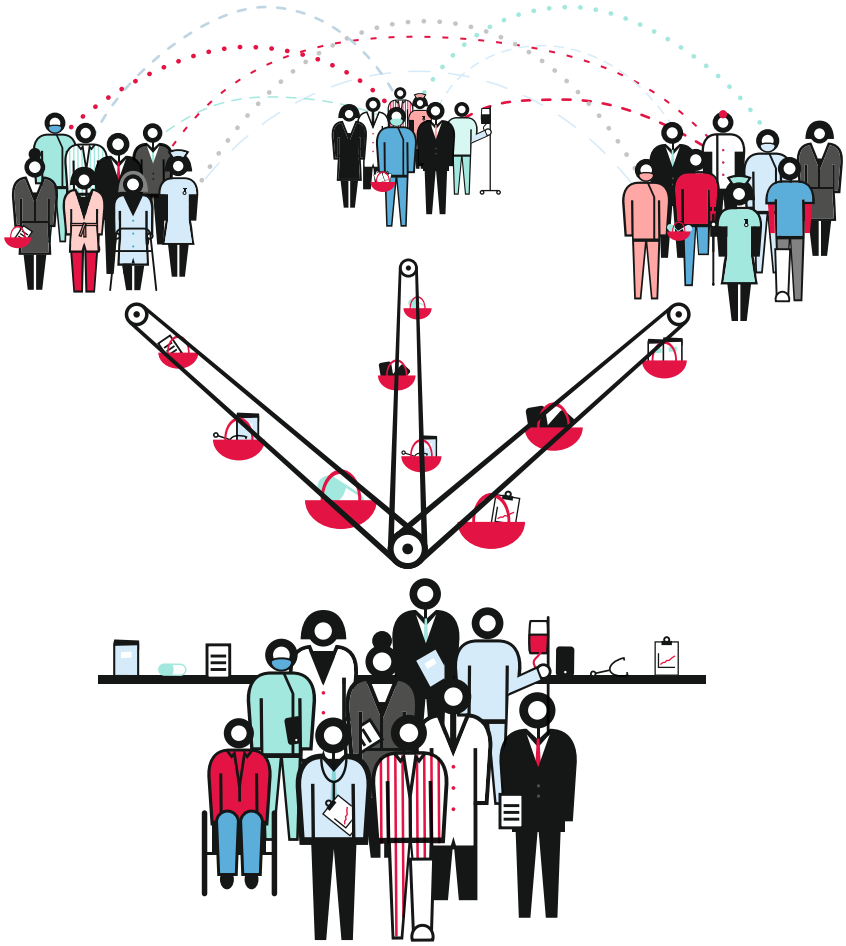
The Health Foundation
Inspiring Improvement

Using clinical communities to improve quality

Ten lessons for getting the clinical community approach to work in practice



Learning report

December 2013

Acknowledgements

The Health Foundation would like to thank all those involved in the Closing the Gap through Clinical Communities improvement programme.

We would also like to thank Christine Whitehouse and Professor Mary Dixon-Woods for writing this report.

This learning report is based on the independent evaluation of the programme conducted by Professor Mary Dixon-Woods and colleagues at Leicester University. The research team have also published a number of articles from the evaluation, including the following:

- Aveling EL, Martin G, Jiménez García S, Martin L, Herbert G, Armstrong N, Dixon-Woods M, Woolhouse I. Reciprocal peer review for quality improvement: an ethnographic case study of the Improving Lung Cancer Outcomes Project. *BMJ Quality & Safety* 2012;21:1034-41 doi: 10.1136/bmjqs-2012-000944
- Aveling EL, Martin GP, Armstrong N, Banerjee J, Dixon-Woods M. Quality improvement through clinical communities: Eight lessons for practice. *Journal of Health Organization and Management* 2012;26(2) doi: 10.1108/14777261211230754
- Armstrong N, Herbert G, Aveling EL, Dixon-Woods M, Martin GP. Optimising patient involvement in quality improvement. *Health Expectations* 2013;16:e36-e47 doi: 10.1111/hex.12039

The team expect to publish further articles about their findings. Visit www.health.org.uk/articles for an up-to-date list of published journal articles.

© 2013 The Health Foundation

Using clinical communities to improve quality
is published by the Health Foundation,
90 Long Acre, London WC2E 9RA

Contents

Health Foundation commentary 4

1 Introduction 5

2 What is a clinical community and how does it work? 6

3 Why use the clinical communities approach? 9

4 The clinical community approach: ten key lessons 11

5 Conclusion 18

6 Further reading 19

Health Foundation commentary

If there is one thing that we have learned about improving quality over the past 10 years, it is the importance of clinical leadership and engagement. As care becomes more complex, it is no longer enough for clinicians to focus solely on the quality of their own work: they need to consider their role as part of a contribution to the overall patient experience. Improving the quality of care has become a team sport.

There have been a number of approaches to engaging clinicians in improvement work in recent years – most notably clinical audit and the collaborative model. And while both can point to their benefits, they are not without their limitations. The absence of a clear method for action on the back of the data is often cited as a weakness in audit. The highly structured approach to implementing changes through the collaborative model is often felt not to reflect the complexity of current healthcare.

The Health Foundation's Closing the Gap through Clinical Communities improvement programme set out to explore whether there are alternative ways to bring together clinical teams to improve the quality of care. The premise was that too often there was a gap between the evidence and routine care and that closing this gap needed the engagement and leadership of clinical teams. Supporting 11 clinical communities to come together around shared goals, to learn from each other but with the latitude to develop and apply local solutions, the programme has led to a range of improvements in the quality of care which continue to be sustained today.

The programme was independently evaluated and identified some key lessons about how the teams worked as clinical communities to deliver improvements. This report offers those contemplating similar endeavours an alternative model for improving healthcare quality. At a time when working through networks and across organisational boundaries is becoming increasingly important, this report provides valuable insights for those wanting to improve the quality of care.

Dr Jo Bibby
Director of Strategy
The Health Foundation

1 Introduction

Gaps are often found between how healthcare should be delivered, as defined by high-quality evidence, and the care that patients actually receive. Closing these gaps is an important priority for health systems everywhere. But finding the right structures to facilitate improvement is not easy.

This report introduces an approach – the clinical community – used by the Health Foundation's Closing the Gap through Clinical Communities programme to support and secure improvements in health systems across multiple sites. The structure of a clinical community is a simple one, comprising a core team that supports site teams to make change happen locally.

The report presents 10 key lessons from the programme about when to use a clinical community, how to make it work, and how to avoid potential pitfalls. These lessons are summarised below.

The clinical community approach: ten key lessons

1. **Choose the right challenge for a clinical community approach:** Clinical communities are well suited to areas where the problem to be tackled can be addressed by changes to processes and behaviours (rather than large-scale redesign) or where debates need to be had about what 'good' looks like.
2. **Build a strong core team:** Clinical communities have at their heart a well-regarded, experienced core team to lead, motivate and organise the community.
3. **Recruit a community:** Clinical communities need to have boundaries porous enough to ensure inclusion of all relevant stakeholders, but tight enough to help them stay focused on clear goals.
4. **Resource the community properly:** Clinical communities cannot function on goodwill and good intentions alone.
5. **Start with a clear 'theory of change', but review and adapt in light of learning and experience:** A clear theory of change that articulates the goals of the community and the how and why of their achievement is essential.
6. **Foster a sense of community and belonging:** Communities should choose achievable goals around which members can unite; each member is made to feel part of the solution and responsible for reaching the solution.
7. **Recognise and deal with conflict and marginalisation:** Clinical communities should deploy tactics for ensuring inclusion and avoid creating situations that show up differences in status or performance.
8. **Find a balance between 'hard' and 'soft' tactics:** Clinical communities should use a mix of both 'soft' persuasion and appeals to professional goodwill, and 'harder', more directive methods to achieve their goals.
9. **Use data wisely:** Data collection and feedback, throughout and beyond the lifetime of a project, is central to all improvement efforts; if used effectively, it can make a compelling case for improvement.
10. **Recognise the contextual influences on improvement and the need for customisation:** Core teams need to work with members to generate bespoke solutions where possible, without losing sight of their goals or shifting too far from what is likely to achieve change.

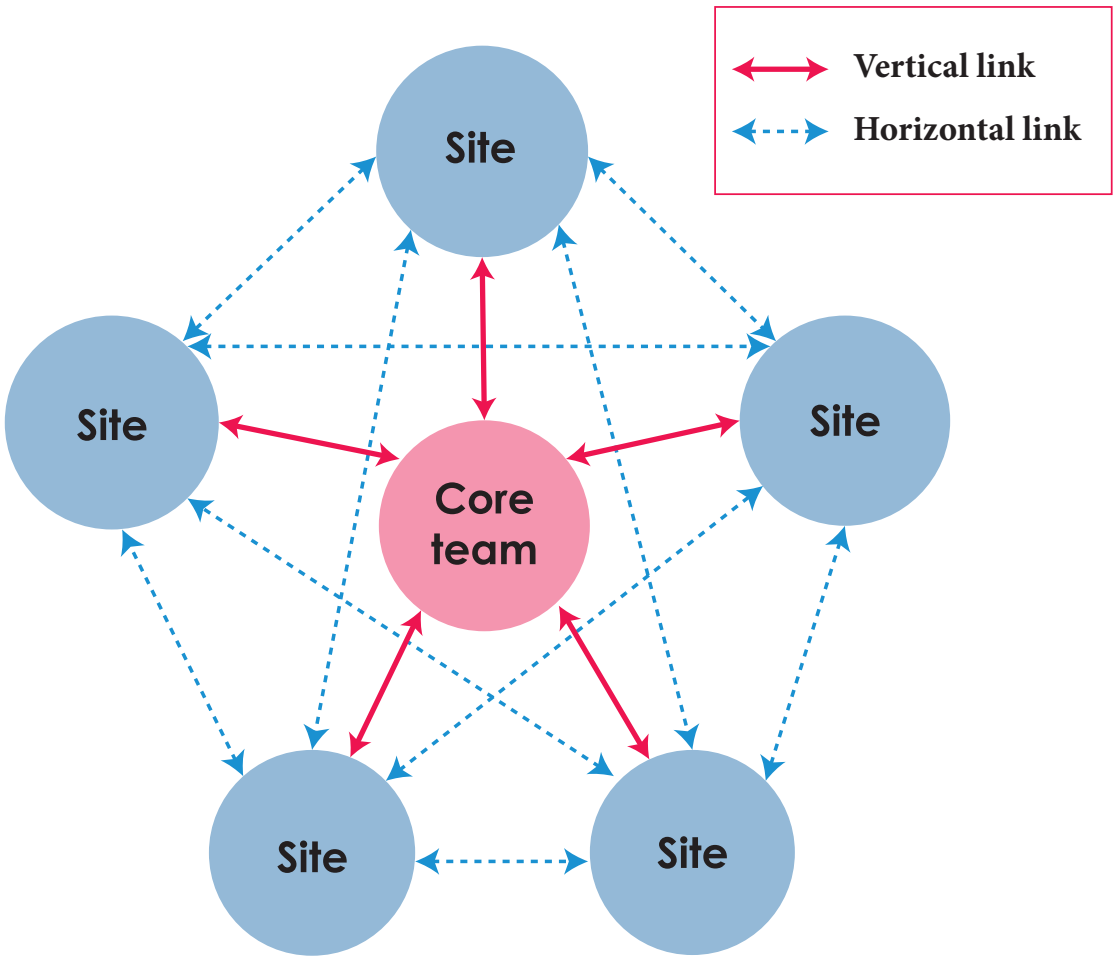
2 What is a clinical community and how does it work?

Clinical communities are organising structures for supporting and securing improvements in health systems across multiple sites. The structure itself is a simple one, comprising:

- a core team to provide high-level leadership, direction, coordination and organisational support
- site teams in participating organisations that make change happen locally.

The core team enables the community to be vertically integrated (focused on shared goals) and the site teams in participating organisations allow horizontal integration (thus activating peer influence and knowledge-sharing).

Figure 1: The structure of a clinical community



The fundamental principles of clinical communities are professional leadership and inclusive membership. They encompass all partners who have a stake in improvement – including, importantly, patients. Members join because they want to make change happen; they are united by a common purpose and set of aims, and they agree to work collaboratively to deliver their shared goals. Clinical communities balance the tension between independence and interdependence, and between efforts and results, by providing vertical accountability (people know they are answerable for delivering on their goals) and horizontal learning (by linking peers).

A clinical community provides an organising structure for improvement, but, crucially, the specific improvement methods are chosen by the community itself according to the problem it seeks to solve. Clinical communities evolved from previous approaches that use collaboration to achieve improvement, such as clinical networks and collaboratives, and they share many characteristics with them. But, unlike some of these approaches, they do not subscribe to any particular improvement methodology; there is no fixed design or blueprint for activities. They can use multiple designs, strategies, methods and measures, drawing on pre-existing improvement models (collaboratives, plan-do-study-act (PDSA) cycles, and so on) or creating new ones.

Closing the Gap through Clinical Communities

From November 2009 to May 2012, the Health Foundation ran Closing the Gap through Clinical Communities. This improvement programme used the clinical communities approach to support 11 projects to close the gap between best practice and what actually happens in routine care. The projects covered a wide range of areas, from improving care for newborns with brain injuries, to reducing the rate of blood-borne viruses among those with substance misuse problems. For more information, visit www.health.org.uk/ctgclincomm

An independent evaluation of the programme, led by Professor Mary Dixon-Woods and colleagues at the University of Leicester, chose three of the projects as case studies for detailed exploration; these had both similarities and differences that allowed meaningful contrast and comparison. All three projects made notable progress and reported significant achievements (see overleaf).

Closing the Gap through Clinical Communities – project achievements

1. Improving Lung Cancer Outcomes Project (ILCOP) – www.health.org.uk/ilcop

ILCOP is a clinical community that aims to improve the quality of care and outcomes for patients with lung cancer.

Achievements:

- Development of a patient experience questionnaire to collate data specific to lung cancer.
- Thirty reciprocal peer-to-peer review visits involving over 230 professionals. The multidisciplinary service reviews that were part of these visits were described by 99% of participants as good or excellent in their ability to identify areas for improvement.
- Submission of over 70 quality improvement plans by participating teams.

2. The Abdominal Aortic Aneurysm Quality Improvement Project (AAA-QIP) – www.health.org.uk/aaa-qip

AAA-QIP is a clinical community that aims to reduce perioperative mortality following surgery to treat patients with abdominal aortic aneurysm (AAA – weakness in the wall of a major blood vessel).

Achievements:

- Contributions to the National Vascular Database (NVD) increased from 380 to 475 cases a month.
- The time lag for data entry was reduced and recording of clinical activity and outcome data increased. In one region, the overall contribution improved from 69% to 91%.
- National data showed a decrease in the national average mortality rate for elective AAA repair, to below the target of 3.5%.

AAA-QIP was conducted in a rapidly changing environment and was not a controlled study, so the achievements above cannot be attributed solely to the project. However, the clinical community is likely to have contributed to the rising tide of improvement in this area.

3. Chronic Kidney Disease Engaging with Clinicians and Patients (ENABLE-CKD) – www.health.org.uk/enableckd

ENABLE-CKD is a clinical community that aims to achieve better quality of care and quality of life for patients with chronic kidney disease (CKD).

Achievements:

- A care bundle (a small number of care practices designed to be done consistently for a defined patient group) and patient self-management package were developed and refined over the course of the project. Training on these elements was delivered in 29 participating practices, and 20 completed the project in full.
- By the end of the project, the care bundle had been used with over 1,300 patients, and over 900 patients agreed to be involved in the self-management package.
- Most participating practices improved their registers of chronic kidney disease patients.
- Both professionals and patients improved their understanding of the condition and corrected misconceptions.

3 Why use the clinical communities approach?

The programme evaluation identified many strengths of the clinical community approach – primarily its strong appeal to professional values, its focus on the wellbeing of patients and its ability to engage everyone in the improvement efforts. Practitioners welcomed the way clinical communities sought to re-empower them **as professionals**; patients welcomed the opportunity to be part of the discussion about what changes needed to be made and how to make improvement happen.

Participants across the projects were enthusiastic about the potential of a professionally-led, professionally-owned approach to improving quality. In a healthcare context laden with other priorities, many driven 'top-down', the clinical community projects were seen as offering something different.

> **I think people get quite comfy with things and I think trying to change anything takes quite a lot of energy and I don't think they'd have all happened at once. I'm not sure they'd have happened full stop, to be honest, I think the [clinical community] thing has really made the difference there. (Participant)**

The clinical communities were effective at pulling people in voluntarily using persuasive argument and strengthening the sense of 'peerness'. They were also successful at relaying and amplifying calls for change that were part of a broader 'direction of travel' within a clinical area. They provided a focused forum that made the need for change visible and that could work on solutions. The communities facilitated debate, secured commitment to improvement, and were often able to work beyond traditional professional boundaries to engage multidisciplinary groups across complex care pathways.

The clinical communities encouraged the active involvement of a variety of stakeholders, and were especially strong at listening to, and acting on, the views of patients. Patients and carers were given a genuine voice: they were included in setting priorities and devising solutions. Beyond that, clinical communities were successfully able to draw in often neglected groups such as management, clerical and IT staff who have particular experience, skills and influence crucial to implementation. As such, the approach made room for those who had the know-how, drive and influence to make change happen.

Clinical communities further excelled in demonstrating flexibility and suppleness. The deceptively simple structure of the clinical community eschews a specific formula for improvement, meaning that the projects were capable of dynamic learning in response to unfolding events and knowledge gained on the ground. Clinical communities thus encouraged ingenuity and innovation, and allowed for sensitivity to local contexts.

The clinical community approach was especially useful in focusing attention on improvement activities, and in helping healthcare professionals to secure organisational, managerial and collegial support for the work.

> **It's a way of getting things done effectively and getting people to do things, you know, it's quite a powerful way of effecting change, bit more power than you just trying to start things off. (Participant)**

By strengthening peer influence through increased opportunities for interaction, comparison and a shared sense of community, clinical communities were able to strengthen the impetus for participants to 'get in line' and start to improve, even where mandatory requirements were not in place.

These strengths meant that the approach avoided many of the problems associated with top-down, highly standardised approaches. Because changes coming from within clinical communities were seen to be under healthcare professional and patient ownership, they were much less prone to being seen as imposed from outside, and therefore ignored or undermined.

Professor Dixon-Woods says: 'All three clinical communities studied were able to make improvements, some of them very impressive, over the course of their projects. A real strength of the clinical community approach was the way it spoke to professional values and retained ownership of improvement within the professions, but also made patients and other stakeholders part of the solution for each community.'

But implementing the clinical community approach, like any effort requiring large-scale cooperation and coordination, was not straightforward.

'Of course, all clinical communities faced challenges,' commented Professor Dixon-Woods. 'We have examined these challenges and how the teams met them. We've also learned a lot from the previous literature on making improvements using approaches based on collaboration and networks. As a result, we've been able to identify the 10 lessons which we feel are key to getting the clinical community approach to work in practice.'

4 The clinical community approach: ten key lessons

The evaluation of the Closing the Gap through Clinical Communities programme identified ten key lessons about when to use a clinical community, how to make it work and how to avoid potential pitfalls.

1. Choose the right challenge for a clinical community approach

Clinical communities are well-suited to areas where best practice is known, and where the actions of community members can ensure those practices are consistently delivered. Where the underlying scientific evidence for best practice is sound, the job of the community is to find ways of ensuring that care meets those standards of practice.

Clinical communities are likely to be particularly suitable for areas where the changes involved require changes to processes and/or behaviour. They can support change by helping sites to make operational improvements and by altering culture through peer pressure and professional norms, as well as some friendly competition. Clinical communities may be particularly successful when they are aligned with broader directions of travel (eg national policy or professional consensus) and when they offer participants advantages in achieving what they are charged with achieving anyway.

Where an evidence base is lacking, a clinical community can provide a forum for agreeing on a broad direction of travel and gaining consensus on best practice, enabling members to move forward where other types of approach may stall. However, this is a slow approach that can be precarious. Clinical communities may be especially prone to difficulties when the changes proposed have large resource or structural implications, or involve complex coordination problems. These kinds of problems may require an external mandate to make change happen, rather than a clinical community.

Clinical communities can help, however, in reaching consensus on whether a problem exists and providing direction on what to do about it. Different groups within a clinical community may diverge considerably in their understanding of a quality problem and in their views on the most appropriate solution. An important task for the core team is to frame the problem and reach agreement on how it should be tackled.

- Convincing data are crucial in demonstrating to members that a problem with quality exists and change is needed. Finding measures of quality that are clearly relevant to the problem, and securing agreement from members that they are valid, is essential.
- Data are most effective when they are comparative, allowing members of the community to assess where they stand in relation to the standards and where they stand relative to others.
- Emotional engagement, for example through patient stories, is important in demonstrating the impact of the problem on patient well-being.
- Opportunities for debate and challenge about quality problems and the proposed solutions should be welcomed; they are an important feature of effective clinical communities. If members are ignored they may quickly become disillusioned.

The AAA-QIP project was successful in persuading participants that better data collection would help reveal variations in practice and help drive up quality. It did this by changing professional attitudes and norms towards data entry and collection over time, so that participants began to recognise it as a valuable way of learning and improving. In contrast, it proved more difficult to reach agreement on a single clinical pathway for managing abdominal aortic aneurysm because of ambiguities about best practice and the absence of a mechanism for enforcing standards.

2. Build a strong core team

Rapid disintegration can occur within structures that rely primarily on social connections and voluntary effort. Clinical communities are a particular challenge because they require diverse professional groups to cooperate, sometimes across multiple organisational, clinical and sector boundaries. Clinical communities therefore need a strong core team that can provide leadership and vision, help integrate across the community, ensure coordination of activities, and generate focus, energy and enthusiasm. The core team has to bring the right people together, manage tensions, build coalitions and make decisions following consultation.

An effective core team will have the following characteristics:

- It has a strong set of values revolving around being committed to improving the care of patients, and is able to sign others up to these values.
- Its leaders are insiders in the professional community it seeks to influence. While they do not necessarily have to hold senior positions, they must have knowledge and authority within their sphere. They may have a role as 'champions' of clinical communities, though care needs to be taken not to give too much prominence to particular individuals rather than the community itself.
- It includes effective patient representation, with appropriate structures for ensuring that patients are proper members who are neither marginalised nor treated too deferentially.
- It combines leadership and vision with effective administrative and logistical support.
- It has legitimacy, authority and credibility. Its members are well embedded within wider networks, structures and professional/clinical groups.
- It includes people with excellent chairing and facilitation skills – both for clinical community events and steering group meetings.
- It includes representation from the relevant stakeholders who need to be engaged, including those that are often overlooked (eg clerical and IT staff).
- Its members have 'nous' (contextual knowledge and political know-how), and are mature individuals who are prepared to learn and adapt, are capable of identifying and managing tensions, and have the wisdom to know when to insist and when to give way.

The core team for ENABLE-CKD was based in and around the charity Kidney Research UK. It included clinical and non-clinical members, all with a high level of credibility among their colleagues. An Advisory and Dissemination Board offered a wider stakeholder perspective from other agencies and charities, as did mentors and specialists who provided advice to the core team on areas such as sustainability and generalisability among different population groups. A separate Patient and Service User Advisory Group (PSUAG) was formed specifically for this project. Its leader, a patient with kidney disease and NICE (National Institute for Health and Care Excellence) adviser, was a member of the core team and

provided a constant patient presence and an effective communication channel between the core team and the PSUAG.

3. Recruit a community

A useful way to think of the overall structure of the clinical community is as a series of 'nested' communities – within participating sites the structure is replicated. Within each community is a core team that coordinates and leads, but their efforts rely on mobilising a wider community of relevant stakeholders. Within each participating site, the local leaders will have to engage colleagues to make the changes needed.

Participants in a clinical community include all those with a stake in seeing improvement happen. This means that clinical communities go beyond 'the usual suspects' and include diverse groups, including clinical professionals, patients, managers, IT personnel, clerks and commissioners. The community must, of course, avoid being fragmented by too many competing priorities or unclear boundaries; the ability of the core team to agree a unifying vision and clear goals is critical. The core team needs to be able to convince busy people that becoming part of a clinical community offers a relative advantage – or that remaining outside the clinical community would constitute a disadvantage.

Recruiting participating sites to a community is not always straightforward, but is likely to be most smooth when existing structures and networks are used. Clinical communities can recruit across many organisations – such as all involved in caring for patients with lung cancer – or they can be created within a single organisation (eg all out-patients services across a trust). The key principle is that care needs to be taken to ensure appropriate representation and inclusion.

ILCOP's core team included clinical and non-clinical members, as well as a wider steering group. The project was well connected to existing professional networks (both formal and informal) and to the Royal College of Physicians (RCP). Some individuals on the core team were seen as national leaders in the lung cancer community and were associated with some of the substantial improvements seen in lung cancer care over the past decade. The project team also included representation from a number of interested parties beyond the NHS, as well as various professional groups. A good deal of effort went into securing this representation, with the involvement of major charities – Macmillan Cancer Support and the Roy Castle Lung Cancer Foundation – seen as particularly important to ensure that the patient's voice was heard. The core team was able to draw on the credibility of the RCP and of individual core team members, and the wider professional networks in which they were embedded. The core team sent all project communications to multiple recipients within each hospital trust, including the lung cancer lead, nurse specialist and multidisciplinary team coordinator, who formed the local team at each site. Beyond this, ILCOP relied on community members themselves to mobilise further involvement locally where needed.

4. Resource the community properly

'Professionally led' should not be taken to mean unpaid or voluntary: clinical leads of core teams cannot manage projects on top of clinical duties without the support of dedicated staff. The core team needs to have access to technical expertise (data interpretation, project and change management) in addition to 'political' skills (advocacy, marketing and relationship building). They should have access to infrastructural resources (such as mailing lists) and forums (regional and national meetings) to promote the project's activities.

Local leaders in participating sites are critical nodes in clinical communities; responsible for making change happen in participating units and organisations. They are the key point of contact between participating site staff and the wider community, often charged with cascading

information, ideas and implementation strategies, and with reporting back on achievements and difficulties. Perhaps the most important, and certainly most challenging, role for local leads is engaging their colleagues in improvement efforts, including those more peripherally involved in the intervention. They may need to take on a 'championing' role, where they draw on their own credibility and work to provide the environment that enables others to make changes.

Local leaders need in-kind support such as training, bought-out time and managerial input. They need support to organise meetings and other activities; establish and arrange auditing and monitoring of implementation efforts; collate and analyse impact data at local level.

Critical to the success of the AAA-QIP project was the funding for the core team members who got things done at an operational level – the project manager, data manager and project assistant, who coordinated project activities and provided organisational resource and support to participating teams. The wider project team and participants agreed that these staff members were essential to success of the project.

5. Start with a clear 'theory of change', but review and adapt in light of learning and experience.

To maximise the chances of success, clinical communities need to have a clearly articulated and soundly based theory of change that guides their activity. A theory of change is, quite simply, a plan that identifies a problem, specifies how to resolve it and – crucially – explains why and how the plan will work. It identifies the goals that have been agreed by the community, the practical changes that need to be made, by when and by whom. Clarity on the theory of change at the outset is essential, but so too is learning as the project moves forward, leaving room for customisation and evolution.

Agreeing and communicating the theory of change with participating sites so that they understand the logic behind what they are doing, as well as what they are being asked to do, is essential – not least in ensuring that local adaptations are appropriate.

Use of the clinical community approach itself needs to be part of the theory of change. This ensures that core teams think in advance about how to, for example, build links with other sites and harness peer pressure effectively.

Clinical communities can take advantage of the fact that they are stable enough to ensure that a programme retains its integrity and original purpose, but dynamic enough to improvise in response to learning and unexpected challenge.

ILCOP's theory of change drew on the logic that many improvements that needed to be made were local in character. The core team sought to draw on the will of professionals to improve their performance, the role of credible data in harnessing this will, and the need for external facilitation to mobilise and direct improvement. They were keen to avoid a didactic, directive approach, and instead aimed to use dialogue and exchange among peers to drive improvements. Their primary change strategies involved using data from the National Lung Cancer Audit to stimulate local recognition of where changes needed to be made, and patient experience questionnaires and reciprocal peer review visits to identify local priorities for improvement. ILCOP asked participating sites to devise their own quality improvement plans rather than prescribing areas on which they should focus their efforts. When it became evident that some of these plans were not sufficiently ambitious, they provided feedback to sites to encourage them to aim higher.

6. Foster a sense of community and belonging

A key feature of clinical communities is the way they engage the support of peers and bring together individuals and organisations that might not otherwise be in contact. Clinical communities allow people from many different backgrounds to spend time together purposefully in pursuit of improvement. However, it takes active effort to ensure that all members feel they have a voice, that it will be listened to, and that action will follow.

Each participating site will have links with the core team, but clinical communities work especially well when participating sites also build horizontal links with each other and thus learn from peers. Bringing together individuals from different organisations and backgrounds is important to sharing knowledge and building network ties. It can be particularly important at the start of an improvement effort, when differences in opinion, knowledge, skills, levels of experience and even commitment may need to be resolved.

The core team can pre-empt doubts and difficulties, and facilitate the strength of bonds between the participating sites, in a number of ways. For example, they can provide opportunities such as teleconference calls for teams to discuss their concerns, clarify expectations, and establish a shared understanding of the aims of the community. Face-to-face meetings are, however, often critical to success. Organised project activities, such as workshops, regional meetings, training sessions and launch events, are essential to building clinical communities – and not just at the beginning. Ongoing communication (both formal and informal) can foster team spirit and increase the strength of the social ties between members. The experience of success and hearing about others' experiences of making changes can convince people that change is possible. These events and meetings should allow opportunities for authentic debate and discussion. Well-briefed and skilful facilitators may be helpful in enabling this.

In its efforts to improve levels of data submission to the National Vascular Database (NVD) and then publish it, AAA-QIP held meetings to bring together participants from all different disciplines based at multiple sites. These meetings provided important opportunities to secure engagement from clinicians who had in the early stages voiced concerns about the validity of NVD data, and the appropriateness of the NVD as a vehicle for data collection. Some saw the NVD as tedious and inferior to existing data collection systems. A wide-ranging programme of regional meetings opened opportunities for discussion and debate with those overseeing the running of the NVD, and teams from across the country became directly engaged in the discussions. Rates of data return increased substantially over the course of the project. By its end, the debate had moved on from the early complaints about whether clinicians should contribute, to how best to ensure good quality data.

7. Recognise and deal with conflict and marginalisation

Like all efforts that depend on cooperation and voluntary effort, clinical communities are prone to problems of conflict and marginalisation. Clinical communities need to anticipate tensions between different groups (eg managers and clinicians), different types of health professionals (eg surgeons and other theatre staff) and individuals or teams from competing units or units with different baseline levels of performance.

Tactics for ensuring inclusion include having representatives of potentially marginalised groups in key positions on the steering group, carrying out training, or organising carefully structured and well-facilitated discussions – pairing colleagues from the same professional background, for example. It is important to avoid creating situations that show up stark differences in status or performance – such as forums where 'high performing' teams are pitted against 'low performing' ones.

Discussion can help generate a shared sense of commitment to, and responsibility for, change interventions. But poorly facilitated debate may lead to fragmentation and a sense of exclusion or alienation among some individuals or groups. Particular care needs to be taken to ensure that groups whose views are often neglected, or not even invited in the first place (patients or clerical staff, for example), are given meaningful opportunities to contribute. If, for instance, patients cannot participate in a technical discussion, having them sit there but unable to comment may feel like tokenism; patients need to be involved in appropriate ways.

ILCOP found ways of including groups who had not previously felt empowered, including the multidisciplinary team (MDT) coordinator. They did this by emphasising the importance of this role in ensuring correct information was available to the MDT and using inclusive language. The clinical lead at one participating site said 'she now bosses us around!'.

8. Find a balance between 'hard' and 'soft' tactics

The power of clinical communities derives from the professional norms, social ties and collective pressure of their members, and the commitment to patient care that they share. But with competing pressures and different interests and views, it may not be enough to rely on a clinical community to self-organise and deliver on improvement.

Core teams need to find a balance between 'hard' and 'soft' tactics. They might begin with soft tactics, such as persuasion and increasing the sense of collegiality and common interest, and escalate from these only if they do not produce sufficient change. Harder tactics push people to engage, and may invoke possible reputational and financial risks associated with failure to improve. They therefore need to be used very carefully and cautiously. The core team must know when a harder strategy is likely to act as the extra prompt needed to induce engagement, and when it risks alienating members and being counterproductive. Aligning the work of the clinical community with other forces for change in healthcare delivery – national policies, managerial edicts and commissioning expectations – can be helpful, ensuring that soft and hard tactics are pushing in the same direction, and positioning the clinical community as a helpful resource rather than a coercive force.

Nevertheless, support may be needed for the leaders of the core team, particularly from their wider professional communities, to drive through changes that may not be popular with everyone.

In ILCOP, the core team relied primarily on soft tactics, such as persuasion, information provision and reminders. Over time, these tactics sometimes proved insufficient to gain enough ground. For example, getting all teams to submit a quality improvement plan took a lot of chasing from the core team, and getting teams to return local data about their interventions was even more difficult. Although ILCOP had required sign-off from trust chief executives, there was no requirement that middle managers be involved, or that trusts contribute a minimum level of resources to support implementation. In the absence of such 'hard edges', the core team depended on the skill, authority and enthusiasm of local team leads to engage all the necessary stakeholders and persuade them to cooperate or release resources.

9. Use data wisely

Sharing and comparing data can help to establish shared values, especially where there is geographical distance between teams. It can help in stimulating some friendly competition and show teams what can be achieved. Regular feedback of individual team-level and community wide data, especially in periods in between face-to-face meetings, can help keep teams 'on task' and generate a sense of progress – or, alternatively, the need for increased effort.

However, collecting data through the Closing the Gap through Clinical Communities programme proved challenging. Participating sites often struggled with establishing data collection systems and interpreting data, though many were able to overcome these issues over time.

The core team has an important role in lessening the burden of data collection by making it easy and, where possible, integrating it with ways in which data are already being collected and used. Feedback of data needs to reach all members of the community, including relevant clinical, technical and clerical staff, and ways of feeding back patient experiences need to be built into interventions. Comparative data collected over the longer term are likely to be most effective in promoting change, and care needs to be taken not to alienate community members who appear to be poorer performers.

The ENABLE-CKD project trained 29 practices, but not all returned data to the project (20 practices gave sufficient data for analysis), despite the efforts of the project team. It proved very difficult to persuade some practices to engage in the effort of data collection.

10. Recognise the contextual influences on improvement and the need for customisation

External pressures and priorities can impact the improvement work being done by clinical communities. Allowing participating sites to customise aspects of the intervention to fit with their own processes and preferences helps secure local 'buy-in' and ensure a practical and useable intervention.

Core teams need to encourage participating sites to try out and refine aspects of the intervention, supporting them with the tools to do so. At the same time, they have to walk a careful line to ensure that local customisation does not come at the expense of a meaningful change in practice. The tendency to revert to the status quo if too little is demanded needs to be actively managed by the core team.

General practices amended some elements of the ENABLE-CKD project to suit their local context. For example, the care bundle for CKD patients was used both in ad-hoc consultations as well as in dedicated CKD clinics. However, sometimes sites were not sure about the degree to which they were 'allowed' to make amendments or changes. Care bundles are built on the idea that the same things are done every time for every patient. Over time, the core team, though clear that the elements of the care bundle were not negotiable, learned to tolerate and even encourage local adaptations within limits.

5 Conclusion

A clinical community is a professionally-led, professionally-owned network that aims to enhance knowledge, promote new ideas and harness collective action. It works by mobilising peer influence to change behaviour; generating energy and solutions for problems from within the community itself; capturing the creativity and collective wisdom of the community; and offering flexibility and adaptability. The communities include multiple perspectives and all relevant groups – clinicians (nurses, doctors and other clinical staff), patients/service users, clerical staff, managers and others with the required expertise or involvement in the care process – who work towards shared goals.

The clinical community approach offers a highly promising way of achieving improvement in complex health systems. Though it will require further study, the approach is likely to have considerable value in future improvement work. It is already being used beyond the original programme.

In the UK, NHS QUEST (a coalition of foundation trusts) established three clinical communities (nutrition and hydration, pressure ulcers and falls) during 2013. They used the learning from the Closing the Gap through Clinical Communities programme to design and deliver the improvement work within each community. Maxine Power of NHS QUEST comments that: 'These 10 lessons for getting clinical communities to work in practice are invaluable for success'. Ailsa Brotherton from Salford Royal NHS Foundation Trust (a member of NHS QUEST) adds that 'The lessons are especially useful for the ones that you may not instantly consider, such as recognising and dealing with conflict and creating the right balance of softer and harder tactics.'

In the US, the Johns Hopkins Hospital and Health System has also embraced the clinical communities approach. It has drawn learning from the Michigan Keystone Project, which successfully mobilised a state-wide clinical community to reduce the rate of bloodstream infections resulting from the use of central venous catheters in intensive care units. Professor Peter Pronovost, an intensive care specialist, was one of two central programme leads for that programme. He says:

'Over the last decade we learned that extrinsic motivation through pay for quality or regulation has limited impact. It should supplement rather than supplant intrinsic motivation, which emerges though professionals and peer norms. Clinical communities embrace intrinsic motivation. They are based on a profound respect for the wisdom of clinicians, who are too often not afforded the support and autonomy they need to improve. Clinical communities seek to change this by drawing upon peer norms, supporting clinicians with robust improvement science, and encouraging local innovation and accountability. We have an urgent need to improve quality of care, and clinical communities are one of the rare examples of an effective, sustainable and scalable intervention.'

The NHS QUEST network is linking with Johns Hopkins Medicine to share learning and will publish results as they become available.

6 Further reading

For further reading about all 11 projects in the Closing the Gap through Clinical Communities programme, visit: www.health.org.uk/clincomm

To find out more about NHS QUEST's work on clinical communities, visit: www.quest.nhs.uk/about-us/news/nhs-quest-embraces-clinical-communities-to-take-quality-improvement-forward/

To find out more about Johns Hopkins' work on clinical communities, visit: www.hopkinsmedicine.org/news/publications/dome/february_2012_/striving_for_consensus_on_quality_

The Closing the Gap through Clinical Communities evaluation

The researchers have already published a number of academic articles about the evaluation of the Closing the Gap through Clinical Communities programme, including:

- Aveling EL, Martin GP, Jiménez García S, Martin L, Herbert G, Armstrong N, Dixon-Woods M, Woolhouse I. Reciprocal peer review for quality improvement: an ethnographic case study of the Improving Lung Cancer Outcomes Project. *BMJ Quality & Safety* 2012;21:1034-41. doi: 10.1136/bmjqs-2012-000944.
- Aveling EL, Martin GP, Armstrong N, Banerjee J, Dixon-Woods M. Quality improvement through clinical communities: Eight lessons for practice. *Journal of Health Organization and Management* 2012;26(2). doi: 10.1108/14777261211230754.
- Armstrong N, Herbert G, Aveling EL, Dixon-Woods M, Martin GP. Optimising patient involvement in quality improvement. *Health Expectations* 2013;16:e36-e47. doi: 10.1111/hex.12039.

The team expect to publish further articles about their findings. Visit www.health.org.uk/articles for an up-to-date list of published journal articles.

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

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

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

We conduct research and evaluation, put ideas into practice through a range of improvement programmes, support and develop leaders and share evidence to drive wider change.

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

For more information, visit:
www.health.org.uk

Follow us on Twitter:
www.twitter.com/HealthFdn

Sign up for our email newsletter:
www.health.org.uk/enewsletter

© 2013 The Health Foundation