An evaluation of the Health Foundation's Engaging with Quality Initiative

Third annual report

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Preface

The Health Foundation (the Foundation) 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, the Health Foundation 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 an evaluation of the overall Initiative. This evaluation began in July 2005 and the final report from the Evaluation team is due in July 2009. However, this date will be kept under review as some projects have agreed an extended delivery date.

The initiative was inspired by the claim that clinicians are attentive to the need to improve quality in healthcare but are often not sufficiently or appropriately engaged in this process. EwQI has funded eight professionally led projects, each of which involves clinicians in different ways in different approaches to quality improvement. By conducting, evaluating and communicating the results from both the projects and the Initiative, the Foundation 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 (who are hosting two projects), Physicians of Edinburgh, and Physicians of London (who are hosting two projects), and Imperial College in collaboration with the Association of Coloproctologists. All the projects involve clinical areas where there is thought to be a bridgeable gap between good and actual practice. Each project includes measures to narrow the gap and to measure how successful this has been. They all promise a final report evaluating their outcomes.

To support reflection and communication, the Evaluation team produces an annual report. The annual report is a vehicle for explaining to others what has been done, and which also offers reflections on what has been achieved. It is an interim formative evaluation intended to update the Health Foundation on the activities and progress of the Evaluation team as well as to provide the opportunity for mid-Initiative learning and adjustment.

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 the Foundation, but it might also be of interest to those in and connected to the EwQI scheme. For more information, please contact:

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Chapter 1
Developing context and background

1.1 What is quality improvement?

The UK Royal College of Nursing (RCN) makes the following observation on quality improvement (QI):

> All healthcare systems strive to provide safe and good quality healthcare; improve patient experience, tackle inefficiencies and update practice in the light of evidence from research. The health departments of each of the four countries in the UK have developed standards for the NHS in order to monitor these aspects of delivery.
>
> The standards set out common requirements for services and staff. The standards agree on the need for quality assurance as a core requirement – 'a process of improving performance and preventing problems through planned and systematic activities…' (NHS Quality Improvement Scotland 2005, p7). Managers and clinicians also now share responsibility for quality of care, making improvements and addressing safety issues (Health and Social Care Act 2003).
>
> We know from quality improvement studies about the bond between clinical and organisational change. Making changes requires planning and high level support.
>
> We know that getting evidence into practice cannot be done by simply publishing clinical guidelines and expecting change to happen. Similarly patient safety issues arise for a variety of reasons. Blaming individuals when systems break down does not help to improve safety.
>
> We can learn much from the research but also from other people's experience of quality improvement. But good descriptions of methods and strategies for change are still not widely reported. Finding ways to encourage this type of learning is a priority if quality improvement is to be one of the 'central components of all activities of the healthcare organisation' (Department of Health 2004, p12) (Royal College of Nursing, 2007).

The RCN lament the lack of 'good descriptions of methods and strategies for change'. The EwQI will, among other things, help to provide such descriptions. There remains uncertainty about what QI actually is, however. In the context of a recognition of unacceptable variation in the quality of healthcare (Department of Health, 2001) there is a growing view, illustrated by the RCN's observations above, that clinicians have (or at least should have) a growing role to play in many aspects of QI initiatives, such as influencing regulation and standard setting, shaping incentives, and contributing to IT systems and to healthcare delivery models. However, the recognition that clinicians should have a greater role has yet to be accompanied by an

evidence-informed understanding of how to achieve this role. Furthermore, there is uncertainty about who is responsible for QI and who should participate in it. Batalden and Davidoff (2007) suggest we should define QI as 'the combined and unceasing efforts of everyone – healthcare professionals, patients and their families, researchers, payers, planners and educators – to make the changes that will lead to better patient outcomes'. They go on to identify the kinds of knowledge this requires and the kind of 'meta-knowledge' required to create such a system. Even if this were correct the exhortation is pitched at too high a level of abstraction to be a guide to action. It would require substantial further work to generate both a researchable topic and guidance for decision-makers. The questions of **what** is likely to deliver benefits in any given situation, **who** should be involved in delivering these benefits, and **how** they should be delivered and measured are much less abstract and more practical. Our final report in 2009 will directly address these points. In this report we describe our progress towards answering these and related questions to identify and assess more explicit 'methods and strategies for change'.

There is a wide range of activities that can be considered QI. We regard **quality** in healthcare as the ability to apply current knowledge to individual and population level health interventions in pursuit of preferred health outcomes. **Quality improvement** involves stepping back from the immediate challenge of delivering care to reflect on the benefits of alternative ways of delivering care and, where appropriate, changing how care is delivered. It will often include an element of 'learning by doing' but should always involve an assessment of the resources required and the improvements in quality achieved. It is therefore not just another word for 'doing a better job' or 'working harder'. It is not always (or even often) 'whole system reform' but it does involve improving the design of at least one part of the system through which healthcare is delivered. Illustrating the kinds of things this might involve, the scope of the Cochrane Review Group 'Effective Practice and Organization of Care' includes case management; revision of professional roles; use of multidisciplinary teams; and formularies and changes in medical record systems and financial interventions.

We are aware that not all change is improvement. QI requires a specification of the level at which improvement is anticipated (micro, meso, and macro) and the clinical setting where it is expected to work. It requires some statement of the relationship between the proposed actions and a set of measurable changes that are of benefit to patients and/or public health. And it requires some reduction in the indicators of poor quality such as:

- failure to apply scientific evidence
- provision of inappropriate care
- unjustified variations in practice (eg by practice, time of consultation, age, gender, and geography etc)
- avoidable patient harm.

To be sustainable, it also involves connecting these intended improvements in quality to the preferences and satisfaction of service users, user organisations, and political representatives to maximise the benefits of health interventions. These preferences might reasonably include not only efficacy and effectiveness but also fairness.

For the purposes of understanding this evaluation, it is important to recognise that QI may overlap with research, in that both require a 'stepping back' from routine work and the systematic collection and analysis of data. However, it is not the 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 delivering benefits (however these are defined). 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 challenge 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 rationale 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 having 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 interlocked 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 because the projects will have been influenced by the evaluators then the independence of the evaluators might be compromised. But it is generally agreed that the benefits of the evaluators' positive contributions through what has amounted at times to formative evaluation outweighs the possible dangers to the independence of the final evaluation.

It can be concluded that a capacity to engage, to manage and to systematically learn are essential to successful QI activities. In these respects, it is useful to reflect on whether or not the medical Royal Colleges are well placed (or even uniquely well placed) to provide these supports. In our final report we will comment on this.

1.2 The context

Since the previous annual report for this Initiative (August 2007), there have been some important contextual developments. In January 2008, the Department of Health announced new arrangements for clinical audit with the management of the National Clinical Audit Programme (NCAP) awarded to a consortium involving the RCN, the Academy of Royal Medical Colleges and the Long Term Conditions Alliance. Simultaneously, wider reforms are taking place in the NHS. To name a few: Lord Darzi's interim review was published in October 2007 and the final one in June 2008; efforts to strengthen patient choices and the 'personalisation' (including NHS choices); a heightened concern with patient safety manifest in continued clinical governance alongside particular worries such as *Clostridium difficile* infection (and where patient safety ends and quality improvement begins is a question for a separate paper); changes to Payment by Results; changes to medical training; continued changes in commissioning; the implications of polyclinics; and the expanding role of foundation trusts.

Chapter 2
Key issues

2.1 Our emerging understanding

In previous annual reports (2006 and 2007) we have reported on our developing view of the arguments underpinning EwQI. This included a growing view that context was vital in the success of QI activities (what works here may not work there) and that clinicians were well placed to understand and act on their knowledge of context in selecting and delivering QI initiatives. We see no reason to depart from this view but in the light of our interactions with the projects, it is becoming clear that context sensitivity and clinical engagement is not enough. Clinicians on their own may lack the insights that patients and their representatives can bring; they may lack the systemic and financial analysis available to management and commissioners, they may not have the project management and research skills, and they may lack the political and professional influence to establish sustainable change. Clinicians engaging in QI need alliances and supports that are not always readily available.

However, there is no simple 'user-led' route to QI. If clinicians need alliances and support so do other groups. We discuss in more detail later in this report our findings on service user involvement (broadly defined) but it is clear that improvement involves an alignment among three things: information about what works better; the motivation to act upon this; and the capacity to deliver. Patients and their representatives often have invaluable sources of information (including their own experience); are motivated in very particular ways; and may have distinctive capacities. The question is not how these patient-based resources can replace clinician-based resources, but how they can work together. Doing so will also involve a recognition that patient and clinician resources will not always sit together comfortably; working together in the long run will require ways of managing tensions and resolving disputes.

For this reason we suggest a small but significant departure from the definition of quality in previous annual reports that quote the Institute of Medicine 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' (Institute of Medicine, 2007).

The key word here is 'professional' knowledge. To the extent that this implies only the medical profession, we feel it misses important dimensions such as knowledge held by patients, or articulated in systematic reviews, or communicated through journal clubs, or driven by wider social movements concerned with, for example, childbirth, mental health, ethnicity, and disability.

2.2 Emerging findings

As commented above, context matters. The challenge to the Evaluation team is to step back from the individual experiences of each project and to identify the wider themes. A key stage in this process will involve a systematic interrogation of the projects' final reports supported by the secondary material collected through the regular meetings between the Evaluation team and the projects. These will be contrasted and compared both with each other and with the wider evidence base. It is therefore premature to outline any conclusions but it is possible to identify the issues that we anticipate will be significant in the final report. These include:

- Most clinicians want to improve the quality of the care their patients receive and many believe that it is not just a lack of resources that prevents this. Participating in QI activities, however, takes them away from the direct provision of care (the benefit of which is clearly visible) and into changes that will only provide indirect benefits. It seems likely that clinicians will be less likely to participate in QI activities the more indirect the route to providing benefits, the more uncertain the scale of such benefits, and the more dispersed (and hence less visible) the benefits to patients.
- In this light, the commitment to the projects shown by some clinicians suggests that the sort of concrete quality improvements found in the EwQI scheme is important. The projects' final self-evaluations and the Evaluation team's Delphi survey may cast light on this. It may also be the case that the encouragement given to the project teams by being part of the Initiative to identify in advance the intended benefits is another reason for clinician engagement.
- There is some uncertainty about what 'QI' 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 (Institute of Medicine, 2001).[1] For example, adherence to guidelines should produce improved clinical effectiveness but we also want to understand at what cost, with what other consequences, and whether it is a one off benefit or a sustainable improvement.
- We have also seen how delivering QI can, in practice, 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. These factors are perhaps more prosaic and less intellectually exciting than other barriers to QI but they seem to the Evaluation team to be equally important.
- There appears to us to be a shifting pattern of underlying systems to support QI and these are not always well understood by participating clinicians and nor is it clear that they always work together to provide a consistent and reliable base. These underlying systems include the regulatory bodies, professional self-regulations, clinical guidelines, commissioning, financial incentives, and the requirements of good governance. Furthermore, existing clinical quality measurement systems, where they exist, may be unstable and under-funded (although in clinical audit, this may be being addressed).
- Across the board, it is inevitable that some projects will perform better against their intended outcomes than others. Indeed, if every project succeeded fully then the Initiative would most probably be accused of excessive conservatism and a lack of innovation. Some relative lack of success is almost inevitable in the challenging world of QI in healthcare, especially given the innovative approach adopted by this Initiative.

[1] 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).

However, even with ostensibly less successful projects, from an evaluation point of view 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 satisfactory final self-evaluations.

- We have had two experiences of preparing teams for their final self-evaluation reports. It is unlikely that the two projects concerned are atypical and, based on these experiences it remains likely that 'self-evaluation' involves a vocabulary and way of analysing that is not fully familiar in the health sector. If this is true it poses a challenge for delivering QI across the NHS since QI always includes aspects of self-evaluation within it.

2.3 Working with the projects

Working with the projects in a structured way in the final year of the Initiative remains a key task for the Evaluation team. The Evaluation team's detailed report on this year's self-evaluations, completed in November 2007 can be found in Appendix 4. 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. For example, this is involving additional 'end of project' meetings to support their final self-evaluation report. This is in addition to what was anticipated and, in one case, has involved two additional trips to Scotland. All of this places considerable demands on the Evaluation team's resources. In addition, several projects are completing after the planned end-date and the Evaluation team has absorbed the financial and planning implications of this, just as it has dealt with earlier changes in project teams' management and internal problems of communication. Late completion has stretched the available resources. In addition to our work with the projects, the Health Foundation's expectations for regular information in the form of face-to-face meetings and telephone discussions have also increased.

This raises interesting questions concerning the preparedness of relatively well-informed and committed teams from within the healthcare system. It may also have implications for how the Health Foundation develops its QI activities into the future. The shared assumptions of both the Health Foundation and the Evaluation team were that the projects would find the more 'researcherly' aspects of QI (measuring costs and impacts, and evaluating processes) easier than has in fact been the case. This suggests that either future projects should avoid QI packages that exceed their capacity to measure, validate and learn from the activities or that, where a promising improvement package appears to exceed this capacity, additional (and specific) supports should be put in place. This conclusion is not dissimilar to our comments on project management which suggest that the ambition of the improvement package should not exceed the project management capacity of the team. It suggests that tailored, well managed, and well analysed QI should be preferred to projects with potentially greater impact that lack the capacity to know if this has been delivered.

2.3.1 Self-evaluation and final reports

The projects' self-evaluation reports will be at the heart of the data used in our evaluation. The formats of the projects' submissions have 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.

We have worked with two projects on their final self-evaluation reports and in the coming year we will work with the remaining projects on this. This is fundamental to securing final reports that can be used effectively in our own final report (see later in this report). Our intention is to use the projects' final reports to generate a set of mini-hypotheses for each project (eg if we secure high quality clinical audits the results will be trusted; if we communicate trusted results they will provide a basis for local action plans; and local action plans, if successfully implemented will produce improved patient care). We will then assess the evidence presented in support of or against each mini-hypothesis. In this way we plan to develop a matrix, charting each project and each mini-hypothesis, and estimating the strength of evidence. Following this process we can assess the relevance of contextual factors. This will allow us to address the following questions:

- What was intended?
- To what extent did it work?
  - How strong is the evidence for this?
  - What were the contextual factors apparently associated with success?

2.3.2 Logic models

As reported in previous annual reports, we have also encouraged project teams to revisit their logic models[2] as part of updating the state of their interventions or QI activities. 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 will encourage project teams to return to these as part of their final self-evaluation.

2.4 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 involvement is more extensive than in others. However, the users understand that, in at least some instances, involvement is an effective facilitator of QI. 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, disseminating and implementing emerging findings.

We explore the question of user involvement more fully in Chapter 3.

[2] Logic models were described in detail in our 2006 annual report. They provide a brief, visually clear way of laying out the context, inputs, processes, outputs and outcomes on one piece of paper.

2.5 Clinician involvement

Planning for the Delphi survey, which is targeted at clinicians involved in EwQI, is well developed and the draft approach is outlined in detail later in this report. It was planned to be completed by July 2008 but delays in projects completing, coupled with our view that we wanted to conduct a single Initiative-wide project (as far as the projects would allow) has delayed this and we will now complete this before the end of 2008. All but one project is committed to this timeframe.

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, service 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.[3]

2.6 A platform for QI?

In the Evaluation team's previous annual reports our understanding was that it is helpful to think of there being three things common to successful QI and these have been clarified as:

- a 'platform for quality improvement' (the basic support required to run any QI initiative)
- the motivation for QI (what makes people want to do it)
- facilitators of QI (what is associated with successful delivery).

The platform for QI provides the essential organisational and informational capacities, and includes:

- performance information (such as clinical audit) that is accurate, trusted and relevant
- a capacity for project management, including identifying and keeping resources, managing risks, and maintaining financial information systems
- an appropriate QI model and a project management plan that is achievable and adequately resourced
- an adequate communications system.

The motivations of clinicians, managers and patients include the desire to see patients benefit; the search for peer esteem; financial incentives; formal status; and the admiration of family and friends. Initially we used the term 'incentive' but we now prefer 'motivations' since some commentators have interpreted 'incentives' too narrowly, as the pursuit of nationally determined financial benefits; whereas we see clinicians as motivated by more than financial gain. Facilitators include trusted 'champions', a supportive change in guidelines, new financial incentives, new and compelling evidence about the effectiveness of treatment and so forth. In our final report we will identify the relevant evidence and assess it in relation to this triad.

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

2.7 Draft of final report structure

The Evaluation team now has a draft outline of the final report. This was agreed within the Evaluation team in the autumn of 2007. More recently we have been encouraged to adopt a structure designed to promote concise and effective communication and this we are happy to do. The draft structure is outlined and discussed later in the report (Appendix 5).

Chapter 3
Service user involvement in EwQI projects – a discussion

3.1 Background

One of the requirements of the EwQI was that the projects should 'work with patients' representatives and expert patients, and encourage participating clinicians to work with patients' (the Health Foundation ITT for the external EwQI evaluation, February 2005). The need to involve patients in all aspects of healthcare, including research and QI work is well recognised, finding expression in the UK in, among other things, the statutory requirement that NHS organisations involve and consult patients and the public about health service planning (Coulter and Ellins, 2006); through initiatives such as UKCRC's policy on involving users in research and the commitment of its members (including INVOLVE) to this policy; the NHS Institute for Innovation and Improvement's work on user involvement in QI projects; the DH Expert Patients programme; and the Health Foundation's work through QQUIP on a systematic review of patient-focused interventions. The concept of 'patient involvement' includes two rather different things. First it can refer to shared decision-making between a patient and a practitioner. Secondly, it can refer to a process of collaboration in some aspect of healthcare more widely – in this case in QI activities. None of the projects explicitly have a focus on the former but all of them intend to include 'patient involvement' in the second sense. This is the focus of this chapter.

While the need to involve patients in this second sense is widely accepted, the evidence base for doing so is still weak (Nilsen et al, 2006; Schunemann et al, 2006) and the barriers to effective involvement are considerable. Discussing the involvement of patients in service development, Coulter and Ellins (2006) cite a list of constraints which include 'lack of clarity about aims and objectives; resource limitations and organisational constraints; professional or managerial resistance; problematic relationships between stakeholders; and concerns about representativeness'. And, in their paper on the use of patient survey data in QI, Davies and Cleary (2005) cite a wide range of organisational, professional and data-related barriers.

Given this background, members of the Evaluation team interviewed 15 people involved on the EwQI project teams as service-users, user representatives and project managers in order to

explore their experiences. The aim was to identify what, in the EwQI context, had helped and/or hindered effective involvement, and what such involvement had, and in future should, entail. This chapter therefore covers not only what we found, but also some of the key questions that these findings raise.

3.2 Getting involved

3.2.1 Who should be involved?

People from a wide variety of backgrounds are involved as 'service-users' in EwQI projects. They include patients, carers, chief executives, and employees of charities.

As a term, 'service-user' is not only clumsy but also unhelpfully broad. Is it possible to generalise about who should be involved in a particular project, or should this always be project-specific? What characteristics are needed? What background is appropriate? What skills are helpful? Interviewees mentioned good communication skills and a good general understanding of the relevant disease or condition. Is training needed to help people fulfil this role, and if so what sort of training is required? What support do service users require?

At the start of their review of patient-focused interventions Coulter and Ellins (2006) note, 'There is a growing belief among policy-makers that patients/citizens can contribute to quality improvement at both an individual and a collective level.' Taking this further, Williamson (2007) compares the complexities of patients' and clinicians' views of various aspects of healthcare provision and its quality, and distinguishes the 'structure' of the patient side into patients, patient groups and patient representatives. She also identifies a radical/non-radical dimension that contributes to differences of view within each of these three parts, and notes the importance of involving a range of voices in any project.

Our interviewees helped us to develop these insights:

- **Individual contribution:** several interviewees stressed the importance of a service user being a patient, a person who had had the relevant disease, and could bring that personal experience to bear. They noted the power of individual patient stories, although we also heard from clinicians concerned that sometimes these accounts were used to repeatedly hammer a single issue. What all interviewees agreed as important is the ability to develop a wide understanding of the disease and the range of care available, and be able to speak for others – as an informed patient. There are also limits to any individual contribution. One interviewee made it clear that service user should '…not expect to be able to contribute to all the (sometimes technical) issues raised at project meetings; you could only contribute in relation to what you yourself knew'.
- **Collective contribution:** patient representatives from the charities also speak for patients, though not necessarily from direct personal experience. What they can add, however, is the weight and longevity of their organisations, and their consequent ability to engage at 'various levels in various ways' in QI in addition to specific involvement in any one project. One interviewee mentioned the added value of his organisation's ten-year engagement with the relevant specialist group, and the consequent development of regular Saturday meetings between patients and specialists was that it raised and explored issues of interest to patients.

In all the EwQI projects, service users have been involved centrally as members of the project teams and on steering groups: sometimes as a lone voice, but in most cases with some support from at least one other service user. In some of the projects (five out of eight) considerable efforts have also been made to encourage participants to involve service users locally, building on or developing local service-user networks.

Given this range of contributions, project teams (and steering groups) need to be clear from the start what contribution they are seeking not just from service users but from all the members of the team – service users, clinicians, project managers and statisticians, and so on.[4] Project teams also need a good understanding of the potential contribution that service users could make to a QI project given favourable circumstances, and of any specific limitations to that input.

3.2.2 Selection of service users

All the interviewees had experience of involvement as service users or patient representatives prior to their involvement in the EwQI. Most were selected through personal contacts; others through advertisement. Many interviewees (five out of eight) had known some members of the EwQI project team prior to the project (in some cases for a number of years) and stressed the importance of the mutual respect gained through such established relationships, although, as one interviewee pointed out, this respect was not a consequence simply of longevity but because 'there were good people involved'.

The fact that the selection of service users (in this small sample) was clearly not random raises questions. Should involvement be happenstance, or occur through personal contacts? Is there an undue risk of bias in such circumstances? Is there a case for a formal recruitment process? Would there be any negative outcomes if there were formal recruitment, such as limiting the pool of those involved? How were other members of the project team recruited? How much does experience matter, and what experience and skills are required? Whose experience matters? A recent study on consumer involvement in research found that only three out of eight principal investigators had previously worked with service users or carers (Barnard et al, 2006).

3.2.3 Motivation (and payment)

Asked about their motivation interviewees mentioned the same combination of 'reasons related to their personal situation, their experiences of health or social care services (often negative) as well as … a more general commitment to getting involved and bringing about change' (Tarpey, 2006) found in studies of why people get involved in research. As one interviewee noted, however, time and resource constraints create a risk of bias – there is a tendency for those involved to be the relatively wealthy or salaried patient representatives from the charities. This raised the issue of payment. Interviewees' experiences differed, and so did their views. We were told that payment could be a 'double edged sword': without it service users lack parity with others attending meetings and being reimbursed for their time, but paying people might attract them for the wrong reasons. Many interviewees mentioned the significant amounts of time that they had given to the project. We found that where a fee had been paid, for example for attendance at meetings, there were also sometimes attempts to ensure parity with other professionals as a 'matter of principle'. Sometimes only expenses were paid. Some interviewees got nothing. Some sought nothing.

The interviews encouraged us to consider questions that cannot be answered in this Annual Report: How can an appropriate cross-section of people be attracted? Does payment help? If so how should it be organised? Does payment reflect the true cost of patient involvement? Is it

[4] This clarity about the role of service users is fundamental not only to effective public involvement, but also to its evaluation. For example, Coulter and Ellins (2006) note, 'There is very little reliable evidence about the effectiveness of public involvement methods, for which the lack of an agreed evaluation framework is a major factor. Before developing a coherent framework for the assessment of outcomes, the intended aims of public involvement must be specified and defined.

right that only patient representatives and not patients are paid for their time? INVOLVE (2006) issued a detailed policy on payment of people involved in research in August 2006 which covers all the issues raised above. This could be used to guide QI projects.

3.2.4 How and when should service users be introduced to the project and to the team?

All interviewees stressed the importance of service users having an adequate and appropriate understanding of the project and its aims and objectives. In part this depends on timing. If service users are not involved early they will be 'left in the dark about decisions already taken and about the rationale behind them'.[5] Interviewees involved in the design of their projects and in the application to the Health Foundation also told us what an important bonding experience this had been. If they are to contribute fully and effectively, service users working with the central project team need to be involved as early as possible in the design and planning of the project.

The issue, therefore, is not when users should be involved but, given early involvement, how much additional prior understanding is also required. Is a detailed understanding of QI methodology or research techniques required? Interviewees thought not. Is a detailed understanding of the relevant disease and current approaches to care and of current gaps in that care also needed? Interviewees thought that this was something the service user or patient representative should be able to offer. More importantly, where there are gaps in knowledge the key factor is relations within the project team that allow all its members, including service users, to ask questions when they don't understand something. These relations, in turn, depend on how service users are introduced to the project team or steering group. Interviewees emphasised how important it was for service users to be 'introduced early and as an **equal** member of the project team' if tokenism and tendencies to see users as 'fashion accessories' are to be avoided. One interviewee thought that this was so crucial that it might be necessary to offer potential service users training in presentational skills to help them handle this initial step as well as possible. Service users need to be introduced as equal members of the team.

What of service users working with local participants who out of necessity are recruited at a later stage after the early planning has been done? They too need to understand the project and work out what is needed. Explaining the aims and objectives of the project and the potential contribution of service users in terms that they can understand is therefore a key task for the central project team through its communication strategy. There should also be a clear expectation that, as in the central team, local service users are seen, and see themselves, as equal members of participating teams. This has one particularly important component, mentioned by several interviewees, people's time is important – equal membership of a team (at any level) means having equal opportunities to walk away from a project if involvement seems to them to have become purposeless.

3.3 Role in the project

Interviewees described their roles in the project by outlining what they had done. Activities included attending meetings; helping to design the project and its communication strategy; setting outcome measures; helping to design questionnaires; interviewing; interpreting data; discussing how findings should be reported; report writing; and giving presentations. Some had also played a large role in supporting other service users at a local level.

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[5] Equally, in schemes such as the EwQI involving several projects with the potential for sharing views across the scheme, service users need to have an adequate and appropriate understanding of the wider scheme if they are to share their expertise and experiences effectively with others.

3.3.1 Clarity of role

Most EwQI service users felt that their role in the project had been clear from the start and that all involved had understood it and supported them well. But this happy situation was not shared by all.

How was the service user's role in the project defined, and by whom? Was the service user involved in this process? Was that role clear and explicit from the start? Was the service user able, if necessary, to adapt that role over time? Were the roles of other members of the project team clearly defined or not? There is potential for confusion. In one study on patient involvement in research, service users were asked to describe their role using four categories: researcher, service user, carer, and other. Out of 61 respondents ten described themselves both as service users and as researchers. As the report pointed out, however, this view of their role was not necessarily shared by others in the project or even by the respondents themselves at the start of the project – roles can be unclear and therefore disputed, and can also change over time.

3.3.2 Support

The support provided to service users varied hugely between the projects, but all the project teams found it more time-consuming and resource intensive than anticipated. Practical support included provision of access to IT equipment and training; training in presentation skills; willingness to explain and discuss the more technical aspects of the project; help with transport to meetings and care in the timing of meetings to meet the needs of sick people; timely and understandable information about the project, and so on. Several interviewees also mentioned the crucial need for moral support for people who were often unwell themselves and were working in an unfamiliar setting with recognised experts in the field.

3.3.3 Ethos

All the interviewees commented on the need for service users to be treated as equals by other members of the project team or the steering group, and on the need for respect and trust among those members (see above). In the absence of these characteristics the effectiveness of the service user on the group was undermined. How this parity was achieved varied from project to project and included:

- service users who already had good relations with members of the project team established before (in some cases well before) the Health Foundation-funded project was initiated and were able to build on these
- steering groups who recruited multiple service users/patient representatives in an attempt to ensure an appropriate balance to the group of professionals and users
- positive attempts by project team or steering group members to identify and utilise all the relevant skills and expertise of all their members, including service users
- chairing meetings in ways that recognised nuances of understanding among members and people's possible contributions
- developing relations of trust and understanding among team members so that people were not afraid to ask questions when they had not understood something
- providing external support to service users. Approaches included support from external mentors, such as a leadership development consultant or another external 'expert' service user and buddy systems. Telephone help lines were also suggested

- training: this can be informal (through involvement in the project) or formal. Several interviewees stressed the need to train service users alongside the professionals also engaged in QI.[6,7]

A second set of principles, developed by Telford *et al* (2004) through a Delphi process is given in Appendix 3.

It is possible, on the basis of this list and other work (The Health Foundation, 2007; INVOLVE, 2007; Telford et al, 2004) to develop a set of principles to cover this relation between project teams and service users at both central and local levels. One such list includes:

- varied and effective methods of communication (eg regular telephone contact and easily understand language)
- respect for the knowledge and insights of service users
- strong personal commitment from everybody to ensure service-user involvement improves the project and its outcomes
- willingness to accept additional time/resources required.

3.4 Outcomes

3.4.1 Experience of service users

A majority of interviewees were happy with the role they had played in their project, and felt that they had had a good impact. We were not able to explore the views of other members of the team in all cases but where we did it was clear that this view was also shared by them. What interviewees had achieved had met, and in one case at least, exceeded their expectations. But, again, there were exceptions. It is as important that we learn from these as well as from the positive experiences.

One study suggests that the experience of service users covers the following parameters (which can be either positive or negative):

- empowerment – mutual respect; valuing different knowledge and experience; development; learning; growth; expressing a potential; and having a recognisable impact.
- support – empathy, sensitivity, and individual contact
- communication – need for clarity of roles and responsibilities, expectations and the use of appropriate language
- resources – time, skills and money
- motivation – enthusiasm, commitment and inspiration.

3.4.2 The impact of service user involvement on the projects

How should the impact of service users on a project be measured and evaluated? The following list of possible outputs is adapted from Barnard's study on the involvement of consumers in primary care research:

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[6] See, for example, the training developed as part of the Royal College of Psychiatry's QI programmes.

[7] For example, on shared decision-making between doctors and patient, Coulter and Ellins (2006) say, 'Communication skills training should be the main mechanism by which clinicians learn about and gain competencies in the principles and practice of shared decision-making, but the extent to which it is explicitly included in medical curricula is not known. There is evidence that such training can be effective in improving communication skills … Coaching for patients in communication skills and question prompts can have a beneficial effect on knowledge and information recall. These interventions also empower patients to become more involved in decisions'.

- changes to design of the project
- new/revised questionnaires, interview designs etc, created by service users/carers
- new ways of collecting data found by service users/carers
- suggesting patient-relevant outcomes, and suggesting ways of measuring those outcomes
- increased access to other service users to provide relevant data
- explanations of the data, relating directly to how people experience the services
- use of service-user networks to tell people about the findings of the project
- use of findings, for example suggesting ways to change services, based on the findings of the project.

In the context of the EwQI and our own findings from this set of interviews we would also add:

- developing a communication strategy for the project
- advising on the form in which findings should be released, and, in particular, whether or not they should be anonymised
- exploring and developing links with policy makers.

Chapter 4
Preparing for the Delphi

4.1 Introduction

This chapter outlines our approach to the Delphi and it includes a draft of the contents of the instrument. The instrument is close to completion but there will be a further round of discussions in the coming months. It is, however, still a draft and further work is needed (including meeting the need to take steps to follow up and try to boost the response rate). We would welcome any early comments.

Clinicians are crucial to the quality of healthcare delivery and engaging clinicians is a major leverage point in the drive to improve healthcare. It is clear that engagement is not a one-way process. It is not about asking clinicians to be more engaged. An organisation such as the NHS must develop reciprocal competencies to enable it to respond to opportunities, regardless of its position in the cycle of organisational growth and change (Reinertsen et al, 2007).

Aim 3 in the Evaluation team's research protocol states:

> We will conduct a web-based Delphi survey to identify:
>
> (a) How clinicians can be best engaged in quality improvements initiatives.
>
> (b) What impact this is thought to have on clinical outcomes.
>
> (c) 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.

4.2 Delphi survey

We will use the Delphi method to conduct a web-based survey of participating clinicians. The Delphi method was developed at RAND in the late 1950s as a way to collect and synthesise expert judgments (Gordon and Pease, 2006).

The Delphi method differs from a conventional survey in that participants are invited to reassess (in several rounds) their initial judgments in the light of the overall pattern of results, including the average or median of responses and reasons of participants for holding extreme positions (FISTERA, 2005). By keeping the process of questionnaires and feedback

anonymous, Delphi is intended to avoid undesirable group effects (social desirable answers, assertive individuals often leading the discussion) (Garson, ????). Although the process tends to move to consensus, this is not necessarily the objective of the Delphi method. A median score may reflect considerable divergence in views, but the survey results will allow the experts to understand the reasoning that lies behind divergent views. This knowledge may lead to some secondary convergence of views, but not necessarily.

4.3 Design of a Delphi survey

A conventional Delphi is designed to collect opinions from experts about a particular issue (in our case engagement of clinicians in QI initiatives). The steps are (in general):

1. Description of subjects/issues to be considered.
2. Development of (electronic) rating forms (numerically answered questions using a nine-point rating scale) and scoring instructions.
3. Identify participants from the required disciplines (number).
4. Approach participants (send instructions and rating forms).
5. In round 1, participants would be asked to provide their judgment about the set of questions/issues (ie fill out rating form).
6. Collect rating forms.
7. Analyse responses anonymously (level of agreement – see Appendix 3).
8. In round 2, the range of ratings would be presented to the group, and all participants holding opinions at the extremes of the range would be asked to reassess their opinion in view of the group's range and to provide reasons for their positions.
9. In round 3, the emerging group judgment on particular issues would be presented along with the reasons for the extreme opinions. Each member of the group would be asked to reassess his or her position in view of the reasons presented.
10. Analysis of final level of agreement.

Results will yield lessons for developing effective ways to continuously engage clinicians in QI initiatives that will yield positive clinical outcomes.

4.4 Web-based survey

At a project meeting in November 2007, we decided to use a two-round Delphi survey (by email/web-based).[8] We will conduct the first-round survey **per project**. For this purpose, we will ask each clinical lead in the projects to forward the survey to all the participating clinicians to help ensure a good response rate. In April 2008, we approached the project managers of each project to see if this was a good idea and to get an indication of the potential respondents (see also sample size below and Appendix 4). Overall, people were happy to forward the survey to the project participants but two important issues came up. Firstly, facilitators might not know all their staff e-mail address and secondly, not all staff in the NHS have a Trust e-mail address. We have discussed the possibility of producing hard copies of the Delphi too, but believe this is not a good idea as it will mean that we have to manually enter scores into the computer database.

The web-based survey should take around ten to twelve minutes to complete. The project leaders are encouraged to attract, as much as possible, clinicians to fill in the survey via a

[8] We should try to avoid paper-based surveys.

website. To get people involved it is important to include the first round within the lifecycle of the projects. Please note that the response rate for online surveys ranges from 2 to 30 per cent (http://en.wikipedia.org/wiki/Statistical_survey). However, because potential respondents will be contacted via people they know (at least indirectly), and because it is on a topic related to their current work, and because the survey instrument will be quick and easy to complete, we anticipate better than average response rates. We also intend to re-invite those who don't respond in the first instance to the survey to help increase the response rate and representativeness of those within our sample.

4.5 Development of rating forms and instructions

What we want to measure with the Delphi are the **views** of clinicians involved in EwQI regarding:

- barriers and facilitators to engage clinicians in a process of quality improvement
- consequences of engaging clinicians in QI on clinical outcomes
- use of external influences to leverage clinical engagement in QI at Trust level.

Inputs for developing the survey questions (rating forms) are:

- results from questions that projects have asked their clinicians about their role in QI (questions provided by us to project teams)
- results of surveys or interviews with selected participants that several of the projects are undertaking (eg general survey sent by the Health Foundation)
- literature review.

4.6 Identifying and approaching participants

4.6.1 Sample characteristics and size

There is no agreement on the panel size for Delphi studies, and there exists no recommendation or definition of what constitutes a small or large sample (Atkins et al, 2005). Many published Delphi studies use panels consisting of ten to one hundred or more panellists. These are often convenience samples, dependent on availability of experts and resources.

The clinicians should have similar training, knowledge and understanding – these are all characteristics that influence the outcomes of Delphi surveys. It is recommended that the following criteria are used for selecting participants (Atkins et al, 2005):

- knowledge of and practical engagement with the issue under study
- capacity and willingness to contribute to quality improvement
- assurance that sufficient time will be dedicated to the Delphi survey
- good written communication skills.

We have endeavoured to keep the survey short, and anticipate that the clinicians we are approaching will comply with the other criteria.

We have decided to invite all clinicians that are participating in each of the projects.
A summary of what we received at the time of writing is:

- POISE project decided not to be involved
- IBD project: 210 clinicians (second round will start in September)
- PEARLS: about 40 facilitators in 24 units. Each unit probably has about 30–40 staff involved in their project

- NCROP: 100 study sites (number of participants unknown) participating in NCROP audit
- Bowel Cancer: there will be approximately 300 clinicians. We should keep in mind that when this project did their own survey they got just over 100 responses
- Epilepsy and CAP: total about 40–50 (combined). However, this would be multidisciplinary teams (consultants, junior doctors, pharmacists, nurses etc)
- Self-harm: includes previous and participating teams. There were 30 previous participating teams (number of participants unknown)
- POM-UK: probably 40 current trusts (80–240 people); and 48 previous participating trusts (96–288) people (number of participants unknown).

4.7 Collecting and analysing data (round 1, 2)

Data analysis comprises the following activities:

- Collect rating forms, including narrative comments.
- Analyse data. The data will be analysed using descriptive statistics (mean scores and a summary of explanations given by respondents and by the particular respondent).
- Collated data from the first round will be presented to participants in an aggregated (anonymous) form. Participants will be asked to fill out the rating forms again (round 2).
- On the basis of the analysis of the second round we will draw conclusions on the level of agreement between clinicians.

4.8 Draft web-based survey outline, invitation letter, and outline of how the results will be analysed (round 1)

We conclude this chapter with the draft web-based survey and invitation letter, and an outline of how we will analyse the results.

Engaging clinicians in quality improvement initiatives

Welcome to the Web-based Delphi survey on engaging clinicians in quality improvement initiatives. All healthcare professionals have a growing role to play in many aspects of such initiatives, including influencing regulation and standard setting, shaping incentives, contributing to IT systems and to healthcare delivery models.

We would be most grateful if you would complete this survey by sharing your views on improving the quality of care through the Engaging with Quality Improvement Initiative project in which you are involved. The survey should take about 10 minutes to complete. Most of the questions only require you to tick a box.

Please note that participation in this study is voluntary. All of the answers you provide will be treated as completely confidential. Findings will be used in the evaluation of the Engaging with Quality Improvement Initiative as a whole, and no information will be attributed to any individual. We are only asking for your name and email address to identify who has answered the survey.

For questions or further information concerning this survey, please contact:

Amanda Scoggins
Tel: +44 (0) 1223 273 881
Fax: +44 (0) 1223 358 845
Email: scoggins@rand.org

Section A. General Information

Survey completed by:

Name/ title	Single open-ended response of maximum 255 characters
E-mail address	Single open-ended response of maximum 255 characters
Main area of specialty or role	Single open-ended response of maximum 255 characters
Your grade/job title (eg consultant)	Single open-ended response of maximum 255 characters
Date	**[generated automatically by server upon survey submission]**

Below you will find five sections describing various aspects of clinical engagement in quality improvement. Dimensions of quality, as defined by the Institute of Medicine, include clinical effectiveness, safety, patient-centeredness, timeliness, efficiency and equity. We kindly ask you to read each section carefully and express ***your views*** on each aspect using a rating scale (1–5)**.**

We acknowledge you may not be familiar with certain aspects of engaging with quality improvement. In this case, we kindly ask you to answer 'don't know' (DN).

Section B. Activities to engage clinicians in quality improvement

Below we provide *a list of activities to engage clinicians in quality improvement* that are identified in the literature. Please express your views on how important you think that each activity is in improving quality through your involvement in your Engaging with Quality Initiative project by using a scale from 1–5 (where 1 is very unimportant and 5 is very important).

If you feel that we have not listed all possible activities to engage clinicians in quality improvement, you're invited to submit activities which you feel are not represented.

Please choose one.

1: Very unimportant; 2: Fairly unimportant; 3: Neither unimportant nor important;
4: Fairly important; 5: Very important; DK: Don't know

	1	2	3	4	5	DK
B1. Undertaking clinical audit	☐	☐	☐	☐	☐	☐
B2. Providing training for clinicians and managers (eg Continuous Medical Education)	☐	☐	☐	☐	☐	☐
B3. Keeping up-to-date with clinical practice guidelines	☐	☐	☐	☐	☐	☐
B4. Taking part in regular **formal** discussions with colleagues about improving healthcare quality (eg gaining formal feedback and advice from colleagues or attending clinical review meetings)	☐	☐	☐	☐	☐	☐
B5. Taking part in regular **informal** discussions with colleagues about improving healthcare quality (eg discussing how patient plans can be improved)	☐	☐	☐	☐	☐	☐
B6. Doing rapid learning cycles (eg Plan-Do-Study-Act)	☐	☐	☐	☐	☐	☐
B7. Performing peer review of practice with the aim of improving quality	☐	☐	☐	☐	☐	☐
B8. Participating in clinical networks	☐	☐	☐	☐	☐	☐
B9. Being a member of clinical governance committee(s)	☐	☐	☐	☐	☐	☐

continued

	1	2	3	4	5	DK
B10. Keeping up-to-date with how best to provide best care to each patient (eg reading journals)	☐	☐	☐	☐	☐	☐
B11. Using appropriate IT support systems to support healthcare quality improvements	☐	☐	☐	☐	☐	☐
B12. Writing about how to improve healthcare quality (in peer or non-peer reviewed literature)	☐	☐	☐	☐	☐	☐
B13. Helping patients and service users to participate in improving healthcare quality	☐	☐	☐	☐	☐	☐
B14. Other (please specify)						
B15. If you wish to further elaborate on your answers or if you have any comments on them, please use the space provided below.						
Single open-ended response of maximum 2000 characters						

Section C. Effective ways of supporting clinical engagement in quality improvement

Below we list *ways of providing support for clinical engagement in quality improvement* identified in the literature. Please rate on a scale of 1–5 (where 1 is very ineffective and 5 is very effective) the effectiveness of each potential way of providing support in your Engaging with Quality Initiative project. Where you think a potential way was not available in your project, please tick 'not applicable' (NA).

If you feel that we have not listed all possible ways of support for engaging clinicians in quality improvement, you're invited to submit possibilities which you feel are not represented.

Please choose one.

1: Very ineffective; 2: Fairly ineffective; 3: Not ineffective nor effective;
4: Fairly effective; 5: Very effective; DK: Don't know; NA: Not applicable.

	1	2	3	4	5	DK	NA
C1. Involving Royal Colleges	☐	☐	☐	☐	☐	☐	☐
C2. Involving patient organisations	☐	☐	☐	☐	☐	☐	☐
C3: Securing good inter-professional relationships	☐	☐	☐	☐	☐	☐	☐
C4. Allocating time to quality improvement activities	☐	☐	☐	☐	☐	☐	☐
C5. Allocating budget to quality improvement activities	☐	☐	☐	☐	☐	☐	☐
C6: Availability of champions (i.e. leaders in quality improvement)	☐	☐	☐	☐	☐	☐	☐
C7. Communicating candidly and often about quality improvement	☐	☐	☐	☐	☐	☐	☐
C8: Securing interest of Trust/Board	☐	☐	☐	☐	☐	☐	☐
C9. Applying reward systems	☐	☐	☐	☐	☐	☐	☐
C10. Committing the Trust/Board to engaging healthcare professionals to improve the quality of healthcare	☐	☐	☐	☐	☐	☐	☐
C11. Other (please specify):							
C12. If you wish to further elaborate on your answers or if you have any comments on them, please use the space provided below.							
Single open-ended response of maximum 2000 characters							

Section D. Barriers to engaging clinicians in quality improvement

Below we provide possible *factors identified in the literature that may serve as an obstacle to engaging clinicians in quality improvement*. Please express your views on the extent to which each factor is an obstacle to you in improving quality in your Engaging with Quality Initiative project by using a scale from 1–5 (where 1 is not an obstacle and 5 is a large obstacle).

If you feel that we have not listed all possible obstacles, you're invited to submit other obstacles.

Please choose one.

1: not an obstacle; 2: minimal obstacle; 3: small obstacle; 4: considerable obstacle; 5: large obstacle; DK: Don't know

	1	2	3	4	5	DK
D1. Limited number of staff available for quality improvement	☐	☐	☐	☐	☐	☐
D2. Lack of leadership	☐	☐	☐	☐	☐	☐
D3. Lack of widely shared knowledge (eg access to performance data)	☐	☐	☐	☐	☐	☐
D4. Poor handover from other staff	☐	☐	☐	☐	☐	☐
D5. Lack of financial rewards	☐	☐	☐	☐	☐	☐
D6. Use of financial sanctions	☐	☐	☐	☐	☐	☐
D7. Lack of non-financial rewards	☐	☐	☐	☐	☐	☐
D8. Lack of performance targets	☐	☐	☐	☐	☐	☐
D9. Lack of continuity of the care pathway	☐	☐	☐	☐	☐	☐
D10. Lack of patient or service user involvement	☐	☐	☐	☐	☐	☐
D11. Poor protocols	☐	☐	☐	☐	☐	☐
D12. Other (please specify)						

D13. If you wish to further elaborate on your answers or if you have any comments on them, please use the space provided below.

Single open-ended response of maximum 2000 characters

Section E. Consequences of engaging clinicians

Below we provide *possible consequences of engaging clinicians in quality improvement* that were identified in the literature. Please rate on a scale of 1–5 (where 1 is very unlikely and 5 is very likely) the extent to which each consequence results from your Engaging with Quality Initiative project.

If you feel that we have not listed all possible consequences, you're invited to submit consequences which you feel are not represented.

Please choose one.

1: very unlikely; 2: fairly unlikely; 3: Neither unlikely nor likely; 4: fairly likely;
5: very likely; DK: Don't know.

	1	2	3	4	5	DK
E1. Improved patient satisfaction/experience	☐	☐	☐	☐	☐	☐
E2. Greater standardisation of professional practice	☐	☐	☐	☐	☐	☐
E3. Cost-effective services	☐	☐	☐	☐	☐	☐
E4. More equitable care	☐	☐	☐	☐	☐	☐
E5. Uniform patient reports (eg standardised discharge letter)	☐	☐	☐	☐	☐	☐
E6. Greater quality control (i.e. safe care)	☐	☐	☐	☐	☐	☐
E7. Improved rules, regulations, and legislation	☐	☐	☐	☐	☐	☐
E8. Decreased patient waiting times	☐	☐	☐	☐	☐	☐
E9. Increased patient waiting times	☐	☐	☐	☐	☐	☐
E10. Increase in costs to the organisation	☐	☐	☐	☐	☐	☐
E11. Cost savings for the organisation	☐	☐	☐	☐	☐	☐
E12. Other (please specify)						

E13. If you wish to further elaborate on your answers or if you have any comments on them, please use the space provided below.

Single open-ended response of maximum 2000 characters

Section F. Attitudes towards the value of engaging clinicians in quality improvement

F1. Please list the three most important activities that you see as quality improvement.

Single open-ended response of maximum 500 characters

1.

Single open-ended response of maximum 500 characters

2.

Single open-ended response of maximum 500 characters

3.

F2. How do you perceive engagement of clinicians in quality improvement?

Please rate on a scale of 1–5 (where 1 is very unimportant and 5 is very important).

☐ Very unimportant ☐ Fairly unimportant ☐ Neither unimportant nor important
☐ Fairly important ☐ Very important.

F3. Did the Engaging with Quality Initiative project successfully engage you in quality improvement?

Please rate on a scale of 1–5 (where 1 very unsuccessfully and 5 is very successfully).

☐ Very unsuccessfully ☐ Fairly unsuccessfully ☐ Neither unsuccessfully nor successfully
☐ Fairly successfully ☐ Very successfully

F4. Has your attitude towards the value of engaging clinicians in quality improvement changed due to your involvement in your Engaging with Quality Initiative project?

Please rate on a scale of 1–5 (where 1 is not at all and 5 is extremely).

☐ Not at all ☐ A little ☐ Moderately ☐ Considerably ☐ Extremely

F5. Please could you specify *how* your involvement in your Engaging with Quality Initiative project has changed your attitude?

Single open-ended response of maximum 500 characters

Thank you very much for taking the time to complete this questionnaire.

Invitation letter

Dear [clinical lead],

Re: Engaging clinicians in QI initiatives

RAND Europe and the Health Economics Research Group from Brunel University would highly appreciate your co-operation in inviting all clinicians participating in your project [name of project] to take part in a two-round web-based Delphi survey on engaging clinicians in quality improvement initiatives. The survey will help us understand how best to engage clinicians in a process of quality improvement and secondly what consequences this engagement has.

The survey is addressed to all clinicians participating in projects associated with quality improvement initiatives funded by the Foundation (Engaging with Quality I – EwQI).

Please could you inform your colleagues that completion of the survey will last approximately 10–12 minutes and focuses on:

- Barriers and facilitators to engage clinicians in a process of quality improvement.
- Consequences of engaging clinicians in QI on clinical outcomes.
- Use of external influences to leverage clinical engagement in QI at Trust level.

All answers will be treated in confidence and cannot be traced back to specific persons. After analysing the results per project and overall, all clinicians will be asked again to fill in the survey again taking into account mean scores (2 round survey).This means, that for each question we will show your score and the mean score of all respondents.

This information is important to us because we are trying first to understand how best to engage clinicians in a process of quality improvement and secondly what consequences this engagement has. We hope to identify lessons for clinicians and for the healthcare system as a whole.

Please complete the survey on-line at [name website]

Given the timeframe for this evaluation, we would greatly appreciate your responses before [date – within 2 weeks – follow up will be once by email].

Should you have any questions, we may be reached at the numbers listed below. We very much look forward to your response.

Thank you for your time and effort.

4.9 Analysing results

For each survey item, we will calculate the following statistics:[33]

- mean (average): the measure that represents the arithmetic average for the group of experts
- 95% confidence interval: representing the upper and lower limits between which 95% of the sample of expert scores will be expected to fall
- 5% trimmed mean: calculation of experts' average score with exclusion of the highest and lowest 5% of the scores; the difference between the mean and the trimmed mean shows whether there are many outliers in the rankings among the experts in the sample
- standard deviation: describes the variability of the score distribution.

We need to decide about the level of agreement – the literature offers little guidance on the level of agreement required as cut-off for consensus in a Delphi study. The levels vary from 55 to 100%. It is, however, important to determine this prior to data collection.[34] Because of the diversity between professional groups, we might choose to use the lower limit (55%) as the measure for agreement among the clinicians.

Letter to project manager for estimate of sample size per project

Dear [project manager]

The RAND Europe and Health Economics Research Group (HERG) Evaluation team would like to invite all clinicians participating in your EwQI project to take part in a two-round web-based Delphi survey on engaging clinicians in quality improvement initiatives. The survey will help us understand how best to engage clinicians in a process of quality improvement and secondly what consequences this engagement has. We anticipate the survey will only take 10–12 minutes.

We are currently in the early stages of designing the survey and need to know the size of our potential sample. This is very important to ensure we have a statistically representative sample.

Could you please let me know **how many clinicians** are participating in your Engaging with Quality project? (please include all study sites).

Further, **will it be possible to obtain e-mail address for all participating clinicians** (i.e. doctors and nurses)? If RAND Europe was able to obtain e-mail addresses these addresses would only be used for the purposes of the Delphi survey. If not, would it be possible to receive their postal addresses?

Ideally, we would like to ask each **clinical lead** in your project to forward the survey to all the participating clinicians to help ensure a good response rate. Could you please let me know whether you think this is possible? If not, could you please suggest how you think we should go about contacting all participating clinicians?

The Evaluation team is conscious that your project team may have already surveyed participating clinicians as part of your project. With this in mind, our survey will be voluntary and we will keep the length of the survey to a minimum to reduce the burden on clinicians.

I would be grateful if you could please respond as soon as possible. Please don't hesitate to contact me if you would rather discuss these issues over the phone.

Kind regards,

Chapter 5
Progess against aims

5.1 Summary of activities

- Continued development of each project team's understanding of, and progress towards, a successful self-evaluation through face-to-face meetings and feedback on their self-evaluations.
- Develop process for supporting the projects' final report to ensure consistency with each other and with the aims of the Initiative.
- Support two project teams through this process for developing their final report.
- Plan Delphi and liaise with projects with letters and follow up calls over its delivery.
- Discuss how to synthesise results, identify key issues, agree structure and style of final report and reflect on the emerging findings that might inform it.
- Complete interviews with projects, reflections on user involvement, and paper on user involvement in the Initiative.
- Provide briefing paper on understanding costs for projects.
- Contributions to and participation in residential events.
- Support the Health Foundation through acting on request to speak at Conference on Clinical Audit.
- Liaison with the Health Foundation through monthly telephone meetings, six-monthly face-to-face meetings, and written reporting.

5.2 Progress against research protocol

It had been anticipated that the penultimate 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 and that they were prepared for their final evaluations. However, due to agreed delays in projects' completion dates, we have had to stretch the evaluation resources over a longer period. Obviously the Evaluation team has no control over the completion dates and delays have added to the difficulty of managing our resources in the final stages of this Initiative. For example, the completion of the Delphi has moved back by some six months to

accommodate progress in the projects. Thus while progress has been good, and while we are on target to complete the final report next year, progress against the agreed evaluation protocol has been flexed. This is a necessary precondition for the successful evaluation of the whole initiative. The continuing strain this puts on the budget and on our own management, identified in previous annual reports, should be noted.

5.3 Initiative aims

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

We have made available, and supported the use of, self-evaluation pro formas, project diaries and key-learning-point reporting forms. We request that the Health Foundation ensures 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. This was successfully done in the case of the project with the Royal College of Physicians in Edinburgh. We have conducted interviews on user involvement with the projects and written a paper on user involvement that draws upon the interview data and wider sources. We have provided projects with a briefing paper on understanding costs. We have supported two projects through preparations for their final report.

A report on the second round self-evaluation returns from the project teams is at Appendix 4. As promised in this report, detailed feedback to each team on their return has been prepared. This feedback has already been sent to the two teams who are finishing all or part of their project before the others (the Colorectal Cancer Audit and the EPI-SNAP component of the RCPE project). It was discussed with them in detail at one-to-one meetings (at which relevant Health Foundation personnel were also present) in order to provide the teams with an agreed basis for their final reports. The provision of feedback to the remaining teams awaits discussion with the Foundation about the timing of the final stages of their projects.

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?

Drawing the findings from each project will be a challenge. We propose to deal with this through a structured re-analysis of the projects' final reports, transforming these into a series of mini-hypotheses (that may be only implicit in their report) and identifying the evidence they produce to support these hypotheses. This is described in more detail in Chapter 1. We anticipate that this will produce interesting and significant insights and provide a more solid basis for considering what works, in what circumstances, and why.

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

We have made support available to the projects on how to conduct their own surveys on this and we will also conduct our own Delphi. We have also been monitoring the progress of clinical engagement through our routine interactions with the projects in face-to-face meetings and at residential events. We hope to write up the findings of the Delphi survey as a separate publication. The residential events planned for July 2008 have also offered further insights to help meet this aim (and indeed Aims 4–6). Within this Aim, we will also complete the interim evaluation of the support team presented to the Foundation 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

Owing to the timelines in the projects, the key task in this aim has slipped into the coming reporting 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.[9] In autumn 2008 we will review the outcome of the Support Team's meetings to identify facilitators, processes and illustrations of externally supported, clinically led quality improvement, and consider how well the EwQI has addressed these. If these meetings do not generate sufficient information we may supplement them. 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

The concluding tasks for this aim were always planned for the final year of the Initiative. We will use Jocelyn Cornwell's paper on the professional bodies as a benchmark and establish how far professional bodies have progressed primarily through a series of in-depth interviews with the bodies participating in the Initiative. The interviews will focus on the bodies' contribution to the quality agenda, including standard setting, the development of quality measures, data collection and analysis, peer review and quality interventions. We also attended and spoke at the annual conference of coloproctologists on the theme of clinical audit and quality improvement. This work will be completed in the next reporting 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. Our own work will lead to a summative assessment of the overall cost of the Initiative and its consequences. As part of this work we continue to encourage the teams to explore the cost consequences of their projects. Overall the work we do under this Aim will necessarily include

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[9] Leatherman and Sutherland (2003, p 44) identified these as ways in which Royal Colleges could use their influence.

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.

Summary of meetings

In this section we list the meetings members of the evaluation team have attended during the past year:

- Meetings to discuss final self-evaluation reports: (1) Bowel Cancer: 21 December 2007; and (2) Epilepsy: 26 March 2008
- Residential meeting: November 2007
- Two sets of meetings with project teams to discuss self-evaluations
- Service user interviews
- Attending conferences in Scotland and London on behalf of project
- Meetings with the Health Foundation, including monthly phone meetings; six monthly face to face meetings; and other meetings as requested.

In summary this annual report provides a vehicle for explaining to others what has been done and offers reflections on what has been achieved. It is an interim formative evaluation intended to update the Foundation on the activities and progress of the Evaluation team as well as to provide the opportunity for mid-Initiative learning and adjustment.

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Appendix 1
Self-evaluation pro forma

EwQI Self-evaluation Diary

Q1. Background	Date	Author	Entry
• Why was this project needed?			
• Who are the intended users of the results of the project?			
• What is the communication strategy with people/groups listed above?			
• Why did you think that your approach would be effective?			
• Did you consider other approaches? If so, why were these rejected?			
• 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?			
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?			
• Description of improvement intervention and target audience: • Who developed it and when/how/by whom was it implemented? • What factors facilitated/hindered its implementation?			

continued

Q2a. Development and implementation of improvement interventions – *continued*	**Date**	**Author**	**Entry**
• How were the interventions evaluated? • What performance measures/quality standards were used and who developed them?			
Q2b. Data collection, analysis and feedback	**Date**	**Author**	**Entry**
• What data were collected to support the project and how were collections organised?			
• How were data validated?			
• How and by whom were collection processes developed and evaluated?			
• How were data analysed and fed back to units?			
• How was the data used and by whom?			
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?			
Q2d. Involvement of other groups	**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?			
• Were any other groups involved: eg, healthcare managers? If so, what were their roles?			
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?			
• Which parts weren't fully realised? • What factors hindered achievement of these parts?			
• How did recipients of the project perceive it?			
Q4. Who did what?	**Date**	**Author**	**Entry**
• Who was involved in designing, implementing and evaluating the project? • What was their contribution?			
• What was the role of your professional body and was it actively supportive?			

continued

Q4. Who did what? – *continued*	**Date**	**Author**	**Entry**
• 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?			
• Identify sources of external support and describe how these were used with comment on their value to the self-evaluation.			
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.			
• Increase in the levels of professional engagement in QI.			
• Increase in the capacity and infrastructure for QI in the professional bodies involved in the project.			
• Increase in the knowledge base			
• Sustainable arrangements for improving quality of care in this field of medicine.			
• A transferable system of quality improvement to other areas of medicine.			
• An increase in knowledge and understanding of quality improvement in healthcare.			
• Describe any unintended outcomes.			
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			
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?			
• Could this have been achieved more easily in other ways?			
Q8. Why did the project work?	**Date**	**Author**	**Entry**
• What factors helped or hindered?			
• What were the key ways of bringing about change (eg, repeat audit, training, information provision) and how well did these work?			
• Could the project be seen to have worked for some people but not for others?			

continued

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?			
• How will wider changes in the healthcare system support or undermine the improvement processes identified by the project?			
• How might the result of the project 'fit' with wider changes (eg, in the professions, funding, training, organisational context)?			
• In retrospect, how would you have modified your project in the light of this self-assessment?			

Appendix 2
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[36] as agreed with the Health Foundation 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 National Service Frameworks), development of quality measures, data collection and analysis, peer review and the evidence-based design of improvement strategies.[37] 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:

- including questions, alongside the results of the outcomes of Aim 4, 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.

Appendix 3
Summary of principles and indicators of successful consumer involvement in NHS research

The principles and indicators of successful consumer involvement in NHS research (from Telford *et al*).

Principles	Indicators
1 The roles of consumers are agreed between the researchers and consumers involved in the research	• The roles of consumers in the research were documented
2 Researchers budget appropriately for the costs of consumer involvement in research	• Researchers applied for funding to involve consumers in the research • Consumers were reimbursed for their travel costs • Consumers were reimbursed for their indirect costs (eg carer costs)
3 Researchers respect the differing skills, knowledge and experience of consumers	• The contribution of consumer-skills, knowledge and experience were included in research reports and papers
4 Consumers are offered training and personal support, to enable them to be involved in research	• Consumers' training needs related to their involvement in the research were agreed between consumers and researchers • Consumers had access to training to facilitate their involvement in the research • Mentors were available to provide personal and technical support to consumers
5 Researchers ensure that they have the necessary skills to involve consumers in the research process	• Researchers ensured that their own training needs were met in relation to involving consumers in the research
6 Consumers are involved in decisions about how participants are both recruited and kept informed about the progress of the research	• Consumers gave advice to researchers on how to recruit participants to the research • Consumers gave advice to researchers on how to keep participants informed about the progress of the research

continued

The principles and indicators of successful consumer involvement in NHS research (from Telford *et al*). – *continued*

Principles	Indicators
7 Consumer involvement is described in research reports	• The involvement of consumers in the research reports and publications was acknowledged • Details were given in the research reports and publications of how consumers were involved in the research process
8 Research findings are available to consumers in formats and in language they can easily understand	• Research findings were disseminated to consumers involved in the research in appropriate formats (eg large print, translations, audio, Braille) • The distribution of the research findings to relevant consumer groups was in appropriate formats and easily understandable language • Consumers involved in the research gave their advice on the choice of methods used to distribute the research findings

Appendix 4
Report on second self-evaluations

EwQI project self-evaluations – second responses

The aim of the EwQI project self-evaluations is to encourage the teams to reflect on their projects **as they are being implemented** in order to identify what changes they have achieved and to explore why this is so. The EwQI projects are at different stages and the second self-evaluation returns reflect this. This paper describes the picture emerging from these returns, noting key achievements and the challenges faced, and identifying some emerging themes.

Background

There was considerable variation in the formats of the first self-evaluation returns that we received in 2006. This made it difficult to compare and contrast those responses. We therefore developed a table that incorporated the nine questions from the the Health Foundation/RAND self-evaluation guidance (November 2005). This pro forma was intended to ensure that returns were comprehensive and easier to update. In April and May 2007 we had one-to-one meetings with all the EwQI project teams to discuss their second self-evaluations (due with the Health Foundation by the end of June 2007), and asked them to use this pro forma. (A copy of the pro forma is in Appendix 1.)

A table has advantages as a 'living document' or diary, but it can also be restrictive, providing only a rather 'thin' account of each project. To add depth and detail we therefore suggested that the project teams also select a (small) number of significant events over the past year and report separately on these, in addition to the pro forma. Selection of topics was left to the project teams, although we made some suggestions based on the previous year's returns and on what the project teams had told us about their work over the last year. These topics included recruitment, peer review, patient involvement, data collection, and the development and use of change diaries. We also suggested that this separate report (the Record of Significant Events – RSE) might take the form already used by one project team: a grid for each significant event that covered 'achievements' and 'lessons learnt', and 'challenges' and 'action taken'.

We also encouraged the teams to explore **why** change has occurred. In order to do this we suggested that they update their logic models, identifying changes in project design or implementation and exploring the reasons for those changes.

Process

This section describes what we received.

Half the second self-evaluation submissions were returned on time. Two others were late (one team asked for a delay in order to accommodate the return more appropriately within their project timetable), and two were very late, the final return coming in September. This caused delay in analysing the returns and writing this report.

Six out of eight of the second self-evaluation submissions followed the pro forma, compared with the three returns that used a table in the first round. Responses to the nine evaluation questions were more complete in the second round, although the differences in presentation between the two sets of returns make it impossible to quantify this improvement. There were still gaps, but these are now clearer and increasingly the teams have indicated where responses will be provided later. Two teams used tables in both rounds and we found that this made it much easier to see where the return had been updated, and how the design and implementation of the project had developed and changed. In general, however, we also found, as anticipated, that the pro forma tended to encourage brevity and provided little scope for detailed reflection on specific issues.

Three of the six teams who produced a pro forma also provided an RSE. The seventh team provided an RSE but no pro forma, and the eighth team followed a structure of its own choosing that took no account of the pro forma. As an adjunct to the pro forma, we found the RSEs helpful. They provided a richer account of specific achievements (such as meeting a recruitment target) and of specific challenges faced.

Although they encouraged some reflection, the RSEs had relatively limited explanatory value. This was most obvious in the two cases where teams had used the RSE format to consider their projects as a whole. The RSE does not encourage, and was not designed to encourage, detailed consideration of the causal links between context, mechanisms and outcomes that can help to explain why identified changes have occurred. The logic models we developed for each project at the start of the Initiative were intended to help the teams get inside this 'black box', but the teams appear to have used them only as one-off summaries of their starting positions rather than as dynamic models to help them identify and explore the theories underpinning their projects. Only one team returned a (slightly) updated logic model in this round, and even then made no attempt to link it to the rest of their return.

Content – general

This section describes what the second self-evaluation returns covered. Detailed, individualised feedback on each submission will be sent to each team prior to their next, and final, self-evaluation returns.

Background and implementation The second round returns provided updates on the background and implementation of each project, indicating changes that had occurred since the first return. Several teams recorded internal changes, describing how they had re-designed or adapted their projects during implementation. Others described external changes, initiatives that overlapped with their own objectives and which might therefore impact on the counter-factual. For example, one team noted that the Department of Health had finally decided to

develop an National Service Framework (NSF) for the relevant clinical services and had set a clear timetable for doing so; the NSF is due to be published when the project completes. In general, however, responses on the counter-factual were not substantially updated in this round.

Early achievements All the returns reported early achievements and associated challenges in some detail. The two topics most comprehensively covered were recruitment of participants (including retention and communication) and data collection (including feedback), and the general lessons learnt about these aspects of the projects are considered in the following section. Another topic that was widely discussed was patient involvement (which is the subject of a separate paper).

Outcomes and progress to date Not all the teams are yet in a position to report on outcomes, but three of the early starters (March/April 2005) were able to do so. The outcomes achieved included some intended improvements in care, some failures to obtain improvement, and some changes in attitude among participants. More work is planned by two of these teams (who will complete in March 2009) to explore why these results were achieved. The third team is due to complete in March 2008, and detailed feedback has already been provided to them in anticipation of a meeting in December 2007 to discuss their final report.

The fourth early starter (May 2005) has been much delayed. One arm of this project has been extended for an extra year (to May 2009); the other arm is due to complete in May 2008. The other four projects started later (October/November 2005) and were also delayed for various reasons (ethics approval, slow recruitment, and change of project manager). One has been extended to June 2009. The other three will complete as planned in October 2008, April 2009, and September 2009 respectively.

Economic evaluation Responses on this topic in the first round were sketchy, and there was very little additional information in six out of eight of the second round returns. It is not clear if these teams have identified any resources to help them with this aspect of the evaluation. The two remaining teams told us a little more about their intentions, but in minimal detail.

Sustainability The majority of the returns (five out of eight) included a response to this question. These responses were, on the whole, however, descriptions of how the teams had tried to build sustainability into their projects from the start through subscription schemes, by promoting system or process change, or by seeking to develop capacities in Trusts through training and other support. One project intended to complete in March 2008, and this team made it clear that they will need further grant funding. The two teams using subscription schemes have seen how well these have worked to date, and are planning further work to make them more attractive to potential participants. One other team hoped (rather vaguely) to 'develop interventions that can be supported by existing practices' but also identified the need for ongoing support for a database. The other teams saw sustainability as something to be tackled later.

Two key topics – emerging lessons

This section describes some of the common challenges the project teams faced during the second year of the Initiative, concentrating on the two aspects of the projects on which many of the teams reported at length.

Recruitment of participants One measure of willingness to engage in QI is willingness to be recruited into an appropriate study. In our *Second Annual Report* we noted that QI is perceived by many clinicians 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. What the self-evaluation returns told us was that recruitment has been a success story for the project teams. The EwQI projects had ambitious targets: one team, for example, planned to recruit 80% of eligible Trusts in the UK to a new audit. The returns confirmed that six of eight of the project teams met, or nearly achieved, their targets, that is, 75% of Trusts in the case of the audit just cited. The seventh team improved recruitment to an existing audit, although only marginally. The eighth team has so far only recruited to pilot sites.

Specific points were as follows:

- Recruitment to the EwQI projects was a huge task that took far more time and resource than anticipated. Aptly described by one team as a repetitive process, what was most needed was persistence, being readily available to local teams, and a consistent approach to enquiries. There was a need for strong project management – several teams stressed the importance of being well organised beforehand and the need for hard work and flexibility.
- There was a general emphasis on recruiting clinical teams rather than individuals, though the first approach was often to individual clinicians. There was also widespread, though not general, recognition of the need to involve others in the Trusts such as managers, including chief executives, even though they were not expected to be active participants.
- There was a need to develop clear messages for potential participants in order to 'market' the project locally. Good communications were vital – both for recruitment and for retention. A lot of telephoning was required, constant email contact, the production of appropriate flyers, newsletters and guidance for participants, a dedicated, regularly updated website – in general a lot of day-to-day interaction between the central and local project teams.
- The 'platform for QI' (to use the terminology of the *Second Annual Report*) that was available to each team varied from project to project. One component of this platform is organisational capacity. Where this varied locally it impacted on recruitment. Thus there were already local teams working in the relevant clinical field in five of the projects, and recruitment was a matter of targeting these teams and persuading them to participate. In the other three projects local teams had to be built as part of the recruitment process, a more complex task.
- All the teams relied heavily on their lead clinicians to motivate and chivvy colleagues. Some also benefited from an established network of enthusiastic clinicians. The potential of such networks was generally recognised, and where they did not already exist project teams sought to establish and maintain them.
- The incentives that project teams could offer participants varied from project to project, although the picture is confused because some teams thought they were doing audit or research rather than quality improvement. Among the incentives identified in the returns were 'free' access to audit and feedback, and support in complying with existing national standards.
- The returns also discussed disincentives, especially the difficulties of getting Trusts to release staff to the project in the present climate of NHS reorganisation and financial deficits. Some teams reported that local staff had been working on the project in their own time.

Data collection, collation, analysis and feedback A second component of the 'platform for QI' is informational capacity. Our *Second Annual Report* noted that existing clinical QI measurement systems, where they exist, are often unstable and under-funded. All the EwQI

projects supported clinical audit and feedback, some (four out of eight) also undertook organisational audits, and all used surveys in one form or another to explore patients' or clinicians' attitudes; but their starting points differed.

Specific points were as follows:

- All bar two of the EwQI project teams had to develop audits from scratch. This meant that they had to design the questions, design and build data collection systems, consider what feedback to provide and then pilot all these processes. This took time and resources.
- In the other two cases there were existing audits but these were very different. One was a one-off audit that was undertaken two years before the EwQI project started. The second was a well-established on-going audit funded in part by the Healthcare Commission that had been started four years previously.
- All the EwQI audits were, initially, 'free' to participants (excluding the not inconsiderable time involved in gathering and entering data locally), and costs were met from Health Foundation funding with, in one case, some continuing support from other sources. Two teams are now charging participants for the use of their audits. The rest face the issue of **whether** their audit should be sustained, and, if so, **how** that can be done once Health Foundation funding ceases.
- Data on clinical care were collected from case notes and entered onto databases by hand-in wards or hospital departments. To collate and analyse these data and provide feedback to participants, project teams have set up electronic data systems. Their experiences with these differed considerably. In four projects the electronic databases chosen by the teams have worked well, minimising potential delays in data entry and analysis, and allowing rapid feedback to participants. Two teams were able to provide feedback in five weeks or less. Crucial factors appear to have been local expertise (all four projects had support from others in their College), careful preparation in advance, and a degree of pragmatism about what was appropriate and affordable within the timescale and budget of the project.
- Two other projects experienced very considerable delays getting their electronic databases up and running, and found the whole process expensive and time-consuming. One is continuing to use parallel paper and electronic systems, and feedback has been slow, dictated by the pace of the paper system. The second project has not yet found an affordable system.
- All the teams faced the standard concerns about the validation and completeness of their audit data. One project team took these concerns very seriously, working hard to develop robust audit tools that minimised bias. For them this was of first importance because their assumption was (and is) that sound audit data alone can promote improvements in clinical practice. Other teams took a more pragmatic view. They saw audit and (rapid) feedback as part of a wider process of improvement that also included other interventions at local level – training, peer review visits, action planning and so on. The audit was therefore seen as a tool to be developed in use, not in isolation. There is a balance to be struck.
- Data on patients' and clinicians' attitudes were collected through surveys and questionnaires. Some project teams were very familiar with these methodologies, and were able to use tools that had been validated in other studies. Other teams did not have the relevant experience or expertise, and had to learn on the job. There could have been opportunities to share information and understanding across the Initiative and develop the available methodologies but in practice this did not happen except in the two instances where two projects were based in the same college.

Emerging themes

Our understanding of the context within which the EwQI projects are working was outlined in our *Second Annual Report*. Any large research or audit project is challenging but large scale QI projects present additional difficulties. This section identifies some of the general issues emerging from the second round returns.

Uncertainty about QI One challenge is the widespread uncertainty about what QI involves. This was evident among the project teams at the start of the EwQI, there was a tendency for the teams to see their studies in terms of the sort of research or audit projects with which they were familiar. In some cases this led to delays. One team had difficulty getting ethics approval because in their initial application to the ethics committee they wrongly described their project as a clinical trial rather than a QI project (albeit with a research component). When they described what they were planning to do more clearly, both they and the committee were less confused, and approval was granted.

The Health Foundation is providing extensive support to help the project teams develop their understanding of QI as they go along. There is evidence from the returns and from interviews with individual team members that this is being achieved. But if such support is needed – and the EwQI is not testing this because all the projects are treated the same – then there are issues about how much support is needed, and about how much time the teams should devote to 'learning on the job', rather than to the implementation of the project.

There is an apparent tension between reports that QI is widely perceived by clinicians to be a relatively low status activity with poor rewards (see our *Second Annual Report*) and the willingness of clinicians to engage in the EwQI projects (as demonstrated by high recruitment rates). Uncertainty about QI and an impression that it is all about (unintelligible) system change could explain the first view; the emphasis in the EwQI on clinical engagement and clinical performance may explain what actually happened, but this remains to be explored.

Change A second challenge is change – the very thing that the EwQI projects are seeking to promote. Research seeks to **identify** beneficial change using a pre-defined protocol and identified measures of outcome. Clinical audit seeks to **measure** change, using pre-defined procedures for collecting and analysing clinical data. QI, on the other hand, seeks to **make** change during the course of the project through rapid and repeated iterations of intervention, measurement of outcome and feedback. As part of this process the project itself is subject to change and development as it goes along, and this, in turn, places further demands on the project teams. For example, one EwQI team has altered the list of clinical outcomes they are seeking to improve following an initial audit that indicated that some early goals had already been achieved; another is planning to widen the scope of their project following waning interest among potential participants in the narrower target they were initially pursuing. As well as understanding what QI involves, project managers also need to appreciate what **managing** a large-scale QI project involves. A prime requirement is flexibility in the light of on-going change.

The local teams participating in each project have faced these same challenges but for them there has been no dedicated support programme. Their support has come from regular and repeated contact with the central project teams. Good communication between the central and local teams has therefore been essential. This has taken a lot of time and effort on the part of the central teams, and the returns highlight some useful approaches, including regular newsletters and electronic networks. Key issues are how to provide enough information without overburdening recipients, and how to reach all members of the local team, not just the team leader.

Patient-centred QI There is a wide-held view that QI should be patient-centred. One requirement of the EwQI was that service users should be involved in the central project

teams, and the local teams have also been encouraged to involve service users. The message that has emerged from the returns, and from the additional work we have done on this topic, is that involving service users **effectively** at any level is very resource intensive. This raises the question of what, in practice, is actually achievable with regard to user involvement, especially in QI projects such as the EwQI projects that have a large number of local participants and, inevitably, limited resources.

Platform for QI The 'platform for QI' that is available to the project teams has varied quite extensively from project to project. In some projects certain components of this platform were already in place, including existing organisational capacity such as established clinical teams in the Trusts, or a pre-existing audit. In other projects these components had to be developed, which takes additional time and resources. This suggests that any risk assessment of prospective QI projects should take account of the existing 'platform' that is available and note any missing components. Similar considerations apply re the availability or otherwise of 'facilitators for QI'.

Timing Finally there is the question of timing. Most of the EwQI projects were developed and implemented on the back of very recent guidance from NICE or a professional organisation, and to that extent were opportunistic. One project, however, team has found that as the impact of such guidance fades over time, so too does interest in the project with participants turning their attention to other areas of practice where improvement is also needed. It may be possible to deduce general lessons about the timing or the duration of large-scale QI projects from the EwQI, but it is not yet clear what these are.

Conclusion

The EwQI teams had a lot more to say this time – the second round returns were more comprehensive and complete than those received last year. The pro forma has also helped, making it easier to collate the returns, to identify gaps, and to provide feedback to the teams. But these returns reflect the varying stages reached by each project: some are nearing completion while some have only recently really got going. There was good coverage in all the returns of the development and early implementation of the projects, but there are still substantial gaps, and only a few projects have as yet reported any outcomes. Any conclusions we have drawn are therefore still tentative at this stage and largely relate to the early stages of the projects. This is work in progress.

Appendix 5
Draft outline of final report

In this appendix we outline the intended structure of the substantive content of the final report and discuss how this might be presented for communication purposes.

Aims of EwQI

Choice of topics, QI gaps and applications process

Our role, the Health Foundation's role, support team role, projects' roles (eg self-evaluation)

Ch1 The theory and understanding of QI before EwQI

Introduction: how it differs from audit and research; the state of knowledge of QI – what was the theory behind EwQI? Where did the projects start from?

Who is seen to be needed to deliver QI?

How are key stakeholders best involved in QI (teams, inter-disciplinary, as royal college members etc)?

What mechanisms (tools) facilitate engagement in QI? (audit, peer review, guidelines, plan-do-study-act cycles, training, evidence, etc).

What are the perceived **barriers** to QI: complexity, institutional instability, ethics and research committees, low status of QI activities.

Ch2 Involving in QI: the lessons learned

Introduction: meaning of involvement and engagement. What was known about engagement before EwQI – more generally and by the projects in particular?

Who was involved in EwQI and with what consequences? Were the right people involved?

How were they involved? What worked for different stakeholders? (for example, pester factor, calling on the great and the good etc).

What tools engaged people and groups in QI?

What **barriers** were overcome or proved insuperable?

Summary and conclusion:

Partnership and stakeholder involvement

Royal Colleges and Professional Bodies

Other important players eg managers

Ch3 Managing QI

Introduction: Management, QI and Managing QI

Who was involved in managing QI in EwQI?

How did they seek to manage?

What management tools were used and with what consequences top-down/bottom up etc.

What **barriers** were overcome and what proved insuperable? And how does managing QI differ from research management, how does it differ from managing services? Is there a particular skill set?

Summary and conclusions:

Is there a model of good management of QI?

Ch4 Measuring QI

Introduction: why measure? QI and research.

Who was involved in measuring QI impact in EwQI?

How was QI measured?

What measurement tools were used (cost–benefit anaylsis, qualitative, counterfactuals, logic models etc).

What **barriers** were overcome in measuring QI? What proved all too much and was not overcome?

Summary and conclusions:

What has EwQI added to our understanding of measuring QI?

Ch 5 What have we learned from the evaluation

Who needs to be involved to deliver successful QI

How do they need to behave?

What tools are available and helpful?

What barriers can be overcome and what barriers are likely to prove too great?

Conclusion:

What works, where, when and why?

Appendices

Evaluation protocol

The logic models (including one for whole scheme?)

The projects

Participants

Bibliography

Style and Layout

The Health Foundation has indicated that they wish the final report to conform to strict criteria. Their intention is to have a final report that can have greater impact and be more readily communicated. We will produce a longer version that meets our own requirements of quality assurance and ensures we have fully collated and analysed the data, and a shorter version for wider dissemination which uses the suggested structure but which draws on the same substantive material and arrives at the same conclusions.

The suggested approach follows the recommendations of the Canadian Health Research Foundation (CHSRF). They advocate a '1:3:25' approach to presentation:

> Every report prepared for the Foundation has the same guidelines: start with one page of main messages; follow that with a three-page executive summary; present your findings in no more than 25 pages of writing, in language a bright, educated, but not research-trained person would understand.[38]

The CHSRF openly acknowledge that this is not a structure that meets the requirements of academic writing which is why we would be unable to produce only one report.