Patient outcomes and experiences have improved as a direct consequence of our investments.

Specific patient indicators relating to MaiKhanda and Co-creating Health show positive changes.

Individuals we have invested in are leading successful quality improvement activities in their organisations.

Specific safety indicators relating to our Safer Patients Initiative and Safer Clinical Systems programmes show positive change.

Areas of variable and consistent performance have been identified by award-holding organisations, and interventions have been developed and implemented to close the gap.

We have contributed to the development of ideas and methods about improving the quality of care and its assessment.

Ensuring sustainability and spread

Our approaches have spread to other areas within award sites.

Our approaches are sustained outside of our direct investment.

Other organisations and individuals have drawn upon our approaches and evidence to be used in their funding, implementation and participation in programmes of work.

Our approaches and evidence are drawn upon by healthcare organisations, professional colleges, societies and associations, to feed into training and education and development.

Individuals we have invested in are recognised as advocates, mentors and system leaders for our approaches to improving quality.

Individuals we have invested in are recognised as role models for colleagues.

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 healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.

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