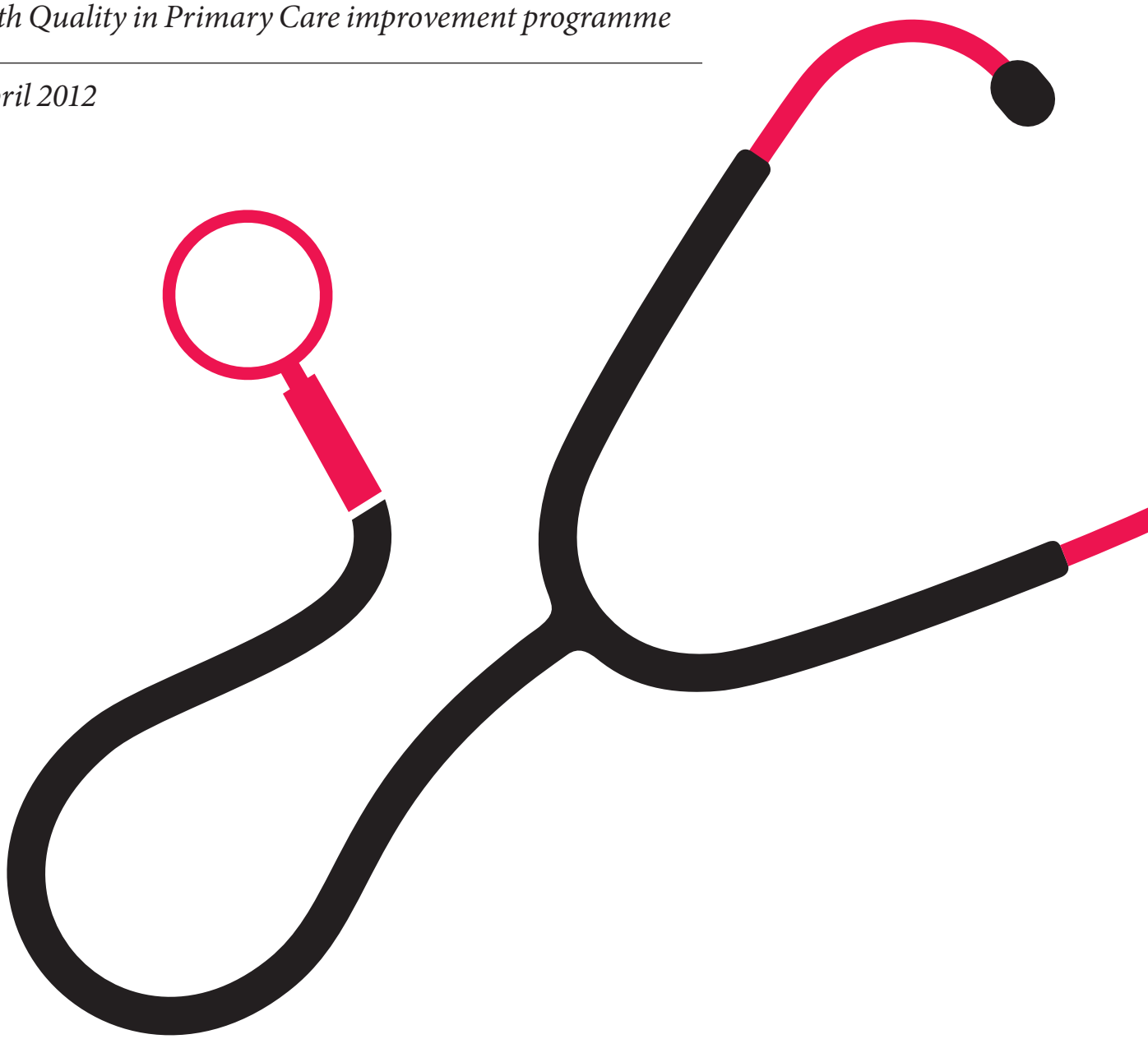
Evidence in brief:

Involving primary care clinicians in quality improvement

The Health Foundation
Inspiring Improvement

Summary of an independent evaluation of the Engaging with Quality in Primary Care improvement programme

April 2012



Identify Innovate Demonstrate Encourage

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For more information, read the full report:

Evidence: Involving primary care clinicians in quality improvement

Available to download from www.health.org.uk/publications

Commentary from the Health Foundation

In 2007 the Health Foundation launched the Engaging with Quality in Primary Care (EwQPC) improvement programme. Building upon a previous initiative in secondary care, it aimed to engage primary care clinicians in clinical quality measurement and enable them to contribute to the knowledge base on improvement.

The Health Foundation funded nine EwQPC projects that would increase the capacity for clinical quality improvement in primary care and engage primary care clinicians in clinical quality improvement. The programme also aimed to enable primary care clinicians to contribute to the knowledge base on improvement and use the evidence generated to embed clinical engagement in efforts to improve the quality of primary health care.

The independent evaluation, undertaken by a team from RAND Europe led by Professor Ling, identified a wide set of benefits. The projects secured and maintained the involvement of clinicians and were associated with changes in clinicians' attitudes, behaviours and understanding. Patient involvement was an important and successful element of the programme.

The projects also learned a lot about the challenges and opportunities of implementing improvement efforts. Measureable benefits for patients were found, but overall they were modest and patchy. Four of the projects have been able to sustain their work since the programme ended.

The evaluation report also offers a candid critique of quality improvement approaches and evaluation methods.

First, the report asks whether the results could have been achieved by other means. The authors identify some distinctive features of the projects funded:

- the focus on aligning different approaches involving multiple groups and organisations
- a concern with continual, self-conscious change across communities of practice
- an effort to get to and change the internalised and collectively reinforced practices that might be at the root of the problem
- an aim to move emotionally as well as improve rationally.

'The problems they [the projects] are well placed to address are those difficult to improve with guidelines, audit and financial incentives alone. They are the problems that are found in how knowledge is used in groups or communities of practice, how attitudes are collectively reinforced by organisational life, and how behaviour is collectively sanctioned.'

They conclude that that there is a legitimate role for quality improvement projects of the type funded through the programme, but add:

> *'However, for this to happen well, and for it to generate learning, each QI project requires much greater clarity about its purpose. Complexity and emergence are not an excuse for lack of clarity about purpose – they make such clarity even more important.'*

This latter point resonates strongly with the findings of a recent review of the Health Foundation's independent evaluations which was undertaken by Professor Dixon-Woods and colleagues, published in a report called *Overcoming challenges to improvement*, available from the Health Foundation website. Dixon-Woods argues strongly for the value of developing a theory of change as part of the design of improvement interventions and keeping it under constant review as an initiative proceeds.

Professor Ling and colleagues argue for greater clarity about which improvement approaches are most appropriate to a particular problem. Again, this resonates with Dixon-Woods and colleagues, who say:

> *'Perhaps the over-riding message is that there is no magic bullet in improvement. This does not mean that nihilism has a place, but it does mean a need to accept the challenges and adopt a solution-focused approach. Much of what we have found concerns tensions and balances, so solutions need to be nuanced, sensitive, and sensible, while maintaining a firm focus on the benefits of improvement for patients.'*

Professor Ling and colleagues also consider how to ensure a good fit between improvement approaches and evaluation methods. They maintain that the improvement projects in EwQPC sit between clinical trials and highly complex interventions and encompass some attributes of each. Reflecting on the emergent nature of most of the projects, the evaluators questions the value of the hypothesis testing approach used by some of the projects in their 'local' evaluations. They also raise concerns about the ability of the projects to undertake 'useable' economic evaluation – the absence of good data on patient benefits and costs can clearly limit their ability to make the business case for further investment in improvement work.

The evaluation provides clear lessons about the challenges of undertaking improvement work and confirms the findings of other similar studies that show differences between ambition and practice.

Dr. Dale Webb
Director of Evaluation & Strategy
The Health Foundation

The projects and the evaluation approach

Key features of the approach taken to improving healthcare quality in the nine projects were:

- formal steps and activities, mapped out in advance and communicated to relevant stakeholders, with activities defined and goals identified
- improving a system, rather than focusing solely on improving skills of individuals
- identifying new ways for different groups of clinicians and patients to work together
- collecting evidence that allows judgements to be made about the worth of the project
- changing what happens for patients.

The nine projects that took part in Engaging with Quality in Primary Care

- Implementing evidence-based primary care for back pain (IMPaCT Back); Keele University
- Improving the quality of mental health in schools (QUEST); Institute of Psychiatry, King's College London
- A whole-systems approach to quality improvement (QUALITY:MK); Milton Keynes PCT
- Primary care domestic violence programme (IRIS); Queen Mary, University of London
- A quality outcomes framework for gastrointestinal (GI) disorders (IMAGE); CORE (Digestive Disorders Foundation)
- Improving the management of back pain in the Community (LIMBIC); Bournemouth University
- Equity, ethnicity and expert patients (EQUITY); The Clinical Effectiveness Group (CEG), Centre for Health Sciences, Queen Mary, University of London
- Quality improvement in chronic kidney disease (CKD); St George's University of London and Kidney Research UK
- Resources for Effective Sleep Treatment (REST); West Lincolnshire PCT

These projects were very varied in scope and scale:

- four projects focused on one clearly defined set of changes in one clinical area in a limited number of sites (IMPaCT Back, QUEST, IRIS, LIMBIC)
- two had a similar tight focus, but sought change in a larger number of practices (CKD, REST)
- one sought change in four different conditions across many practices (IMAGE).
- finally, two projects, (EQUITY and QUALITY: MK) aimed to promote change in a variety of conditions across all general practices within a local health economy.

The Health Foundation commissioned RAND Europe and the Health Economics Research Group (HERG) at Brunel University to evaluate EWQPC through:

- Supporting projects to self evaluate, assessing measurable improvements in patient care and identifying factors associated with success
- A programme level evaluation, building on self-evaluation findings.

The evaluator team worked closely with the project teams on the development of their projects and self-evaluation plans, carried out surveys of clinicians, commissioners, service users, and provided evaluation support, for example on identifying costs and cost consequences analysis.

The project teams were also offered support in developing quality improvement skills, leadership capacity and team working by Karen Picking Associates.

Engaging clinicians and service users

How did the projects engage clinicians?

The overarching aim of EwQPC was to engage primary care clinicians in projects to improve the quality of clinical care; projects were directed and implemented by clinicians. Evidence from the programme suggested that real engagement requires clinicians to act as partners to their colleagues, accept shared accountability for the service provided to patients, offer leadership and work with others to change systems when it is necessary for the benefit of patients.

The EwQPC projects demonstrated that quality is not just to do with changing the procedures that govern everyday practice, but also with changing clinicians' goals. Above all quality is connected to the culture within which clinicians practice and within which they reflect and adapt their practices. The QUALITY:MK team put this succinctly when they said:

'Quality is not an activity, it's a habit.'

Engaging clinicians meant having enough commitment to keep people on board in the face of difficulties and time pressures; it was critically about winning hearts and minds – telling people about quality improvement and giving them tools to improve care.

Key lessons on engaging clinicians

1. Be clear about what is required

It is important to be clear with GP practices about what they are being asked to do. Project teams commented:

'In a future situation there should be absolute clarity about what is involved for all parties who engage.'

2. Appeal to clinicians' professionalism and values

It was important to clinicians' engagement that projects were clinically driven. Cost saving for the organisation was reported to be the least important factor.

Clinicians said that important motivations for their participation were:

- improved professional skills and training
- greater evidence-based standardisation of professional practice
- improved patient satisfaction/experience
- building a knowledge base on how to improve patient experience.

3. Be flexible in piloting and tailoring improvement interventions

Several projects found it helped to take time initially to explore the improvement interventions they were offering and to determine what clinicians thought worked best. This early work then proceeded to a more formal trial of the selected intervention(s). Projects also found they needed a good understanding of context.

> *'Understanding authority structure and information flow within practices is important for a future study.' (IMPaCT)*

4. Involve other members of practice staff

Projects' experiences were that all the practice team needed to be involved.

> *'The use of other Practice staff (physiotherapists, nurses and support staff) to promote the study amongst their GP colleagues has been effective in some practices.' (IMPaCT)*

The IRIS project, for example, found that involving and training receptionists was very successful, and greatly benefited the project through achieving direct referrals and better use of publicity in public areas.

5. Use both financial and non-financial incentives for clinician engagement

It was important to have a range of incentives, of which payment was only a part. Training and mutual learning were also important.

> *'It should be noted that although payments were made to assist in the development of the interventions, ongoing support has been very forthcoming from various clinicians who have treated the work as a development activity and a shared learning experience.' (CKD)*

6. Have influential champions

Project champions helped teams maintain engagement. These champions were often GPs, but projects also used hospital consultants and specialist nurses as champions. What mattered was not who the project champion was, but having the right person available regularly. Each team also needed someone to lead the project within the practice and provide a contact point. As with the project champions, this was often, but not always, a GP.

7. Have good project support

It was crucial to provide support to maintain engagement. Support included help with data identification and collection, rapid and easily intelligible feedback of findings to the practices e.g. through statistical process charts, and communications to share ideas such as newsletters and the LIMBIC wiki.

8. Make service users' needs a central driver

A key outcome of EwQPC was the shift in many project teams from a medical mindset that viewed improvement as a change in the clinical care given to patients, to a more patient-centred view of improvement as change introduced in response to patient needs actively identified by patients.

How did the project teams engage service users?

The different project teams involved a range of service users, including individual service users, representatives of specific patient organisations and members of a PCT public/patient forum. The teams learned the importance of understanding the different roles that these various categories of service user can play, and the need to involve multiple service users on the project teams throughout the projects.

Service users were involved at the formal start of all the projects, and the importance of early involvement was widely recognised. One EwQPC team built on what they had learned and delayed the expansion of their project into other clinical fields until they could involve service users in the early planning stages. In all the projects the roles of the service users in the project teams changed and grew over time, and they became increasingly active in shaping their own involvement.

The joint training for clinicians, service users and other members of the project teams produced a strong collaborative ethos within teams. This continued to develop throughout the programme, and the programme's clinical leads became increasingly confident about making full use of the contacts and in-depth understanding of the service users on their teams. They involved them in various aspects of the projects, such as the recruitment of service users from the wider community, the design of patient questionnaires, help with GP training and redefinition of a project's objectives. For many project teams this represented a real shift from a medically-dominated approach to improvement to a more patient-centred orientation.

Overall, and within a wide range of contexts, the programme's collaborative approach to service-user involvement produced positive procedural gains in individual projects and enhanced understanding among all the members of the project teams.

Impact of the projects

What impact did the projects have on improvements in patient care and health outcomes?

Across all the projects, the general direction of change was positive but slight. The majority of the changes reported by the project teams were improvements in patient care rather than in health outcomes. Measurable benefits for patients were achieved but the changes identified were modest and patchy.

- Only IRIS reported substantial and statistically significant effects on disclosure and referral rates. The IRIS project team also provided sound evidence from other studies linking these improvements to improvement in health outcomes.
- Seven projects reported small improvements in patient care. In only one project (LIMBIC) was this change statistically significant, and this was for only one measure (number of GP visits).
- Three projects reported small improvements in patient outcomes. In two of these projects (IMPaCT Back, IMAGE) these changes were statistically significant.

Spreading and sustaining the projects

How were projects subsequently sustained and spread?

Projects secured continuation and spread of their work after the end of the programme in a number of different ways:

- Quality MK (Milton Keynes whole system quality improvement project) continues to co-ordinate improvement efforts in Milton Keynes, including building QI into the new commissioning process.
- IMPaCT secured funding from NIHR to develop their monitoring tool to help clinic and to target and monitor treatment progress among high risk patients and received follow-on funding from Arthritis Research UK (under the title Start Back)
- IRIS secured funding to continue their work; and has rolled out the model to other health economies. IRIS has had its results published in the *Lancet* and has been featured as best practice in several reports on dealing with domestic violence.
- EQUITY developed a health equity dashboard which is could be used in other conditions to demonstrate reduction in health inequalities by age, gender, ethnicity
- REST's model for PCT /clinician collaboration has received follow-on funding as a translational project, Improving Primary Care Resources for Effective Sleep Treatment (IPCREST), funded by East Midlands Health Innovation and Educational Cluster which aims to spread the learning through seminars, workshops and an e-learning programme for healthcare practitioners

Lessons from the projects and the evaluation

What did the project teams learn about how to implement quality improvement?

Below are some of the main lessons learned by the teams on how to implement quality improvement successfully:

Build sufficient capacity

- Build on past experiences and relationships.
- Recruit good project management skills.
- Pilot work and learn and adapt as the project unfolds.
- Resource IT expertise sufficiently; never assume that untested software will work as planned.
- Use multiple means of communication to reinforce research networks and strengthen recruitment.

Make sure data systems are fit for purpose

- Involve data providers in designing data collection.
- Make sure data providers get feedback and support to maintain their engagement.

Maintain good communications

- Develop multiple channels including face to face, paper and electronic.
- Recruit champions who communicate well and with authenticity.
- Create targeted messages, for instance focused on particular professional groups.

Be able to respond flexibly and adapt

- Foster a culture and structure for learning.
- Establish adaptive mechanisms, and allow change within agreed boundaries.
- Review activities – how would you do it differently next time?

Sustaining the interventions

- Show visible benefits for patients.
- Demonstrate an unique benefit for providers.
- Provide a compelling business case.

Embed interventions in the wider setting

- Use available health research evidence to identify and justify the intervention.
- Use existing practice to facilitate implementation.
- Use existing guidelines, incentives and priorities to support project outcomes and spread learning.

Share vision, share skills

- Co-produce the intervention, involving participants as informed partners.
- Embed training within the project.

Support and spread learning

- Ask external bodies for guidance, information tools to support the intervention.
- Involve external bodies in communicating and endorsing findings to maximise impact.
- Engage with national forums to take learning forward and promote further improvement.

What did the projects learn about undertaking economic evaluation?

Each project was required to undertake an economic evaluation. At the time of writing the report (February 2011), the evaluators had received limited costing data from only four projects, and no completed economic analyses. Four projects told them that they had undertaken, or were undertaking, such analyses but these were not yet available.

Lessons for economic evaluations of quality improvement

- Demonstrate that the intervention results in clear improvements in outcomes or process that are seen as valuable by commissioners. To do this it is essential to have information about what would have happened without the intervention – a counterfactual.
- Understand that improvement interventions are complex and subject to change, which makes benefits difficult to identify.
- Establish early in the project development what data are needed to demonstrate that improvement has occurred and what efforts are needed to collect these data and at what cost.
- Estimate resource use and cost in multifaceted interventions – these may include external costs – and decide what to include.
- Establish the nature and rigour of the economic analysis required. A business case may be sufficient.

What did the evaluation learn about the improvement approaches used by the projects?

Quality improvement projects are one solution among many, but have a particular contribution to make.

There are many competing 'solutions' to the problem of a gap between achievable and actual healthcare in primary care. The relatively clear features of 'industrial models' of quality improvement projects become more diffused and emergent when transposed to a health setting. Other approaches which quality improvement projects relate to (and sometimes absorb) include: guidelines, audit/feedback, use of opinion leaders, financial incentives, setting national standards, clinical governance, annual appraisal, public access to performance information, inspection, and patient safety initiatives.

What differentiates quality improvement projects in the NHS is:

- their focus on aligning these different approaches and involving multiple groups and organisations,
- a concern with continual, self-conscious change across communities of practice,
- an effort to get to and change the internalised and collectively reinforced practices that might be at the root of a problem.

Quality improvement projects aim to move emotionally as well as improve rationally. The problems they are well placed to address are therefore not problems that are easily improved by guidelines, audit and financial incentives on their own. They are the problems about how knowledge is used in groups or communities of practice, how attitudes are collectively reinforced by organisational life, and how behaviour is collectively sanctioned.

Evidence from the EwQPC programme highlights four elements which are crucial to the successful delivery of quality improvement projects in primary care:

- **Leadership**: Quality improvement projects in the NHS involve different groups and individuals who are usually not in 'command and control' relationships. Aligning activities therefore requires skilful leadership (which might need to change during a project's life).
- **Identity**: stakeholders' participation in quality improvement projects is associated with entrenched ways of working and strongly held identities and these can either be barriers or facilitators to quality improvement activities.
- **Knowledge and skills**: Quality improvement projects often require knowledge and skills that are not part of the routine work of the NHS.
- **Sustaining benefits**: Quality improvement projects compete for attention and resources with other approaches intended to improve the NHS. Careful planning is required to ensure that successful or promising quality improvement projects are sustained and spread.

There is a need for greater clarity about which quality improvement approaches are most appropriate to any particular problem. Quality improvement projects often have a distinctive framework, but also integrate different approaches and interventions, which can lead to confusion of purpose and ambiguity.

Conclusions

Evaluation and learning of quality improvement projects are much improved when teams have greater clarity about their pathways to improvement. Key tools include:

- explicit theories of change
- cost templates and cost estimation
- patchwork or hypothetical counterfactuals
- contextual analysis
- milestones towards impacts.

Quality improvement projects require the following planned sequence of activities:

- Development of coherent engagement around a project through leadership, relationship building, political understanding and understanding of group identities.
- Overcoming political and emotional challenges from stakeholders with vested interests and entrenched ways of working.
- Building the values, knowledge and skills needed.
- Planning for spread and sustainability.

Quality improvement projects should have a business case covering the improvement expected over a given timescale. This should include:

- description of the activities involved
- assessment of the sort of context likely to support it
- outline of the costs
- outline of anticipated benefits.

Find out more

The full report, *Evidence: Involving primary care clinicians in quality improvement*, which this summary is derived from, is available to download free of charge from the Health Foundation website at:

www.health.org.uk/publications

The full report includes more details of the evaluation and the methods used, together with in-depth information on all the findings and all references.

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

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

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

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

The Health Foundation
90 Long Acre
London WC2E 9RA
T 020 7257 8000
F 020 7257 8001
E info@health.org.uk

Registered charity number: 286967
Registered company number: 1714937

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