An Evaluation of The Health Foundation's Engaging with Quality Initiative

Second Annual Report

Tom Ling, Bryony Soper, Martin Buxton, Stephen Hanney, Wija Oortwijn, Amanda Scoggins, Nick Steel

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Contents

1.   Preface

The Health Foundation (THF) is an independent charity that aims to improve health and the quality of healthcare for people in the UK. It has a portfolio of activities including programmes to support leaders, to promote innovation, and to research and disseminate issues of high importance relating to the UK health system. In September 2004, THF launched the Engaging with Quality Initiative (EwQI) and, in Spring 2005, appointed a consortium of RAND Europe and the Health Economics Research Group (HERG) at Brunel University to provide the evaluation of the overall initiative. This evaluation began in July 2005 and the final report from the evaluation team is due in July 2009.

The initiative is inspired by the argument that clinicians are attentive to the need to improve quality in healthcare but are often not sufficiently or appropriately engaged in this process. The Initiative has funded eight projects, run by professional bodies, each of which involves clinicians in different ways in different approaches to quality improvement. By conducting, evaluating and communicating these initiatives, THF hopes to have a significant effect on quality in the UK healthcare system as a whole. The award holders are the Royal Colleges of Nursing, Midwives, Psychiatrists, Physicians of Edinburgh, and Physicians (who are hosting two projects), and Imperial College in collaboration with the Association of Coloproctologists.

All of the projects involve clinical areas where there is a gap between available evidence of good practice and actual practice. The projects include measures to narrow this gap and the collection of data on how successful this has been. They will all include a final report evaluating outcomes and the reasons for these, in addition to their regular self-evaluation reports.

To maintain clear lines of communication, the evaluation team is also expected to produce an annual report. This second annual report has been written on behalf of the evaluation team by Tom Ling of RAND Europe, with the involvement of the whole team in the drafting process.

RAND Europe is an independent, not-for-profit policy research organisation that serves the public interest by improving policy-making and informing public debate. This report is a working report, primarily for the benefit of THF, but it might also be of interest to those in and connected to the EwQI scheme. For more information about this publication, please contact:

Tom Ling
RAND Europe
Westbrook Centre, Milton Road
Cambridge CB4 1YG
E-mail: tling@rand.org. Tel: +44 (0)1223 353329

2.   Developing context and background

What is quality improvement?

Government policy explicitly acknowledges both the variability in the quality of healthcare and the role of professionals in leading improvement.[1] Clinicians have a potential role to play in many aspects of quality improvement (QI) initiatives, such as influencing regulation and standard setting, shaping incentives, contributing to IT systems and to healthcare delivery models. However, in the quality improvement activities considered in this evaluation, we are looking at situations where clinicians do more than influence the quality improvement instrument. Rather, we are considering interventions that involve clinicians in the delivery as well as the design of the quality improvement: for example, peer review, professionally led audit and professionally led training.

Quality improvement (QI) in healthcare is (typically) an inter-disciplinary process, intended to improve the quality of health outcomes for individuals and populations by systematically closing the gap between current practice and 'accepted' evidence-based practice. Evidence for these 'accepted practices' might be found in a variety of sources, including guidelines and standards, systematic reviews of the evidence, and professional training content. In the absence of these, 'accepted practices' might be uncovered through surveys of professionals and other experts. Ways of 'closing the gap' include the use of clinical audit, training, rapid learning cycles, peer review, supporting the use of guidelines (for example, through decision support tools). Usually, more than one of these would be used in any intervention.

For the purposes of understanding this evaluation, it is important to recognise that QI may overlap with research, in that both require the systematic collection and analysis of data, but it is not same thing as research. It is 'researcherly' but QI is also an action plan embedded in a wider management process and is inherently focused on delivery. Very often, these action plans will be local and will be sensitive to very specific contexts. While lessons can be learned from them for other QI initiatives, they may not be precisely replicable because they are so context specific. This creates a very particular context for an evaluation of a QI scheme such as the EwQI. It is also relevant that this scheme is not just about eight projects *doing* quality improvement but also exploring how to do QI effectively in a variety of settings. This is the rational for the projects' on-going self-evaluations. A successful evaluation of the scheme depends in part on each of the eight projects successfully collecting and analysing evidence. These self-evaluations rely on the projects committing the necessary resources to conduct the evaluations and the necessary understanding of the wider Initiative to show how their findings contribute to an overall evaluation. The evaluation team has played an active role in supporting the projects to deliver their self-evaluations. Because the research aspects of QI are inter-locked with the action planning and management aspects, this creates a situation where the 'independent' evaluation team is also providing advice and support to the teams they are evaluating. Consequently, there is a concern that the projects will be influenced by the evaluators and that the independence of the evaluators might be compromised.

We anticipate that, throughout the UK and beyond, QI, research and evaluation will probably increasingly interact in coming years with substantial potential benefits. Evidence about the success of QI initiatives might be more systematically collected, allowing lessons to be learned and more clearly targeted. Action plans for QI could become more evidence based. Evaluations could be more informed by a deeper understanding of the contextual constraints and opportunities of different interventions or actions. However, we share a collective responsibility for supporting robust research and independent evaluation. This requires, at least in part, a commitment to quality assurance and to peer review, but it also requires transparency and a shared ethical commitment to objective analysis and reporting.

Ling, Soper, Buxton, Hanney, Oortwijn, Scoggins, Steel

The context

The wider context in which the EwQI projects are operating continues to evolve. In November 2006, the then Secretary of State for Health, Patricia Hewitt, wrote:

> *In all public services, we are making a radical shift from top-down, target driven performance management to a more bottom-up, self-improving system built around the individual needs of service users and influenced by effective engagement with the public. Increasingly, improvement will be driven by the choices made by service users and healthy competition between different service providers. The NHS and adult social care services are no exception.[2]*

The thrust of change established in the NHS Plan in 2000 and reiterated in 2004 has largely been continued.[3] The intentions (if not always the delivery) of these reforms are:

- to give patients and users a stronger voice in selecting care

- to strengthen effective commissioning to provide incentives to improve services

- to encourage a diversity of providers with more freedom to innovate.

Among other things, this has led to an expectation that NHS Trusts should ensure that they audit their medical performance, and this may help those projects involved in this initiative that include an element of audit in their intervention. In Scotland, where one of the projects operates, the context differs in terms of scale (smaller scale allows more inter-personal connections), structure and culture. In particular, the use of incentives as a lever for change is less apparent, and there is a more overtly whole-government approach to delivering improvement (meaning that there is a more overt and systematic effort to draw together different government agencies and programmes in order to secure synergies and efficiencies).[4]

Within the wider literature on quality improvement, the evidence on how to deliver improvement effectively remains unclear. Examples of successful quality improvement activities appear to have different, often very local, barriers and facilitators. The apparent richness and variety of these present a challenge both to quality improvement initiatives and to their evaluation. Many of the issues surrounding quality improvement and clinician engagement have been explored in a literature review funded by The Health Foundation, examining healthcare professionals' views on clinician engagement in quality improvement. The review by Davies and colleagues,[5] published in April 2007, broadly supports our emerging conclusions in our 2006 annual report that the *context* of quality initiatives strongly influences the attitudes of clinicians and the opportunities for successful quality improvement.

In particular, Davies and colleagues note that, in the period covered by their review (1990–2006), the literature suggests that key contextual features are:

> *the substantial and sustained organisational turbulence in the NHS; the conflict between quality assurance and quality improvement; and the sustained and largely critical attention the NHS receives from politicians and the media.*

We are not in a position to confirm or reject these suggestions, but it is at least clear that, despite these global contextual constraints, a significant number of clinicians have been actively involved in this Initiative (although levels of engagement and commitment vary). Even in times of organisational change, clinicians have retained an interest in quality improvement.

Linked pieces of work

THF has funded three other pieces of work of direct relevance to this evaluation. The first is research and analysis commissioned to assess the UK-wide picture of clinician engagement and quality improvement in healthcare. This will be conducted by RAND Europe, and the findings will provide a picture of clinician engagement and QI beyond the boundaries of the EwQI. The aim is to provide a deeper understanding of the context of EwQI and to suggest the broad shape of the counter-factual: that is, what happens to quality improvement in the absence of specific initiatives such as EwQI.

Second, THF is funding a nine-project Engaging with Quality in Primary Care scheme. This will also provide contextual understanding, although only interim findings will be available at the time of writing the final report for EwQI.

Third, THF has been conducting an analysis of its support for, and conceptualisation of, leadership in the NHS. This will provide useful background for that part of our final report that considers the role of the wider support offered to the project teams by THF to back their leadership of QI. Our aim is to create synergies across these THF initiatives.

Finalising the research protocol

Because of the complexity of delivering quality improvement and of evaluating efforts to do so, THF's original Invitation to Tender explicitly recognised the need for a period of 'emergence' in which the parameters and methodologies of the evaluation were agreed. It was anticipated that as the eight projects consolidated their approaches, and as the dimensions of the whole initiative became clearer, there would be a period in which the evaluators progressed from the plans identified in their proposal to the finalised research protocol. This process was completed in March 2006, and the evaluation protocol can be found in Appendix 1 of the 2006 annual report. This year has seen steady progress towards the aims identified in the evaluation aims and methods (provided in Appendices 1 and 2 of this report), and this progress is charted below.

3.   Our account of progress

Our emerging understanding

The rationale behind this Initiative was suggested by Leatherman and Sutherland in 2003,[6] and this insight was later underpinned by the review of the wider literature conducted on behalf of THF by Davies and colleagues in 2007.[7] This literature also demonstrated that it is easier to arrive at emerging questions than crisp conclusions, given the relative lack of empirical evidence about the best ways to engage clinicians in quality improvement. However, it identified certain contextual factors that are relevant for this evaluation:

- There is a rich picture of clinicians' perceptions, with some shared perceptions, but also considerable diversity reflecting local contexts and significant events.

- Significant contextual factors include organisational turbulence and the perceived conflict between quality assurance and quality improvement.

- Another key contextual factor is the sustained and critical attention that politicians and the media give to the NHS.

Like Davies and colleagues, we see no reason, for the purposes of this evaluation, to depart from the Institute of Medicine (IOM) definition of quality as:

> *The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[8]*

The dimensions of a quality service certainly include the aspects, defined by IOM, that care should be safe, effective, patient-centred, timely, efficient and equitable.

Emerging findings

Emerging findings from our evaluation of EwQI also suggest that relevant contextual factors, in addition to those identified by Davies and colleagues, include the following:

- Many clinicians generally perceive quality improvement to be a relatively low-status activity with poor rewards, even though most clinicians in EwQI projects seem to be engaged, and some with considerable energy.

- Given the enthusiasm for, and commitment to, the projects shown by some clinicians, clinicians may be more likely to engage with the sort of concrete quality improvements found in the EwQI scheme, and be less likely to engage in more general approaches that are several stages removed from the patient; however, this is only a provisional observation.

- There is some uncertainty about what 'quality improvement' involves (as opposed to, say, clinical audit, research and peer review) and how to harness the capacity of NHS organisations to deliver this. For some projects, 'quality' meant 'clinical effectiveness', and it has taken time for the other dimensions of quality (safety, patient-centeredness, timeliness, efficiency and equity) to be considered.[9]

- Delivering QI can, in practice, also be disrupted by a variety of local factors such as change of staff, weaknesses in project management, difficulties in knowing what to measure, and problems of leadership.

- Existing clinical quality measurement systems, where they exist, are often unstable and under-funded (although in clinical audit, decisions by the Healthcare Commission to require audit may support the creation of more stable systems).

- Clinicians' willingness to implement improvements in individual performance is more developed than their willingness to focus on system-wide improvement. This might mean that if clinician engagement were the sole driver of quality improvement, some important system-wide opportunities would be missed.

- It is our understanding that THF should be prepared for at least some of the projects to fail to deliver all that they set out to achieve. Indeed, some have faced unanticipated barriers that may significantly limit their achievements. This is almost inevitable in the challenging world of quality improvement in healthcare, and given the innovative approach adopted by this Initiative. However, in all cases, there are important lessons to be learned, and every project will contribute in significant ways to the conclusions and recommendations in our final report, providing they produce complete, final self-evaluations.

Although these findings are not at a stage where they can count as firm conclusions, and should not be quoted as such, they suggest a 'direction of travel' in this evaluation.

Working with the projects

Working with the projects in a structured way remains a key task for the evaluation team. Our aim has been to support the projects in building the capacity to successfully complete their self-evaluations and contribute to the reflective processes of the Initiative as a whole. This aspect of our work continues to absorb more resources than was anticipated in our original proposal. This work has been as necessary this year as last year; although there has been a deepening of understanding in and across the projects, the evaluation tasks that they face have become greater as the projects generate more data and their interventions mature. Additionally, three project teams had a change of management, and the gains in understanding of evaluation made in the first year were not communicated to the incoming team in two cases, and only communicated with some delay in the third. These three teams have all since made impressive progress in addressing the evaluation aspects of their projects. Our main means of communication with the projects has been through face-to-face meetings, but we have also made presentations at away days, attended events linked to the Initiative, and responded by phone and email to various enquiries. During the year, we have had two rounds of face-to-face meetings linked to the progress reports the projects are required to make to THF. This has been time consuming but rewarding for us as evaluators and, we anticipate, there will be benefits in the improved quality of the final self-evaluations. Across the board, the challenge for the projects has been to move beyond a narrow model of clinical improvement towards a model of quality improvement that embraces and develops beneficial interactions between healthcare professionals and service users. Some project teams have found this easier than others.

Self-evaluation reports

Self-evaluation reports will be at the heart of the data used in our evaluation. We reported on these in July 2006 and, at the time of writing, we have yet to receive all the updated versions due to THF in May. This has prevented us from compiling an overview in time for this report, but we have discussed progress at length with individual project teams. In the first year, all bar one of the projects followed the THF/evaluation team questions, and most tailored their submissions to match the numbering of each question. Nevertheless, the format of the submissions varied, with some providing narratives and others bullet points.

The advantage of greater consistency of reporting is that the evaluation team can compare and contrast more easily. The disadvantage is that issues that the projects believe to be important or exciting can be lost. Failure to detail these would be a loss to the projects, to the evaluation team and to stakeholders more widely. Consequently, in our work with the projects during the year, we have stressed the benefits of completing a set of responses to the nine evaluation questions and to a pro forma that encourages consistency but also invites them to identify issues and actions that they believe are particularly relevant, important or interesting. Reporting in these two different ways will produce material that can be systematically compared and will also identify issues of importance to the individual projects. The self-evaluation pro forma can be found in Appendix 1.

Logic models

We have also encouraged project teams to revisit their logic models[10] as part of updating the state of their interventions or QI activities. Logic models mapped the background to each project alongside the inputs, outputs and expected outcomes. At the start of EwQI, logic models enjoyed a mixed, but broadly positive, endorsement from the project teams as a tool for clarifying the purpose and processes of their proposed work. There has been less appetite among the projects to return to these as a vehicle for updating and reviewing progress as part of their self-evaluation. We have considered this and believe that this reflects the fact that logic models appear to give equal weight to all the links connecting inputs to intended outcomes. However, evaluations usually prefer to choose key issues to focus on, leaving some causal links unexplored because they are relatively straightforward to carry out and analytically simple to explain. Our sense is that logic models should be used to identify key evaluation questions, which should then be the focus of attention (but with periodic reviews to consider if the rest of the logic model is progressing as anticipated). We have recommended that project teams keep project diaries where they post their understanding of key issues, and barriers and how these were addressed. This will be a helpful, collective aide-memoir when the final self-evaluations come to be written.

Ethics

Meetings with the project teams revealed wide differences in their approach to formal ethics approval. Some teams were clear that they were undertaking research and therefore required ethics approval for their study in the usual way; others were equally clear that what they were doing was audit, which did not need formal approval. A third group felt that some (research) aspects of their project would need approval; other (audit) aspects did not. These differences, and associated concerns in some project teams and in the evaluation team that significant delay in securing ethics approval might delay data collection – and so compromise the final evaluation– seemed good reason to consider this issue in more detail. We conducted some research and discovered an ongoing re-organisation of the role of Local Research Ethics Committees (LRECs) and an associated debate about the scope of their activities. The Central Office for Research Ethics Committees (COREC) had made a helpful distinction between audit, service evaluation and research, and was clear that LREC activity only applied to the latter. But the position of quality improvement projects in which there is a mix of activities was less clear. We therefore worked with COREC and with some of the project teams to facilitate a smoother application process for the applicants. In the process, we have also been able to contribute to the national debate on how best to ensure the ethical integrity of quality improvement projects in the UK.

User involvement

During the course of our work with the projects, it has become clear that there are different approaches taken to service user involvement: the projects vary according to how users are included in governance, delivery and learning. In some projects, user involvement is more extensive than in others. In our one-to-one meeting with the project teams, we have explored this aspect and have followed this up with meetings with service users' representatives to gain insight about why they participate and how this might be facilitated. This work is continuing, but two key findings have already emerged:

- The importance of project teams thinking about user involvement early, even before they design the project, and involving users from the start

- The need to provide effective support for users to enable them to understand the project and its intended result, and to be fully engaged throughout: for example, in the design of the study, in developing training programmes and outcome measures, and in evaluating emerging findings.

With both user and clinician engagement, it is likely that the 'softer', more cultural factors are important. For example, being approached by a senior clinician may encourage engagement, but being routinely contacted and informed by a QI team member may also be effective. Similarly, users may either feel involved and engaged or marginalised and patronised. To fully explore these motivational and cultural aspects would involve a level of qualitative research that is beyond the scope of this evaluation but, in relation to the involvement of participating clinicians, we are delighted that two of the projects are making plans to provide such an additional piece of research. We have liaised directly with the researchers involved to better understand what they hope to achieve and also to find practicable ways of linking their research to our evaluation. We will also explore clinicians' motivations across the scheme as a whole through our proposed modified Delphi survey.[11]

Clinician involvement

Planning for the Delphi survey, which is targeted at clinicians involved in EwQI, is well-developed and a draft has been prepared. The Delphi survey will identify:

- how clinicians can be best engaged in quality improvements initiatives

- what impact this is thought to have on clinical outcomes

- how this work best interfaces with the engagement of patients, other professionals and health services managers to leverage external commitment to clinical leadership of QI.

It will be implemented in this next reporting year (July 2007–July 2008). It has not been possible to find a single date suitable for all the projects because of their different stages of development in the Initiative. However, a staggered Delphi survey does not present any overwhelming methodological problems (only some practical ones). We have communicated to the projects our need to have access to 'their' clinicians, and they will ensure this is possible.

Emerging findings suggest that we might be able to distinguish between the platform for quality improvement, the facilitators of it, and the incentives for it (although this is still a developing conceptualisation). The platform for quality improvement provides the essential organisational and informational capacities, and includes:

- performance information (such as clinical audit) that is accurate, trusted and relevant

- an appropriate QI model and a project management plan that is achievable and adequately resourced

- an adequate communications system

- an ability to draw on the wider capacities of the health system (for example, the Royal Colleges, NICE guidelines and the Healthcare Commission).

The drivers of facilitation include trusted 'champions', leadership dispersed through the QI initiative, teams that can function well together, and a curiosity to find out what works and to learn from others.

The incentives for clinicians include:

- unequivocal evidence that patients will benefit

- the expectation that any disruption caused by QI will be balanced by improvements in a reasonably short timescale

- the expectation that their professional status will not be weakened.

We are less clear about the incentives for managers, but intuitively this is likely to concern cost-benefit evidence and the delivery of key targets.

In practice, platforms depend on a variety of factors, including an astute awareness of the organisational capacity available, sound project management plans and project managers, good-quality data and a clear communications plan. Only then would it be possible to assess the success or otherwise of facilitators. For some of the projects, we may not be able to assess the quality of the facilitators because the projects have failed to adequately develop the platform for quality improvement. Others appear to be more successful in this respect. We have seen examples of successful 'champions', of leadership that has made a difference, of teams that have come together in the face of significant challenges, and of curiosity about how best to improve. We have yet to collect evidence on what clinicians claim will incentivise their engagement with QI. What is clear is that THF's EwQI has facilitated a significant level of interest and commitment from many clinicians who have actively engaged in the EwQI projects.

The counter-factual

The counter-factual – that is, what happens to quality improvement in the absence of specific initiatives such as EwQI – remains an important issue for this evaluation. The projects were asked to consider the context of quality improvement at the outset in the particular area in which they are operating. At the start of this reporting year (July 2006–July 2007), we completed and wrote up the outcome of a series of interviews with 17 key informants, including clinicians, project managers and researchers. This information can be found in Appendix 2. This work helped to establish the context for EwQI and provides a sense of what might have happened in its absence (for example, guidelines would have continued to be developed; some areas would have conducted clinical audits; some Royal Colleges would have developed their research and quality improvement capacity). In the next 18 months, we will be supporting the projects' own surveys with clinicians, which will include their understanding of what they believe would have happened to QI in their areas in the absence of THF funding. Depending on the clarity of these responses, we will also consider

looking at what has happened to QI among the well-rated, but ultimately unsuccessful in securing EwQI funding, project teams. In either case, we will necessarily rely on the interpretations of those in the health system concerned with delivering QI, rather than on a more objective counter-factual because, in our view, such 'objectivity' would be spurious. In the next year, we will continue to develop our approach to the counter-factual.

An additional opportunity has arisen in a separate THF-funded initiative. THF has funded a survey of clinicians across the UK that will explore these questions. Ideally, this would enable analysis between clinicians in different fields at national and local levels, and between clinicians in different institutions. As far as is practical, we will seek to compare these findings with EwQI clinicians (while recognising that this is a self-selecting group and limiting any claims accordingly).

Two of the projects are also undertaking or commissioning additional qualitative research into their activities. While these will not formally be a part of the evaluation, they will provide a more detailed picture of why clinicians chose to engage in these projects and with what consequences. This will add depth to our understanding of what might have happened in the absence of the EwQI.

The role of the Royal Colleges

Appendix 2, among other things, considers the role of the Royal Colleges in quality improvement. This issue was more systematically investigated in a report for THF during this reporting year by Jocelyn Cornwell and Diana Jakubowska. This provides a valuable benchmark against which to gauge the significance of our findings on this issue. We anticipate that the two qualitative studies mentioned above – coupled with responses to the Delphi survey and the projects' own self-evaluations – will provide rich data on this. We also conducted an interview with the head of a research and training unit from one of the Royal Colleges in order to gain an understanding of the opportunities Royal Colleges have to enhance the analytical capacity of the health system to support quality improvement. In addition, we attended meetings of the central and regional quality improvement networks at another College to explore how they currently operate.

Contribution to EwQPC

The evaluation team provided support for THF's Engaging with Quality in Primary Care (EwQPC) scheme. Drawing on our experience of working on EwQI, we supported the drawing up of the Invitation to Tender, the shortlist and the selection process. As we are now also evaluating this initiative, there were benefits for us in preparing for this second evaluation. Our involvement has also increased our understanding of the particular nature of QI in the acute sector.

THF support for self-evaluations

Our evaluation work has been facilitated by THF's more systematic interactions with the projects during the course of this reporting year. Since THF has clarified the need to deliver self-evaluations to THF as part of the projects' contractual responsibility, it has been easier to interact positively with the projects.

Our interactions with THF have been facilitated by a more systematic and regular sequence of monthly telephone meetings and six-monthly face-to-face meetings. There have also

been many communications on specific issues or more general interactions around the fringes of the Initiative. This has been helpful to ensure clear management and a fruitful exchange of ideas and knowledge.

THF has embarked on an innovative way of funding QI. Funding the delivery and evaluation of QI is, in our view, at least as risky as funding research (where there can be more certainty about the processes to be followed, if not the findings). Furthermore, we know that QI activities have variable outcomes, with context playing an important role. It should therefore be anticipated that the eight projects will deliver with varying degrees of success, and THF should be prepared for this. From an evaluation point of view, such variations would only be a problem if the projects failed to complete their final self-evaluation (and there is no reason why this should happen). However, in our opinion, it is likely that some of the projects will not deliver all the quality improvements they anticipated at the start. We are just as interested in the reasons for this as in the reasons for success, and we do not regard this variation in outcomes as an indication of a failure in the design of the Initiative as a whole.

Draft of final report structure

The evaluation team now has a draft outline of the shape of the final report and is close to agreeing this in the team and with THF. In the next year, we will start to flesh this out with our findings. The date of the final report will have to be agreed with THF, but we jointly share the problem that a number of the projects are likely to complete their work late. This staggered finish means that we need to agree the balance between completeness and timeliness.

The evaluation team and the project teams

As an evaluation team, we have continued to be treated with great courtesy by the project teams. Clearly, there was room for conflict between our need for data – as well as our expectations of the self-evaluation of the projects – and the understandable primary commitment of many on the project teams to immediately benefiting patients. However, far from becoming conflictual, this relationship has been very constructive and supportive in our eyes and, we hope, in the eyes of the project team members.

4 Summary of activities and progress against research protocol

Summary of our activities

- Continued development of project teams' understanding of, and progress towards, a successful self-evaluation.

- Support to project teams for their completion of annual self-evaluation reports.

- Supporting the projects' use of a shared template for end-of-project self-evaluation and defining the objectives of the projects' self-evaluations.

- Developing project teams' understanding of the counter-factual through ongoing support and by writing up results of a qualitative study of current unrelated quality improvement initiatives affecting the projects.

- Presentations and workshops to residential events.

- Two rounds of meetings with all eight project teams on self-evaluation.

- Meetings with lead researchers conducting qualitative research on EwQI projects.

- Applied learning from EwQI to the tendering and selection process for the Engaging with Quality in Primary Care scheme.

- Development of a draft final report structure.

- Improved liaison with THF.

Progress against research protocol

It had been anticipated that the first year of this evaluation would involve close working with the projects to ensure that appropriate data collection and analytical tools were in place across the EwQI. This is a necessary precondition for the successful evaluation of the whole initiative. Broadly, this requirement to work closely with the projects has continued in this second year, which therefore absorbed more of our team's resources than originally anticipated. However, Aims 1–3 listed on the following pages are developing, as project teams – with variable degrees of success – rise to the challenge. (The six evaluation aims and method are reproduced in Appendix 3.) However, the continuing strain this puts on the budget, identified in last year's annual report, should be noted.

As is now clear, progress by the projects has varied, and some projects are slipping behind schedule and will most probably over-run. This has been (and may continue to be) another strain on the budget as we work with THF to attempt to minimise these delays. We will need to adapt the timing of the final report in close discussion with THF, which adds to the difficulties of managing this evaluation. We do not anticipate that any delays in compiling the final report will be caused by the evaluation team, but it is crucial that each project team fully completes its self-evaluation at the end of the project.

Initiative aims

Aim 1:   To work with award holders in developing and implementing their evaluation plans

We have continued to work closely with project teams on this. All have made some progress, but some have made more than others. Given the starting point, we are satisfied that we have contributed significantly in this area and that all project teams will produce at least a minimum of data for their final reports. We have made available, and supported the use of, self-evaluation pro formas, project diaries and key-learning-point reporting forms. THF will need to ensure that if project managers leave teams before the substantive work is completed (but on the dates they were originally contracted for), an alternative mechanism should be put in place to ensure that the report writing is completed.

Aim 2:   To synthesise the data and findings from project-level evaluations

It is now clear that broad questions will need to be answered to compare and contrast the projects. These will include:

- What engages clinicians in QI and with what consequences?
- What role does user involvement play in clinician engagement and in QI more broadly?
- What role have the Royal Colleges and professional bodies played in QI, and what potential have they for doing more in the future?
- What mechanisms (for example, audit, peer review, training) have been successful and in what circumstances?
- More generally, what has been the role of incentives, information and capacity in facilitating/inhibiting quality improvement?

We are satisfied that there will be a great deal to say about all of these. However, THF should not anticipate that much of the data coming out of the projects can be aggregated. In other words, data on clinician engagement would need to take account of so many project-specific factors that it would be unwise to impose a homogenous set of conclusions on such heterogeneous data. This was anticipated in the original Invitation to Tender for EwQI, which recognised the need to focus on context as well as on mechanism. However, complex though this may be, we also believe that there is some kind of narrative story emerging, as suggested in the previous section.

Aim 3:   To gauge increases in clinical engagement in clinical quality improvement, and assess the consequences

We have completed some preliminary work on the context of clinical engagement at the start of the initiative, and we will add this to the project self-evaluations. We have made support available to the projects on how to conduct their own surveys on this. Two of the projects will add more qualitative detail to this through their proposed additional research, and we will treat this as additional case-study material (duly acknowledged) in the final report. We are encouraging project teams to survey their own clinicians and have provided them with key common questions to be included in their survey. THF is also funding additional survey work on clinician engagement across the UK, and this will provide useful background against which to assess clinician engagement with EwQI. The instrument for this latter assessment will be a web-based Delphi survey, and we are finalising the structure for this at the time of

writing. This will necessarily be staggered across the projects as they approach different completion dates. We hope to write up the findings of the Delphi survey as a separate publication. Within this aim, we will complete the interim evaluation of the support team presented to THF last year, with the aim of learning lessons about what support is needed for effective engagement by clinicians in quality improvement, and the extent to which the support offered through EwQI was appropriate, effective and efficient.

Aim 4: To measure the effectiveness of the award scheme (during its life) in leveraging external commitment to quality improvement

This will be an important aim of our work in the next year. It will build on insights from the Delphi survey and from the projects' emerging self-evaluation, but will focus on the leveraging of external commitment in relation to, for example, standard setting, the development of quality measures, data collection and analysis, peer review, and the evidence-based design of improvement strategies.[12] This will be followed by a workshop identifying barriers, facilitators, processes and illustrations of externally supported, clinically led quality improvement. We will also encourage the projects to collect vignettes and illustrations to add weight and vitality to their final reports.

Aim 5: To evaluate the increase in competency and infrastructure for quality improvement in the professional bodies involved in the EwQI

To achieve this aim, we will include questions in the project surveys (under Aim 3) that identify how professional bodies have supported quality improvement. This will be supported by in-depth interviews with each of the relevant professional bodies. These will focus on their contribution to the quality agenda, including standard setting, the development of quality measures, data collection and analysis, peer review and quality interventions. This work is due to be completed in the next year.

Aim 6: To assess the influence and cost consequences of the Initiative

Before the end of the evaluation, we will assess the likely legacy of the projects through an appraisal of the suitability, feasibility, sustainability and acceptability of the legacy plans, and through a wider assessment of their impact on the environment of quality improvement. This will lead to a summative assessment of the overall cost of the Initiative and its consequences. This will necessarily include our interpretation and assessment of the projects' self-evaluations. We will invite feedback from the projects for factual accuracy, but we will reach our own conclusions about their interpretations.

Ling, Soper, Buxton, Hanney, Oortwijn, Scoggins, Steel

Appendix 1: Self-evaluation pro forma

EwQI Self-evaluation Diary

Q1. Background	Date	Author	Entry
• Why was this project needed?			o
• Who are the intended users of the results of the project?			o
• What is the communication strategy with people/groups listed above?			
• Why did you think that your approach would be effective?			o
• Did you consider other approaches? If so, why were these rejected?			o
• What was the project team's understanding of the self-evaluation and its purpose: eg, what questions have we tried to answer through self-assessment?			o
Q2a. Development and implementation of improvement interventions	**Date**	**Author**	**Entry**
• Description of improvement intervention and target audience: • Who developed it and when/how/by whom was it implemented? • What factors facilitated/hindered its implementation?			o
• Description of improvement intervention and target audience: • Who developed it and when/how/by whom was it implemented? • What factors facilitated/hindered its implementation?			o
• How were the interventions evaluated? • What performance measures/quality standards were used and who developed them?			o

Q2b. Data collection, analysis and feedback	Date	Author	Entry
• What data were collected to support the project and how were collections organised?			o
• How were data validated?			o
• How and by whom were collection processes developed and evaluated?			o
• How were data analysed and fed back to units?			o
• How was the data used and by whom?			o
Q2c. Involvement of clinicians	**Date**	**Author**	**Entry**
• How were clinicians involved in processes described in 2a and 2b? • What were their roles and responsibilities? • What were their self-perceived roles in QI?			o
Q2d. Involvement of other group	**Date**	**Author**	**Entry**
• How were service users involved in processes described in 2a and 2b? • What were their roles and responsibilities? • What were their self-perceived roles in QI?			o
• Were any other groups involved: eg, healthcare managers? If so, what were their roles?			o
Q3. Outputs	**Date**	**Author**	**Entry**
• Which parts of the project were implemented as planned? • Were they implemented to time? • What factors facilitated and hindered these parts?			o
• Which parts weren't fully realised? • What factors hindered achievement of these parts?			o
• How did recipients of the project perceive it?			o

Ling, Soper, Buxton, Hanney, Oortwijn, Scoggins, Steel

Q4. Who did what?	Date	Author	Entry
• Who was involved in designing, implementing and evaluating the project? • What was their contribution?			o
• What was the role of your professional body and was it actively supportive?			o
• List the skills and expertise needed to design, implement and evaluate the project. • Was the range of skills available in-house appropriate and comprehensive? If not, what were the identifiable gaps and could you fill them with external support?			o
• Identify sources of external support and describe how these were used with comment on their value to the self-evaluation.			o
Q5. Outcomes – what did these activities achieve in terms of the following improvements and how was change in each area measured?	Date	Author	Entry
• Measurable improvements in patient care.			o
• Increase in the levels of professional engagement in QI.			o
• Increase in the capacity and infrastructure for QI in the professional bodies involved in the project.			o
• Increase in the knowledge base			o
• Sustainable arrangements for improving quality of care in this field of medicine.			o
• A transferable system of quality improvement to other areas of medicine.			o
• An increase in knowledge and understanding of quality improvement in healthcare.			o
• Describe any unintended outcomes.			o

Q6. What difference did the project make?	Date	Author	Entry
• How much difference did the project make in the context of all this other work?			o

Q7. What are the cost consequences of the project?	Date	Author	Entry
• Without attempting to provide a monetary value to the outcomes of the project, how much did the project cost in real terms and with what benefits?			o
• Could this have been achieved more easily in other ways?			o

Q8. Why did the project work?	Date	Author	Entry
• What factors helped or hindered?			o
• What were the key ways of bringing about change (eg, repeat audit, training, information provision) and how well did these work?			o
• Could the project be seen to have worked for some people but not for others?			o

Q9. Sustainability	Date	Author	Entry
• What arrangements are in place to ensure the sustainability of the project's work? • Whose responsibility are these arrangements and how robust are they?			o
• How will wider changes in the healthcare system support or undermine the improvement processes identified by the project?			o
• How might the result of the project 'fit' with wider changes (eg, in the professions, funding, training, organisational context)?			o
• In retrospect, how would you have modified your project in the light of this self-assessment?			o

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Appendix 2: Understanding the state of quality improvement when the EQ projects began – a qualitatively informed account

August 2006

Introduction

In order better to understand the state of play in quality improvement in each of the areas of health care covered by the eight projects in The Health Foundation's Engaging with Quality Initiative (EwQI) initiative, we conducted a series of interviews with seventeen key informants, including clinicians, project managers, and researchers. These interviews were timed to take place after the eight projects had begun so we could gauge the state of quality improvement before the projects had the opportunity to make a significant impact. The interviews took place in locations across the UK between May and July, 2006. Interviewees were selected in consultation with the project co-ordinators. Each interviewee understood their respective Engaging with Quality Project, and the issues around clinical improvement in their clinical area. Interviewees were asked specifically about this context (and not about the state of QI more generally). Interviews lasted between one hour and two and a half hours allowing time for an in-depth discussion. Notes were taken during the interview and written up immediately afterwards. Interviewees were told that their personal views would not be communicated and we have therefore aggregated their comments in this briefing paper. We may use their specific contributions (with permission) in the final evaluation.

The findings from the interviews were combined with information collected from the applicants' proposals, to develop a view of what factors were delivering quality improvements, where the barriers were, and what role the relevant Royal College or professional associations were playing in quality improvement. We also asked interviewees about the role of activities at the local, national and international level, and the role of patients and patient groups in quality improvement.

These interviewees have provided the evaluation team with a valuable source of information about the problems which the projects hope to overcome, and the strengths in Quality Improvement (QI) they hope to capitalise on. This will help to orient the evaluation of each project. However, it should be emphasised that this is a small sample and it is not suggested that the interviewees are necessarily representative or typical of each clinical area as a whole. However, given their participation in their respective EwQ project, and that in each case they were recommended to us by their project co-ordinator, their views are informed and respected. In addition, the views put forward in the project proposals have all gone through a process of internal peer review and external challenge.

What has facilitated recent improvements in the quality of health care in the areas covered by the projects?

There is near unanimity among the interviewees that developing good guidelines has been crucial to improving quality in health care in the UK in recent years. More specifically, it is felt that guidelines that are supported by a strong-evidence base that is compelling to the profession will carry more weight. Conversely, where significant doubts have been raised about the most appropriate treatment or care package, then the guidelines will have less impact.

Beyond this important point of agreement, interviewees perceived there to be considerable divergence in the areas of quality improvement addressed by their projects. Over half believe that local initiatives are also important. Most of these focussed on improved local activities to support the implementation of national guidelines. One was a local initiative designed to pioneer new ways of providing improved care for patients combining local experimentation and evaluation with efforts to disseminate local experiences to other settings. These represent two very different models of quality improvement.

Over half also identify 'changes in practice' as being an important source of quality improvement. These include a range of new ways of delivering services (for example, specialist clinics, early discharge, the adoption of new care pathways). Only two emphasised improvements deriving from medical science[13] (improved drugs and improved surgical techniques). Within this category no two interviewees identified the same change in practice as leading to improved outcomes for patients.

In three of the project areas, continuing education and training had been seen to contribute to quality improvements. Another three identified changes in policy as leading to improvement (for example, GP contracts). Changing attitudes among professionals was seen to have led to improvement in one case but, as we see below, the failure to change entrenched attitudes was more typically seen to be a barrier to improvement. Similarly, although in three areas there were reports of improved inter-disciplinary discussion and working, in at least three other areas it was suggested that poor inter-disciplinary working remained a barrier to quality improvement.

In the wider context of quality improvement, it is also worth highlighting things that were rarely mentioned or not at all. First, despite the hypothesis that Royal Colleges were important to improving quality in only one interview was the information volunteered that Royal Colleges had been important in raising standards. However, as we shall see, it was anticipated that they could make specific and important contributions in the future. Secondly, the Healthcare Commission was not identified in any interview as a source of quality improvement. This may be because it is a relatively recent part of the health service institutional architecture, but given that a key purpose that it claims for itself is to 'improve' this absence is note-worthy. Thirdly, under the general question of recent improvements, conferences and international contacts were not directly referred to at all and indirectly referred to only once (we specifically asked questions about this later in the interview – see below). Information technology was not mentioned as a factor leading to improved health care.

What have been the barriers to delivering quality improvement?

The barriers most frequently mentioned to us concerned, firstly, professional attitudes, secondly inadequate infrastructure, and thirdly training and skills issues. In addition there were more specific barriers relating to funding, limited staff time, IT systems and audit related limitations (delay, participation rates and spurious findings). The overall picture is therefore one of complex and variable barriers with no indication that there is a single cluster of barriers which are holding back quality improvement across the eight clinical areas examined.

'Professional attitudes' cover a range of distinct issues. The issues mentioned include a tolerance for variations in practice (including variations from guidelines). Some clinicians, for example, felt that they had sufficient expertise in techniques that were not recommended, and that in their hands, patient outcomes were better if they used the technique they were skilled in rather than the recommended approach. Others reported (genuinely held) differences of opinion between different professional groups (for example epileptologists and neurologists, midwives and obstetricians, anaesthetists and surgeons) making concerted

action to improve quality that is difficult to achieve. Still others reported professional attitudes that were defensive and tolerated entrenched bad practice with apparently scant regard for better patient outcomes.

Inadequate infrastructure was generally not about insufficient resources (although pressures on staff time will be mentioned below). More commonly this was identified in relation to the complexity of the service. For example, where a patient might gain access to health care through a variety of routes or where tracking patients through their care pathway might be difficult to deliver, it was felt that ensuring consistency of care would be compromised. Specifically, for example, patients with community acquired pneumonia might be treated in a variety of settings. Similarly, self-harming patients might present themselves in a variety of ways to the health service and their subsequent routes through the system might be difficult to track. For these two groups, in particular, ensuring consistent care that followed best practice could be challenging. A related, but distinct, infrastructural problem concerns facilitating multi-disciplinary collaboration. Multi-disciplinary collaboration was mentioned both as supporting quality improvement (where it happens) and as a barrier to improvement (where it does not). It might have been expected that interviewees would have seen improved IT as a means to address multidisciplinary working but only one interviewee specifically mentioned IT systems as a barrier. Three interviewees mentioned inadequate funding as a barrier.

Thirdly, training issues were mentioned as being especially important in two areas. In both cases these related specifically to improved training for nurses. Training was said to be less important for other medical professionals. Nurses were also specifically mentioned in relation to staff shortages where the time needed to plan and deliver quality improvement could be squeezed out by the need to deliver pressing and immediate outputs.

The role of the Royal Colleges and Professional Bodies

One hypothesis behind the Engaging with Quality Initiative is that Royal Colleges can and should play a more central role in improving quality. With some exceptions, Royal Colleges were seen by interviewees (when explicitly asked) to be very supportive (however, the interviewees were members of, or closely linked to, the Royal Colleges). This finding should be balanced against the fact that only one interviewee volunteered Royal Colleges as a facilitator of quality improvement in response to Question 1 (see interview protocol). This support made available by Royal Colleges appeared to be more in creating a positive attitude towards quality improvement than in specific programmes and activities run by the College. For example, they can lend their authority to initiatives and so encourage acceptance and take-up. They were seen to give credibility to professionals wishing to engage with quality improvement. Their role in continuing education and practice was mentioned in only one case and in another case their influence was seen to be 'very limited'. However, in one case, their research and quality improvement initiatives were believed to be central to quality improvements in that area and this suggests a more positive and 'hands-on' role for Royal Colleges may be possible.

Local, national and international activities

International activities were seen to be important or very important in half the areas looked at, but less important compared with local and national activities. In general international activities such as conferences and visits were seen to contribute to the evidence base around effective practice. In one case, the internet (through an international chat room) was seen to be a highly effective way of raising awareness of potential risks associated with rare treatments.

However, interviewees indicated that the main source of quality improvement was from national and local activities. National activities concerned the generation of hard evidence and guidelines, on the one hand, and a supportive environment for change, on the other. Two separate local activities could be distinguished. The first was a bundle of measures to ensure the implementation of national guidelines at the local level (clinical audit, steps to ensure hand washing etc.). The second, less common, concerned local activities to develop new practices, measure their impact, and communicate the results. A strong claim was made on behalf of this latter approach and it would be interesting to explore this as the evaluation of the EwQ initiative unfolds. However, in at least six of the eight areas, the concern was more about variation in local practice as a source of poor practice, rather than variation as a source of experimentation and innovation.

Patient involvement

Patient involvement in a range of activities was regarded positively across most of the areas discussed. 'Collective' representation (through patient advocacy groups etc.) was seen as being appropriate and important, for example in guideline development. Local engagement was seen to be very variable and more limited. An empowered patient, armed with full information about the care package they should expect, was seen to be a potential driver of quality improvement in the future in around half the areas. However, this potential was seen as largely untapped.

Conclusions

From this limited number of in-depth interviews with people aware of and connected to EwQ activities there are a number of conclusions that can be drawn. First, national guidelines are indeed an important basis for quality improvement. These need to be supported by a strong evidence-base and well-communicated to be effective. While this may be necessary, it is not solely sufficient to bring about quality improvements. Supports are needed at national and local levels. Royal Colleges can play (at the very least) a supportive role in delivering this but professional attitudes and inappropriate infrastructure also need to be addressed. Staff time is not the only factor but, especially for nurses, quality improvement is a process that requires time and resources to be explicitly allocated. Patient representatives could be integrated in quality improvement and individual patients are a largely untapped resource in driving forward improvement.

Interviews to identify the state of affairs in quality improvement in the environment of each EwQI project.

Rationale:

Aim 3 of the Research Protocol is to assess increases in clinical engagement in quality improvement achieved by the Initiative. To this end we need to understand the circumstances and consequences of clinical engagement at the start of each project. We will therefore collect documentary evidence. Following this we will conduct interviews with project team members and key informants, who will be identified following advice from the projects. Through these interviews we will explore the state of affairs in the quality improvement context of each project before it has had a chance to influence that setting. This will include exploring the influence of factors such as organisational culture, team building, team support, organisational support, patient involvement, professional body involvement, and so forth, on clinical engagement in quality improvement. We envisage interviewing some two to three people with an understanding of the context of each project. Typically these should be selected from clinicians, Royal Colleges and patient groups but might also include expert academics working in this area.

Interview Protocol

- Explain purpose of the evaluation and the context of this interview.
- Explain that notes will be taken during the interview, anonymised, kept for the duration of the project, and then destroyed. We will say who we met during the research but we will not attribute any views to individual interviewees.

1. In your area of practice, what have been the most important improvements in quality in recent years and how did they come about?

2. What barriers are there/How important is your Royal College in supporting this?

3. How important are more local factors such as activities at the hospital level?

4. How important are national activities (be clear about whether this is UK/England/Scotland)?

5. And how important are international activities?

6. How do patients get involved in quality improvement and with what consequences?

7. How do you expect the project to engage with these activities?

8. Are there any other issues?

Explain what will happen next in the project. Thank you very much.

Appendix 3: Key evaluation aims and methods

Summary of key aims and methods

Aim 1 To work with award holders in developing and implementing their evaluation plans by:

- *Supporting projects to collect reliable and valid data and to identify mechanisms, contexts and outcomes, including overall costs and key measures of effect (including the presentation of a counter-factual)*

- *Helping projects to overcome the practical and methodological difficulties associated with measuring outcomes, including clinical data, non-clinical measurable improvements users' views and process improvements[14] as agreed with THF and projects*

Aim 2 To synthesise the data and findings from project level evaluations by:

- *Supporting the projects to identify and analyse the evidence base for the impact of their inputs and processes on outputs and outcomes in a form that can be aggregated, where possible, at Initiative level*

- *From Initiative-wide data, analysing which improvement interventions, associated with which contexts, produce which improvements in clinical outcomes, which process improvements and which changes in users' views of the care they receive*

Aim 3 To gauge increases in clinical engagement in clinical quality improvement, and assess the consequences by:

- *Gauging the current state of clinical engagement in clinical quality improvement in each of the areas covered by the projects in two ways. First by an examination of the documentary evidence (including their original proposal) made available to us by the projects. Second, by following this up with interviews with project team members and key informants. This will include consideration of current organisational culture.*

- *Assessing the change achieved during the life of the Initiative by supporting each project in designing, implementing and analysing a survey of relevant participants towards the end of each project. This support will include guidance on content and on managing the survey itself. Some of these questions will be Initiative-wide (and will be the same for all projects) and some will be project specific. They will include questions on the role of the professional bodies, patient engagement and cultural change. They will be anonymised but will allow us to identify respondents by function and clinical area*

Aim 4 To measure the effectiveness of the award scheme (during its life) in leveraging external commitment to quality improvement by:

- *Identifying project-based evidence showing the influence of EwQI on public policies and on professional bodies seeking to engage clinicians in quality improvement. This could mean, for example standard setting (such as NICE guidelines and NSFs), development of quality measures, data collection*

and analysis, peer review and the evidence-based design of improvement strategies[15] *This will be followed by a workshop identifying barriers, facilitators, processes and illustrations of externally supported, clinically led quality improvement. This will require ongoing monitoring by the projects. We will also encourage the collection of vignettes and illustrations by the projects to add force and vitality to the final report*

Aim 5 To evaluate the increase in competency and infrastructure for quality improvement in the professional bodies involved in the EwQI by:

Alongside the results of the outcomes of Aim 4, including questions in the end of project surveys (under Aim 3) which identify how professional bodies have supported quality improvement. This will be supported by in-depth interviews with each of the relevant professional bodies focusing on their contribution to the quality agenda including standard setting, development of quality measures, data collection and analysis, peer review, and quality interventions.

Aim 6 To assess the influence and cost consequences of the Initiative by:

- *Assessing the likely legacy of the projects through an appraisal of the suitability, feasibility, sustainability and acceptability of the legacy plans and through a wider assessment of their impact on the environment of quality improvement. This will lead to a summative assessment of the overall cost of the Initiative and its consequences. This will necessarily include our interpretation and assessment of the projects' self-evaluations. We will invite feedback from the projects for factual accuracy but we will arrive at our own judgement about their interpretations.*

References

1   See, for example, Department of Health (2001). Assuring the Quality of Medical Practice: Implementing 'Supporting Doctors Protecting Patients'. London: Department of Health.

2   Department of Health (2006). The Future Regulation of Health and Adult Social Care in England. London: Department of Health.

3   Department of Health (2000). The NHS Plan: A plan for investment, a plan for reform. London: The Stationery Office. Department of Health (2004). The NHS Improvement Plan: Putting people at the heart of public services. London: The Stationery Office.

4   Scottish Executive (2006). Delivering a Healthy Scotland: Meeting the challenge. Edinburgh: Scottish Executive.

5   Davies H, Powell A and Rusmer R (2007). Healthcare Professionals' Views on Clinician Engagement in Quality Improvement: A literature review. London: The Health Foundation, p.9.

6   Leatherman, S and Sutherland K (2003). The Quest for Quality in the NHS: A mid-term evaluation of the quality agenda. London: The Nuffield Trust.

7   Davies H, Powell A and Rushmer R (2007). Healthcare Professionals' Views on Clinician Engagement in Quality Improvement: A literature review. London: The Health Foundation.

8   Institute of Medicine website: www.iom.edu/?id=19174 (accessed 21/08/07).

9   For more on the Institute of Medicine's dimensions of quality, see: www.iom.edu/Object.File/Master/27/184/Chasm-8pager.pdf (accessed 21/08/07).

10   Logic models were described in detail in our previous annual report. They provide a brief, visually clear way of laying out the context, inputs, processes, outputs and outcomes on one piece of paper.

11   The survey protocol is, at the time of writing, between its first and second draft.

12   These were identified by Leatherman and Sutherland (2003, p.44) as ways in which Royal Colleges could use their influence.

13   It is interesting to speculate whether, had these interviews been conducted in the 1970s, for example, there would have been a greater emphasis on new therapies.

14   NICE, CHI, RCN, University of Leicester and Radcliffe Medical Press (2002). Principles for Best Practice in Clinical Audit, London: pp.142–3. This argues that process improvement and users' views of the care they receive are appropriate measures of audit.

15   These were identified by Leatherman and Sutherland (2003, p.44) as ways in which Royal Colleges could use their influence.