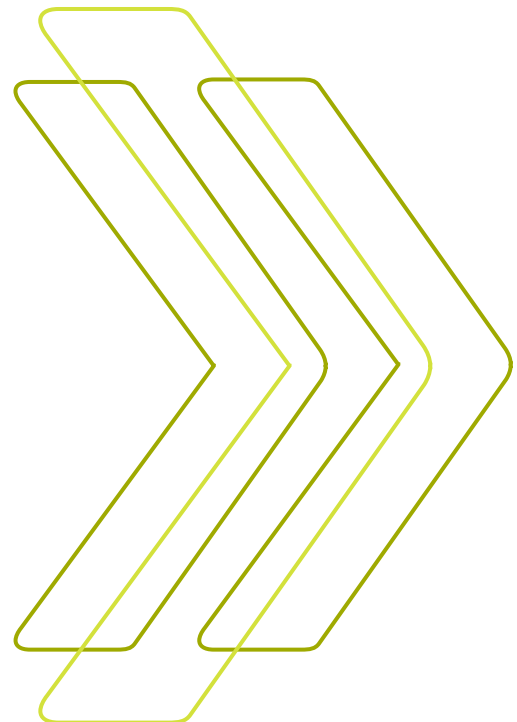


# Improving patient safety through collaboration

A rapid review of the academic  
health science networks' patient  
safety collaboratives

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# 1 Introduction

For an instant in the early 2000s, government put quality improvement at the heart of its strategy for improving quality and safety in the NHS. The NHS Plan of 2000 committed to major national improvement programmes to raise standards. The NHS Modernisation Agency brought together 750 experts to support local NHS organisations in redesigning services and improving outcomes. Sir John Oldham's primary care collaborative – the largest improvement programme in the world at the time – delivered dramatic improvements in access to services and tangible reductions in mortality in just 40 months.

Five years later, the government's commitment to systematic quality improvement had dwindled. The Modernisation Agency was disbanded in 2006, replaced by the NHS Institute for Innovation and Improvement, with a fraction of the Agency's staff. Political attention turned to payments, the commissioning cycle, waiting time targets and regulation as cures for the NHS's quality problems, rather than the hard graft of improvement projects. Within a decade and a half, the Modernisation Agency was recast as the NHS Institute, NHS Improving Quality, the Sustainable Improvement Team and now NHS Horizons – a new entity every three years. The history of quality improvement in the NHS is one of brief fads, unstable funding and endless reorganisation.

It was against this backdrop that the 15 newly established academic health science networks (AHSNs) took responsibility for running new NHS patient safety collaboratives in the mid-2010s. The Mid Staffs scandal had bluntly reminded the NHS of the importance of continuous quality improvement – and the limits of market mechanisms, targets and regulation – in ensuring even basic standards of care. The national advisory group led by Don Berwick following the Francis Inquiry highlighted the need for the NHS 'to become, more than ever before, a system devoted to continual learning and

improvement'. One of the review's main recommendations was for NHS England to 'sponsor the development of new regional or sub-regional collaborative networks across the country, perhaps aligned to and working with the new Academic Health Science Networks' (National Advisory Group on the Safety of Patients in England 2013). The AHSNs started to recruit staff for the collaboratives in mid-2014, tracking down people with skills and experience who had been dispersed during the previous 10 years. They did so in the absence of 'an integrated and coherent quality improvement strategy' for the NHS (Ham *et al* 2016).

This discussion paper, commissioned by the AHSNs, takes stock of their progress in rekindling quality improvement for patient safety through the collaboratives, and reflects on how they might build on initial successes during their next contract period. It seeks to make a useful contribution to the debate on how to support safety and improvement in the NHS, while recognising that it is possible to adopt different perspectives on a complex set of issues. It draws on interviews held in autumn 2018 with leaders and participants in the collaboratives, leaders with experience of overseeing quality improvement at the national level, and experts on quality improvement, as well as a roundtable discussion with NHS leaders in November 2018. It also draws on the body of existing research on the collaborative method. The AHSNs provided funding for The King's Fund to carry out the work. The King's Fund retained sole editorial control, and the contents of the discussion paper and the recommendations are those of the Fund and the authors.

We did not attempt to evaluate the collaboratives' effectiveness. Like other large-scale programmes, the collaboratives can point to considerable successes alongside some disappointments. There is already good evidence that these types of programmes can deliver improvements, but also abundant evidence of the challenges of doing so consistently in different contexts (Bate *et al* 2014; Schouten *et al* 2008). Instead, we aimed to develop our understanding of what has worked best in particular circumstances, what

practices might be applied more consistently across the collaboratives, and what further learning is needed to increase their effectiveness.

After four years of the collaboratives, there is uncertainty about their role within a shifting patient safety and improvement landscape. In December 2018, NHS Improvement launched a consultation on developing a national patient safety strategy for the NHS, including how to improve the patient safety collaboratives. Across England, local NHS organisations have formed sustainability and transformation partnerships (STPs) and integrated care systems, creating new opportunities for supporting improvement. We need to ask how the collaboratives will fit within this changing landscape, and how these tiny teams can best contribute to regional health systems the size of small countries.

Recent history suggests that there are risks in rushing to judgement, and leaping to new structures or approaches before the previous initiatives have had the chance to sink roots. Instead, we believe the focus should be on stability. We tentatively suggest a small number of changes in how the AHSNs lead the collaboratives, and a few principles that might guide broader policy on improvement.

## 2 Establishment of the collaboratives

Interviewees described the flurry of activity within central government and the AHSNs to establish the collaboratives in 2014. Government was understandably eager to demonstrate rapid progress in improving safety following Mid Staffs and implementing the Berwick Review's recommendations. Policy documents from 2014 set out the collaboratives' role in extremely broad terms, leaving considerable scope for interpretation: they were to deliver 'definitive and measurable improvements in specific patient safety issues over the next five years'; and to 'build system-wide capability for patient safety across England through a systematic education and training programme'. Beyond this, there was brief guidance on the appropriate governance and organisational structures of the collaboratives, the types of teams the AHSNs were expected to put in place, and the types of projects they were expected to pursue (NHS England 2014).

One consequence has been huge variation within the AHSNs in how they interpret and act on their mission to improve patient safety. Some interpreted their role as primarily developing the leadership, culture and understanding of quality improvement needed to improve safety in their regions. Others saw their role as primarily running practical improvement projects. Each AHSN adopted its own approach to engaging with the local system, determining priorities and running improvement projects; some focused on large areas such as people with mental health needs or children, while others focused on narrower improvement projects such as falls or pressure ulcers.

At the beginning of the programme, the AHSNs were themselves start-up organisations; some were still recruiting senior leaders and securing permanent office space. This inevitably meant that they took on patient safety from a standing start. One interviewee described the initial challenges of

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securing telephone lines, desks and other basic equipment. When asked about his ambitions for the initial years, he replied 'Simply to find somebody, anybody, with some skills in quality improvement to join the team. After that, our ambition was to get one or two projects up and running and deliver some sort of impact, even if this was at a small scale.' Like other NHS organisations following re-structuring, it took many collaboratives at least two years to build teams, develop governance, forge relationships with the regional system, carry out engagement exercises to determine a sensible list of initial priorities, and get a full work programme up and running.



## 3 Assessments of the first four years

Overall, the majority of our interviewees were proud of what they had managed to achieve in their first four years. Leaders of the collaboratives described an emergency laparotomy collaborative that delivered a 42 per cent reduction in risk-adjusted mortality over eight months; a falls collaborative that reduced falls by 60 per cent at some sites; and a collaborative to reduce inpatient medication errors that substantially reduced prescribing errors. Current collaboratives are delivering tangible improvements in treatment of sepsis, perinatal mental health, and safety in care homes, among many other areas. These appear to be significant achievements in four years given limited resourcing, the need to put in place systems from scratch, and the state of quality improvement in the NHS in 2014, as organisations emerged from a bruising two years of structural reforms. As one informed observer put it, 'It's still very early days for the collaboratives and there is a need to applaud the achievements they have made within the constraints they've been operating under.'

It was clear from our interviews that the leaders of different collaboratives have made very different assessments of their own successes. Some interviewees emphasised the role they had played in increasing NHS leaders' awareness of their role in improving patient safety, creating a culture of quality improvement through surveys and assessments, and developing improvement skills in their regions. For these interviewees, the AHSNs' contribution to culture and understanding in the NHS was more important than valuable progress made within individual improvement collaboratives: 'Without the right culture and strong leadership, anything to do with safety and changing the way people work is a big ask.' Other interviewees saw their successes as primarily delivering tangible results in specific improvement projects, with the side benefit of supporting learning and culture change. For

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these interviewees, the AHSNs were not the right bodies, and did not have the resources, to train an entire sector in improvement; there were other organisations with a mandate and resources to do so, not least providers themselves.

## 4 Warranted and unwarranted variation

Overall, interviewees agreed that the collaboratives' impacts have been highly variable: there were some particularly high-performing collaboratives that had achieved a major impact within their regions; and there were a few that had really struggled to find their feet and deliver tangible improvements in patient safety. In the former, senior leaders of NHS organisations were closely involved and aware of the AHSNs' patient safety programmes. In the latter, senior NHS leaders were not actively engaged in setting priorities and overseeing the programmes and were still only dimly aware that the AHSNs had an important role to play in patient safety. One hospital chief executive with a strong interest in quality improvement told us that he hadn't realised his region's AHSN was working on patient safety.

One explanation for this variation is that the AHSNs started from very different points. Some started work with NHS organisations that had maintained a strong focus on quality improvement, even during the lean years of arm's length tendering and competitive markets. The South West had been running a region-wide safety collaborative for the previous five years. In these regions, AHSNs were able to hire from a cadre of respected improvement experts with strong links to provider organisations, and to work with providers who themselves had considerable expertise of improvement and a history of collaborative working.

In other regions, the AHSNs struggled to find any experienced improvement staff and have been working with providers who lack a deep understanding of improvement. As Plsek has argued, collaboratives require from participants 'a relatively high level of sophistication in the uses of process analysis and data collection tools of quality management... Collaborative improvement efforts do not replace an organisation's quality improvement efforts. Rather they depend

and build on them' (Plsek 1997). To some extent, it is inevitable that the AHSNs will make progress at differing paces, reflecting the resources at their disposal and their regional systems' readiness for change.

In some AHSNs, the senior leaders had quality improvement backgrounds and saw the AHSN as playing a significant role in improving safety as part of a broader strategy for supporting quality improvement. In other AHSNs, leaders brought a background in innovation or technology and saw the AHSNs' role as primarily supporting innovators in connecting with the NHS, bridging between sectors and helping the NHS find useful solutions to particular challenges. While both perspectives and approaches seem incredibly important, interviewees suggested that AHSNs with the latter focus were less likely to see patient safety as a fundamental part of their work programme. In these AHSNs, there is a risk that the patient safety teams lack sufficient leadership support and access to resources. They might also lack senior relationships, connections and clout within provider organisations in the region. A small number of AHSNs may have considered the patient safety collaboratives to be an unwelcome distraction from core work.

These differences in the AHSNs' understanding of their purpose and priorities appear to be reflected in their organisational structures and use of staff and resources. Interviewees argued that the most successful AHSNs had fully incorporated their patient safety staff into broader teams to support innovation and quality improvement. These AHSNs drew from a common pool of staff to deliver a single work programme for innovation and improvement, rather than running separate patient safety and quality improvement projects. In other AHSNs, there were separate patient safety teams, connected but not fully integrated with the innovation and improvement teams, who were responsible for standalone patient safety projects. There is a risk that these teams lack critical mass or access to the full range of capabilities needed to have a tangible impact in their regions.

## 5 Improvement on a shoestring

Overall, it is hard to avoid the impression that the AHSNs, like other organisations in the NHS, are attempting to deliver complex safety and improvement programmes on extremely limited budgets. The national NHS bodies' original plans were to allocate the patient safety collaboratives a budget of £12 million per year. In practice, this was reduced by more than one-third to £7 million per year, or between £375,000 and £500,000 per collaborative. (Some AHSNs have been able to secure additional funding – for example, from the Health Foundation, to support particular programmes.) On average, each AHSN is able to employ a single manager, two part-time clinical co-leads (for one day a week each), and two or three improvement managers to deliver their patient safety collaboratives for regions with populations of between 2 million and 5 million.

This is in stark contrast with the successful models for collaborative improvement in other developed countries that the NHS's patient safety collaboratives were intended to replicate. Our crude estimate is that some internationally renowned improvement organisations secure between five and eight times the funding provided to the AHSNs to run improvement collaboratives to address particular improvement topics (for example, sepsis or neonatal care) over 12 months. This funding allows them to secure senior clinicians with international reputations to lead the collaboratives, experts who can synthesise the latest scientific evidence, collaborative leaders with extensive experience in facilitating group learning and teaching improvement methods, and project teams that provide substantial support to participants during and between meetings.

These disparities in resourcing should surely give pause for thought. Are the AHSNs, with such limited resources, able to capture the most important

elements that have contributed to the success of collaborative models in other countries? For example, are they able to capture specific tangible features of effective programmes such as careful appraisal of the scientific evidence in the preparation phase, or less visible features such as the practical expertise of collaborative leaders or the quality of preparation for collaborative meetings? When resources are so constrained, is there a risk of what Dixon-Woods terms 'cargo-cult quality improvement' – that is, copying the superficial features of programmes that have been successful in other countries, while failing to capture the real ingredients that make them work (Bate *et al* 2014)?

More generally, it is possible to question whether the overall resources dedicated to quality improvement in local NHS systems are sufficient to see dramatic improvement. Staines has argued that local health systems need to pass a minimum investment threshold before they start to achieve the type of significant and sustained quality improvement seen in high-performing health systems such as Canterbury New Zealand, Jönköping Sweden or Intermountain and Virginia Mason in the United States (Staines *et al* 2015).

## 6 Appreciative enquiry

Our interviewees from the AHSNs brought extensive technical knowledge and practical insight into how to structure and deliver successful improvement collaboratives. Interviewees highlighted the importance of a common set of supporting conditions for successful collaboratives – for example, effective engagement with senior leaders of participating organisations from the start, and putting together local teams with the right balance of seniority, technical skills and practical experience. They also pointed to a common set of problems that were likely to lead to unsuccessful collaboratives – for example, choosing topics that did not match local priorities and project teams with unstable membership, insufficient time to dedicate to the collaboratives, or a lack of authority to deliver change in their services. Collaboratives are regularly thrown off course when winter pressures hit, and trusts struggle to protect any staff time for improvement.

At the same time, there were also substantial differences in how the AHSNs select topics and deliver improvement collaboratives. Some were more willing to focus on broad improvement topics for local systems, while others focused on narrower topics with a clearer evidence base. Some attempted to define objectives and measures of improvement clearly at the start and to deliver the programmes within tight timescales, while others felt that greater flexibility was important. Some have focused on defining clear standards of care and applying them consistently, while others have placed greater emphasis on local adaptation.

Overall, both the AHSNs as a collective, and individual AHSNs on their own, feel some distance from having a clear and well-defined methodology for delivering improvement collaboratives to match either the Institute for Healthcare Improvement's (IHI) methodology for its Breakthrough Series, Canterbury New Zealand's approach to developing Health Pathways, or the Virginia Mason Production System. This is hardly surprising – the AHSNs have

been building experience of running learning collaboratives over four years, while these international organisations have been refining their methodologies over two decades. The AHSNs need to develop approaches to collaborative learning that work within the NHS context rather than simply copying other organisations' methodologies, even if their resourcing would allow them to do so.

Given the extent of our experience, there are still quite substantial unanswered questions about the best approaches to delivering collaboratives within the NHS. For example, which types of topics are best suited to learning within collaborative networks as opposed to within individual organisations or integrated local systems? Which approaches are most effective in securing active senior leadership engagement in the work of collaboratives, as opposed to formal commitments of 'buy-in'? What precise preparation needs to be done before collaboratives start? Which features of an improvement programme should be standardised or subject to local variation? Which approaches are most likely to ensure that service improvements are sustained after the collaborative finishes?

When they launched the patient safety collaboratives, the national NHS bodies recognised that quality improvement through the collaborative method was an uncertain, developing approach. Policy documents from 2014 recognised that the patient safety collaboratives would themselves need to innovate, 'using varied methods to drive improvement, owning the responsibility to establish the effectiveness and value of their chosen methods and sharing their safety improvement practices' (NHS England 2014).

Our impression is that the AHSNs have not yet been able to commit substantial energy to this aspect of their work. Given pressures to deliver tangible outputs, they have focused on getting collaboratives up and running. Given pressures to justify the efficient use of public resources, they have focused on demonstrating that programmes have had an impact. This has so far left little space for appreciative enquiry about what works best in what



circumstances. The result is continuing uncertainty about which features of the programmes really support improvement.

One priority for the next licence period might be for the AHSNs to more rigorously apply their own quality improvement methods to their collaboratives, using a generative approach to create new learning on what makes collaboratives effective. If they were to do so, they would probably need to document in a more structured way their approach to collaboratives at the start, how the collaboratives evolved in practice, and their assessments of which features contributed most.

There may also be a case for reviewing which aspects of international approaches should be applied more systematically in the NHS. For example, the IHI has developed a detailed methodology for selecting topics, setting stretch targets, and codifying knowledge at the end of collaboratives to support adoption and spread. There is evidence that teams that do not define their targets early and measure progress are less successful in learning quality improvement (QI) methods and achieving improvements (Øvretveit *et al* 2002). Are the AHSNs confident that they are applying this learning rigorously and consistently, where there is good evidence on what works?

## 7 Technical skills and practical wisdom

Our discussions with interviewees brought home to us the complex set of skills required to lead learning collaboratives effectively. The leaders of collaboratives need to be able to engage credibly with senior clinicians, managers and other staff in NHS organisations, each of whom bring different professional perspectives and may be sceptical of quality improvement methods (for example, the focus on rapid tests of change). They need to motivate these groups, create movements for change and maintain creative tension throughout the programme. They need to support staff in understanding improvement methodologies and help them to apply these tools in practice. Successful collaborative leaders bring expertise in many disciplines: medical science, designing tests of change, using data and statistics, consensus building, systems thinking, and managing change in organisations, among others. Research indicates that if participating teams respect the skills of the faculty leading the collaborative, they make more significant improvements (Hulscher *et al* 2013).

Our interviewees also highlighted the importance of 'practical wisdom' in the management of improvement initiatives. Improvement leaders rely on intuition as much as formal training in deciding how best to manage their collaboratives, improvise and adapt to meet different groups' needs, and 'feel their way' in identifying what will work best for particular groups and what might be holding them back. Interviewees described successful leaders of collaboratives as 'real pragmatists', 'savvy people' with 'practical, pragmatic experience'. Bringing these skills to bear might be even more important than adherence to formal protocols such as the structure of meetings or the approach to group learning. There does not appear to be any easy way for staff to acquire these skills. The only route is extensive experience of delivering interventions in complex systems.

According to interviewees, the most successful leaders of collaboratives also have strong personal relationships and experience of working within their local health systems. They bring a detailed knowledge of the personalities, the history and the dynamics of the local system, which helps them to decide how best to engage with local teams. Collaborative leaders who lack these insights into local context have struggled to be effective. Again, there seem to be no easy fixes for gaining these insights, only extensive experience of supporting improvement in a region.

As interviewees explained, attracting, developing and retaining people with these qualities remains extremely difficult. Staff who were accumulating experience have moved on to new roles because of uncertainty regarding the future of the collaboratives. In some regions, this means that relatively junior staff with limited practical experience are now running the collaboratives. Without the right leaders, there is a risk that collaboratives are pale imitations of effective programmes. More generally, participants in our roundtable discussion compared increasing professionalism among the staff responsible for quality improvement in the health systems of other developed countries with a continued lack of professional training for staff and expertise within the English system. According to one participant, 'the dumbing down of quality improvement in the NHS has been catastrophic'.

## 8 Localism or nationalism?

In 2014, government made a strong commitment to supporting locally led improvement collaboratives. The Mid Staffs scandal had reminded the NHS of the limits of top-down intervention (including targets and sanctions) in improving performance, particularly since they encouraged dissimulation rather than openness to learning. The national advisory group led by Don Berwick had recommended the development of regional or sub-regional collaborative networks rather than a national programme. As the Berwick Review noted, 'the best networks are those that are owned by their members, who determine priorities for their own learning' (National Advisory Group on the Safety of Patients in England 2013). In turn, NHS England committed to enabling organisations outside the centre to deliver locally-owned improvement programmes. NHS England also highlighted the importance of allowing them to set local priorities (Durkin 2014). Senior leaders announced that this would not be a 'top-down initiative', stating that 'It belongs to the local health communities who will provide the energy, ideas and innovations that will make it work' (The Health Foundation 2014).

Our interviewees explained that the collaboratives initially enjoyed broad freedom to select topics for their improvement networks that reflected local organisations' priorities and to work flexibly and collaboratively with local providers. One interviewee described the importance of open and supportive initial discussions. There was 'a real appreciation of an organisation that is coming to them offering help in a non-judgemental fashion... You can almost see them breathe a sigh of relief that we're not saying "you must do this, you must do that".' Another emphasised the importance of ensuring that 'there's no hint of a regulatory approach and that it's all very facilitative'.

Over time, there has been increasing pressure for the collaboratives to focus on delivering national priorities, in particular the three current nationwide programmes to raise awareness of the impact of culture on patient safety, to

improve identification of and support for patients who are deteriorating, and to improve the quality of maternal and neonatal services. Many interviewees were concerned that this renewed focus on national priorities would undermine the collaboratives' ability to respond to NHS organisations' local priorities. They were also concerned that a focus on national priorities could undermine local enthusiasm and commitment to working in improvement networks. They reported mixed experience of pursuing national priorities through the collaboratives, encountering challenges in securing commitment to the programmes and making them relevant to local context. The national programmes had worked well where they responded to local priorities, had a strong evidence base, and focused on effective local implementation rather than superficial compliance. They were less successful where they imposed an overly rigid model with insufficient scope for local adaptation.

There are clearly arguments for and against both local and national approaches to determining priorities and running improvement collaboratives. There may be benefits in ensuring a clearer set of national priorities for the collaboratives, so that they can pool resources where appropriate and work as a coherent network of networks.

Overall, however, we share interviewees' concerns that further attempts to bring the collaboratives into a single national programme – unless handled carefully – will undermine the effectiveness of the model. There is a risk that the collaboratives come to be seen as another arm of the national bodies, responsible for pursuing their agendas, and part of the apparatus for monitoring and intervening in local NHS organisations. If so, this may make it much harder for the AHSNs to maintain strong relationships with local NHS organisations, build movements for change, and create the right environment for improvement. Such a policy would also be inconsistent with successful approaches to quality improvement across sectors and countries, which typically forego top-down direction in favour of empowering local staff to lead change (Hulscher *et al* 2013; Solberg 2005; Wilson *et al* 2003; Øvretveit *et al* 2002). Participants in our roundtable discussion agreed on the need for

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greater clarity of goals at the national level but continued freedom at local level to decide how to implement them.

## 9 Oversight of the collaboratives

When it established the collaboratives in 2014, NHS England made clear that the AHSNs would need to demonstrate their success and effective use of public money. They would be required to 'demonstrate a sustainable and statistically significant reduction in patient harm' within their first year of operation. However, NHS England noted that this should not turn into 'a process of performance management or command and control' (NHS England 2014). NHS England carried out an initial assessment of the collaboratives at the end of 2015, while the AHSN network and NHS Improvement subsequently published a detailed review (AHSN Network and NHS Improvement 2017). In autumn 2018, NHS Improvement completed a further review of the first four years of collaboratives. Each AHSN also accounts for performance in annual contract reviews and in its annual report.

Our interviewees recognised that the AHSNs needed to be held accountable for use of funds to improve patient safety. However, they also expressed concern about aspects of the oversight of collaboratives, including the pressure to deliver complex programmes and demonstrate benefits within very short timescales, and the amount of time small teams needed to dedicate to the process of justifying their collaborative's effectiveness. This was reducing the resourcing available to deliver improvement projects. According to one interviewee, 'there are too many reviews and debates on funding and structure. There isn't enough time to actually do things because we are buried under a justification process nearly all the time.'

There is a risk that this focus on demonstrating near-term impact undermines the AHSNs' ability to learn constructively about how to deliver effective improvement through the collaboratives. One danger is that this encourages the AHSNs to engage in 'comfort-seeking' behaviours: focusing on finding

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confirmatory evidence of the benefits of collaboratives, while making it harder to conduct an honest appraisal of the strengths and weaknesses of programmes. Another danger is that this approach encourages the AHSNs to dedicate too great a proportion of their resources to the process of demonstrating impact, while crowding out those forms of appreciative enquiry discussed above, which might provide more useful practical learning on what works and what doesn't.



# 10 Small teams in a changing landscape

The AHSNs have small teams with an extremely broad set of responsibilities for improving patient safety across very large regions. For arguably very good reasons, the national NHS bodies gave the AHSNs an expansive remit in 2014, with their roles covering engaging with patients and the public, delivering culture change within a large and complex industry, supporting hundreds or thousands of local NHS organisations in learning improvement methods, and delivering collaborative programmes to support quality improvement in specific services. While this open remit has allowed for innovation, it has also resulted in teams who are stretched extremely thinly. Alternative approaches may have also made it harder for the collaborative teams across the AHSNs to work effectively together – for example, developing shared work programmes and combining resources where useful.

At the same time, the range of organisations playing major roles in safety and quality improvement has increased significantly. NHS Improvement is now playing a much more active role in supporting quality improvement, including through Getting It Right First Time (GIRFT) and other national programmes. NHS England is actively supporting improvement programmes, including NHS RightCare. Some hospital groups are developing their own teams and approaches for supporting quality improvement across their sites. NHS trusts are pooling resources and working together to improve performance (for example, the 16 trusts working within the Quest network in the north of England). An increasing number of NHS trusts now have significant quality improvement teams and are using their own methodologies – for example, the Wrightington, Wigan and Leigh (WWL) Way or Imperial College Healthcare’s quality improvement hub. Organisations have pursued these initiatives pragmatically, rather than within an overarching strategy for quality improvement in the NHS.

Alongside these changes, commissioners and providers across English regions have established STPs to agree system-wide priorities, plan how best to use resources, and co-ordinate services. Fourteen of the original STPs are now developing closer partnerships under the banner of integrated care systems. Commissioners and providers are also working in much closer local collaborations. These new partnerships are still, for the most part, at an early stage and developing arrangements for joint working. Interviewees explained that a significant number of the STPs were focusing on immediate operational challenges and had not yet been able to dedicate substantial time to strategies for longer-term quality improvement in their systems. However, some are already considering or starting to develop improvement hubs. Over time, they might play an important role in co-ordinating and supporting regional improvement projects.

These developments inevitably raise questions about how best the AHSNs can contribute to safety and improvement alongside many other teams of experts and national or local programmes. Our interviewees were eager to establish greater clarity about their roles and where they should apply their limited resources to have greatest impact. At the same time, leaders held different views about the best way forward, as well as a sense that regions were at different stages of development and might need different types of support. We discussed various options with interviewees, as follows.

- The AHSNs might focus more clearly on delivering improvement programmes rather than education, training and culture change. Some interviewees argued that the best way for the AHSNs to contribute to these objectives was through practical improvement projects.
- The AHSNs might develop a clearer methodology for determining when they should run regional or cross-regional improvement collaboratives rather than relying on individual organisations to pursue their own independent improvement activities.

- The AHSNs might focus more exclusively on horizontal collaboratives where there are particular benefits in learning across a large number of sites, leaving other organisations to support vertical collaboratives that bring together partners within local systems.
- Alternatively, the AHSNs might dedicate more of their resource to supporting improvement projects that bring together primary care, community services, hospitals and other parts of local systems, given the evidence of benefits of these cross-system improvement projects and the potential benefits of an independent organisation supporting and facilitating them.
- The AHSNs might focus to a greater degree on parts of the health and care system that lacked existing infrastructure and expertise to deliver quality improvement – for example, continuing their work in primary care and with care homes.

While interviewees were eager for greater clarity, there was little consensus about the best way forward. There was also concern that pursuing uniformity for its own sake would prevent AHSNs doing useful things that worked for their regions. These different views reflect considerable continuing uncertainty about the most effective ways of supporting regional systems; what are the merits of attempting to change culture through assessments and awareness-raising versus through practical improvement projects, for example? In part, the range of perspectives might reflect differences in regional health systems: some have leading hospitals with significant improvement capability and alternative sources of expertise such as the Advancing Quality Alliance (AQuA) and Haelo, while others do not.

Perhaps most importantly, there is still considerable uncertainty about the pace and direction of institutional change within regional and local systems. For example, how long will it take for STPs or integrated care systems to coalesce as entities with the resources to lead quality improvement

programmes? To what extent will they play a regulatory role, on behalf of the national NHS bodies within regional health systems? Will they develop the types of culture that have supported improvement in Canterbury or Jönköping? Until we know more, it is very hard to make informed decisions on how the institutions responsible for supporting quality improvement should adapt to a changing commissioning and provider landscape.

# 11 Alternative ideologies for improvement

In part, these alternative perspectives on the AHSNs' future role reflect different views on the best approach and model for supporting quality improvement in the NHS. In 2014, soon after the Lansley reforms, the focus was on improving quality and safety in individual services. People saw benefits in collaborative models that brought services from different sites together to benchmark performance and share learning, alongside these sites' individual quality improvement efforts.

In recent years, interest has shifted, at least to some extent, away from models for improving individual services across sites to models for improving how different services work together in local systems. Rather than bringing the same services from different sites together, the improvement teams in Canterbury and Jönköping focus more on bringing groups of people from primary, community and hospital services within a system together to share perspectives and identify opportunities for innovation.

From our perspective, there is an important role for both approaches to improvement in the NHS. The collaborative model works in part by creating a movement for change and creating an element of competition to improve, while at the same time allowing for learning by comparing different practices across sites. Meanwhile, the Canterbury and Jönköping approaches work in part by cultivating a shared vision among participants in a local system, building sustained relationships across the local system, and developing a common language for system-wide improvement. We need to be able to deploy both toolkits, and it would be helpful to generate a clearer understanding of which approach works best for particular challenges. For each model, there appear to be strong benefits in having organisations that sit slightly apart from regulators and individual provider organisations – such

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as the IHI, Jönköping's Qulturum Institute, or Canterbury's Health Pathways – who can act as conveners, offer improvement support for the system as a whole, and provide a safe space for improvement projects.

# 12 Tentative recommendations

We hesitate to make sweeping recommendations about the future of the collaboratives based on a brief review. Leaders in the national NHS bodies and the AHSNs have greater understanding of the issues discussed here and greater practical experience of supporting improvement. Where there are differences of view, there are good arguments on either side and no obvious way of choosing between them. We hope the suggestions that follow are a helpful starting point for further discussion.

## ***A clearer sense of purpose***

While there were initial benefits in giving the AHSNs a broad remit, they would probably now benefit from having a clearer sense of how they should use limited resources to improve patient safety. This would help them to understand their role alongside other organisations responsible for quality improvement and make it easier for them to work as an effective network. As participants in our roundtable discussion put it, the collaboratives need to have a clear USP (unique selling point) in comparison with the many other organisations involved in safety and improvement.

One option might be for the AHSNs to focus more exclusively on supporting regional or cross-regional collaboratives to deliver improvement in or across specific services, addressing topics where there are particular reasons to believe that collaboratives are the right method for pursuing improvement. They would continue to help change cultures and develop understanding of quality improvement methodologies while doing so.

### ***Integrating safety with improvement***

All of the AHSNs should bring together their staff responsible for patient safety and staff responsible for supporting other quality improvement programmes into a single team and pursue integrated work programmes for improving patient safety and quality improvement. The Berwick Review did not envisage collaboratives that would focus just on patient safety rather than on broader service improvement. In practice, almost all effective collaboratives seek to introduce innovation, support quality improvement and improve safety rather than do just one of these things.

The AHSNs' patient safety teams will lack visibility, relationships and connections into NHS organisations and access to resources if they operate in isolation. The national NHS bodies may be able to help the AHSNs to bring these activities together in how they commission the AHSNs' work – for example, by not requiring them to account separately for their impact on safety and other forms of improvement. A small number of the AHSNs may need to demonstrate stronger commitment to patient safety, alongside other priorities, in their next contract period.

### ***A commitment to localism***

While there is a case for the AHSNs to continue to support national safety and improvement programmes, we would encourage the national bodies and AHSNs to keep in mind the reasons for adopting locally led approaches to the collaboratives following Mid Staffs and the Berwick Review. There were good reasons for seeking to separate the work of quality improvement from the regulatory functions of sanctioning and intervening to address poor performance. There is also good evidence of the benefits of programmes that address local priorities and support local adaptation. Where organisations feel compelled to participate in collaboratives, this undermines effectiveness. Our discussions suggested the need for greater clarity regarding the goals of the collaboratives, but continued flexibility to decide how to deliver them locally.



### ***Adapting to a changing landscape***

The AHSNs will need to adapt to changes in the NHS landscape. They will need to collaborate effectively with STPs and integrated care systems. They will also need to decide how to work in synergy with the growing number of other organisations with an interest in, and resources to support, quality improvement. The most successful AHSNs are building strong links with STPs and local systems and pooling resources with hospitals' improvement hubs to deliver more effective programmes. There are good arguments for retaining improvement teams that sit outside the NHS's regulatory hierarchy and individual providers, who are able to take a system-wide view, act as conveners and provide a safe space for improvement. At this stage, there is considerable uncertainty about how these new regional and local systems will develop.

### ***Sustaining relationships***

One resounding message from this work is the importance of retaining senior improvement leaders with strong relationships with local NHS organisations, detailed understanding of local context and the practical wisdom that comes with practice in supporting improvement. While there will always be discussions about organisational structures, retaining these staff in local systems and helping them to build relationships and experience is likely to have a much greater impact on effectiveness.

The national NHS bodies need to break the cycle of reorganisation of improvement institutions and recurring uncertainty regarding funding that discourages talented staff from taking or staying in improvement roles. Instead, the national NHS bodies and AHSNs should do everything they can to establish more stable improvement roles and improvement careers. As Ham, Berwick and Dixon argued in 2016, 'Above all, the NHS needs a much greater degree of stability and constancy of purpose, the lack of which confounds far-sighted investments, co-operation, trust and growth of knowledge, all of which are essential for continual improvement' (Ham *et al* 2016).

### ***A focus on appreciative enquiry***

We recommend that both the national NHS bodies and the AHSNs refocus their evaluation and reporting away from justifying the impact of the collaboratives towards generating useful practical knowledge of what approaches work best in particular circumstances. We already have abundant evidence that the collaborative model can deliver substantial improvements. What we lack is sufficiently granular information on how to run collaboratives as effectively as possible. In doing so, the AHSNs should be able to develop a much greater understanding for the health system of when to run collaboratives rather than other approaches, a clearer understanding of the active ingredients, and a tighter methodology for planning, running collaboratives and sustaining improvements. They might contribute to developing a common language in the NHS for collaborative improvement.

The national NHS bodies might also explore opportunities to reduce reporting burdens for the AHSNs so that they can focus a greater proportion of limited resources on improvement projects. It also feels important for the national NHS bodies to maintain a partnership model for working with the AHSNs and their collaboratives.

### ***Realism about resourcing and impact***

Finally, we recommend that the national NHS bodies and AHSNs be realistic about the appropriate resourcing for collaborative improvement projects and what small teams can achieve within extremely large regional health systems. As Ham *et al* (2016) argued, it takes time to demonstrate progress through quality improvement. Like other NHS services, there is a risk of asking the collaboratives to do too much, too quickly, at too large a scale given the available resources and the readiness of regional systems. This would undermine their effectiveness and damage the credibility of quality improvement methods in the NHS.

While resourcing remains extremely limited, the best approach would appear to be for the AHSNs to run a small number of collaboratives, but to deliver them to a high standard, adhering to the most important elements of the successful collaboratives in other countries, and to sustain improvements before moving on to new priorities. This could do a huge amount to win greater numbers of clinicians and managers over to the collaborative method.

None of these are particularly palatable messages for a health system with limited resources in search of rapid transformation. The difficult truth is that while quality improvement can have a significant impact, the benefits of individual projects can often be quite limited and it takes significant time and investment before systems start to see substantial benefits. As Ham *et al* have argued, it is crucial for 'leaders at all levels to hold their nerve. As difficult as a quality improvement strategy is, and as long as it may take to harvest the needed changes at full scale, we simply do not see a more promising alternative' (Ham *et al* 2016).

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