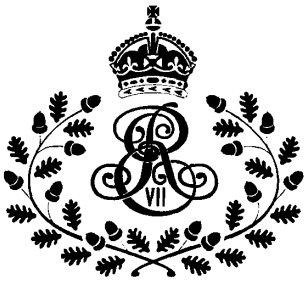
King's Fund

Management College



SURVEY OF SERVICE INNOVATIONS IN NORTH THAMES REGION

Final Report

King's Fund Management College

Updated January 1997

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Acknowledgements

On behalf of the King's Fund Management College, we would like to extend our gratitude to all the people who filled out questionnaires and who so generously gave us time during interviews and site visits and answered our many follow up questions.

Our thanks also to members of the advisory group for their comments and suggestions.

Executive Summary

The Organisation and Management Group (O & M Group) at the North Thames Regional Office of the NHS Executive commissioned the King's Fund in spring 1996 to conduct a survey of service innovations across North Thames Region. The aim was to examine the processes by which service innovations are introduced, to enable the Organisation and Management Group to evaluate the cost effectiveness of service innovations considered to be of high priority and identify the support needed by purchasers and providers to carry out local evaluations of service innovations.

This report describes the approach, analysis and findings of the survey and makes recommendations for developing processes for identifying new and emerging service innovations, conducting appropriate evaluation and disseminating the information to decision-makers in the NHS.

The survey was undertaken in four phases, including a literature review, a postal survey and semi-structured interviews of some of the key individuals involved in a sample of the identified innovations. A database of 357 service innovations has been set up.

A number of broad trends emerged from an analysis of the identified innovations - a move towards service provision in the community, a wide range of governmental and voluntary organisations working together, increased multi-professional working, and a broadening and blurring of roles within and between professions. A large number of factors which, on the one hand, facilitate and, on the other hand, inhibit, innovation was also identified. Amongst the facilitating factors are a clinical or service problem to be solved, a patient/client need to be met, the opportunity to expand professional roles, the presence of a project 'champion', a critical mass of support amongst colleagues and the early involvement of key stakeholders, and good team working and communication. Inhibiting factors include the climate of competition in the new NHS, the volatility of funding and uncertainty over the pick up of 'pump-priming' funding, vested interests in traditional working practices and resistance to change generally (especially amongst groups of clinical professionals), and lack of time. There is often a 'serendipity factor', that is, 'it all seems to come together' with the right people in the right place at the right time.

Innovation can be defined as 'a new idea, a new product or a new service.' However 'newness' is a relative term, and what is new to one may be familiar to another. John Adair (1990) suggests that innovation should be considered as a wider concept which combines two major overlapping processes: having new ideas and implementing them. He differentiates between invention and innovation by describing 'having new ideas' as 'invention' and 'realising' the idea and implementing it into productive work as the process of 'innovation.' Innovations are therefore not entirely dependent upon new inventions: existing services and organisational structures and processes may change gradually and lead to small improvements, a process described as 'incremental innovation'. Although many people emphasise the "new" nature of an innovation, studies have indicated that process and incremental innovations have an equal or even greater importance in commercial success.

The initiatives reported in the survey are very heterogeneous, ranging from the significantly different, or even seemingly unique, (for example, the establishment of a

completely new service) to the relatively commonplace (for example, a small scale addition to an existing service). The extent to which an initiative is regarded as an innovation by those involved depends on their awareness of other initiatives in the same field. Initiatives and innovations may be classified in a number of different ways. Some useful criteria are: who delivers the care, where care is delivered, who is benefiting from care, the way users are targeted and access services, the emphasis of care, organisation of staff mix and patterns of co-operation, provisions for training and means of funding.

The quality of evaluation of initiatives was found to be variable. The report discusses the meaning of evaluation and outlines various evaluation methodologies, recommending an approach which has an 'action research' orientation and combines systematic outcome evaluation with research into process issues, using external feedback to assist in developing and improving services on an ongoing basis.

The report goes on to suggest a useful classification of innovations for the purpose of evaluation:-

- initiatives which are significantly different, or genuinely new:-they represent a marked shift in practice or behaviour and may be large scale
- initiatives which are incremental: whilst not unique, they have some distinctive aspects and are being successfully introduced locally for the first time
- initiatives with organisational implications, including those involving new and extended professional roles and patterns of working.

Initiatives of the first kind would benefit from a systematic evaluation incorporating both a formative (ongoing) element and a summative one (judging the initiative's merit). Initiatives of the second kind would benefit from a monitoring process aimed at assessing the achievement of intended outcomes without needing to collect a huge amount of research data. It is suggested that initiatives of the third kind require a more detailed process evaluation with an emphasis on user and professional perspectives. An evaluation using the 'action research' approach is recommended for all large scale innovations.

The report concludes with the following recommendations:-

- Establish a formal mechanism for disseminating information about service innovations in the region; as a start the database should be circulated to all providers and commissioners.
- Establish learning networks to disseminate and share learning and experiences of service innovations and their evaluability. This was also recommended in a recent evaluation of the LIZ primary care development programme.
- All new and significant innovations should be considered by the Organisation and Management Group (O & M Group) and comprehensive evaluations should be supported in order to draw lessons of general relevance.
- Establish a process for continually updating data using different survey instruments in order to capture innovations of different kinds.
- Make appropriate evaluation a key requirement of all future investment in new service development with guidelines that ensure that evaluation criteria and methods are addressed at the beginning rather than at the end of an initiative.

- Consider the establishment of an evaluation reference and advisory group with expertise on evaluation methodology.
- Encourage and support multi-site evaluation of significant innovations.

1. Introduction & Background

1.1. In March 1996 the King's Fund was commissioned by the Organisation & Management Group (O and M Group) at the North Thames Regional Office of the NHS Executive to conduct a survey of service innovations across the region, as part of the Regional Office's Research & Development Programme.

1.2. The role of the O & M Group is to commission research which will improve understanding of the organisational and management factors which influence the outcomes of health care. It also seeks to evaluate different approaches to the delivery of care and determine whether these approaches improve outcomes for patients. The intention of the survey undertaken by the King's Fund was to examine the processes by which service innovations are introduced, to enable the O & M Group to evaluate the cost effectiveness of service innovations considered to be of high priority and identify the support needed by purchasers and providers to carry out local evaluations of service innovations.

1.3 The King's Fund team comprised Naaz Coker, Steve Manning (Fellows of the Management College), Colin Coles (Professor, Institute Of Health and Community Studies, Bournemouth University) and Sheila Henderson (Project Administrator). An advisory group comprising Nick Mays (Director of Research, King's Fund Policy Institute), Mike Dunning (PACE, [Promoting Action on Clinical Effectiveness], Project Manager, King's Fund Development Centre) Penny Newman (Public Health Physician, South Thames Region and King's Fund Management College) provided a forum for testing the findings and analysis of the survey.

1.4. A survey process was initiated with the following objectives:

- To identify service innovations currently in progress
- To examine the processes by which innovations are introduced and implemented
- To explore the implications of innovations and in particular their impact on
  - patient satisfaction
  - clinical outcomes
  - clinical activity
  - resources
- To establish
  - a database of innovations
  - clarity about what constitutes a service innovation
  - a framework for evaluating the cost effectiveness of innovations
  - the minimum information requirements of purchasers to enable them to make decisions about the support of innovations

2. Approach & Methodology

2.1 The survey was carried out primarily by means of an initial brief questionnaire and subsequent semi-structured interviews of a sample of respondees.

2.2. The work was undertaken in phases as follows:

PHASE 1

- The establishment of the project team, an advisory group and methodology.
- Initial fact-finding and information gathering - using networks and contacts and undertaking a literature review.
- The identification of service innovations and the agencies and individuals involved in them, by means of a postal survey.

PHASE 2

- The design of a framework of questions for semi-structured interviews of some of the key individuals involved in a sample of the innovations identified above.
- In depth interviews, half undertaken face to face on site and half by telephone.

PHASE 3

- Analysis of the information gathered and preparation of preliminary findings for discussion.
- Validation of database and records of interviews.
- Preparation of interim report and circulation for review and comment to Advisory Group and North Thames O & M Group.

PHASE 4

- Presentation, review and dissemination of final report setting out findings and recommendations.

2.3 An introductory letter and brief questionnaire were sent to the chief executives of all 14 health authorities and 63 NHS Trusts in North Thames, with a recommendation that others, for instance, Public Health, Commissioning, Medical and Nursing Directors, and Health Service Research and Evaluation Units, should be involved. The initial response was rather slow. It picked up during mid-summer in response to follow-up letters and telephone calls. The postal survey response form is given as Appendix 1.

2.4 The initiatives submitted in response to the postal survey were coded and sub-coded under three categories - client group, focus and topic - and a database summarising the information gathered was established.

2.5 A sample of about 20% of responses to the postal survey was taken to enable a wide range of service innovations volunteered by a number of different organisations to be examined in more depth by means of semi-structured interviews. In addition to ensuring that a number of different types of innovation on the part of a number of different organisations was explored in

interviews, care was taken in sampling to ensure also that, if possible, the best innovations 'on paper' and several different innovations submitted by the same organisations were included, in order to learn as much as possible about the factors at play in service innovation, especially about what makes for success.

2.6 A total of 63 interviews was carried out, of which 33 were face to face on site, often with more than one of the individuals involved in the initiative. A wide variety of individuals was interviewed. Of the total, 40% were from community/ mental health/learning disability/ service trusts, 37% from acute/ambulance service, 18% from health authorities and 5% from other organisations. Their stated roles and responsibilities of responses diverse: 19% service managers, 17% consultants, 16% project managers/team leaders, 11% managers at director level, 14% senior managers below director level, and 8% nurses or nurse managers.

2.7 The key questions explored during interviews were:

- what, or who, prompted, or stimulated, the innovation?
- in what ways is the initiative seen as being innovatory?
- who are the main stakeholders?
- what are the main benefits?
- what are the costs and how has the initiative been funded?
- what factors have, on the one hand, facilitated and, on the other, inhibited the initiative?
- in what ways has the initiative required or initiated new work patterns?
- how is the initiative being evaluated?
- what problems have been encountered and how have they been overcome?
- with hindsight, what could have been done differently?
- how could the initiative be modified to make it more of a success?

The framework of questions for semi-structured interviews is given in Appendix 2

2.8 The data gathered in interviews was analysed with the aim of identifying especially broad themes and trends, factors facilitating and inhibiting innovation and issues relating to evaluation.

3. Innovation and its management

What is Innovation?

3.1. Innovation (literally) means to introduce something new, a new idea or a new product or a new service. However, 'newness' is a relative term and what is new to one may be familiar to another. John Adair (1990) suggests that innovation should be considered as a wider concept which combines two major overlapping processes: having new ideas and implementing them. He differentiates between invention and innovation by describing having new ideas as invention and realising the idea and implementing it into productive work as the process of innovation. Invention frequently depends on one or two creative individuals, whereas all staff can be involved in the innovation process.

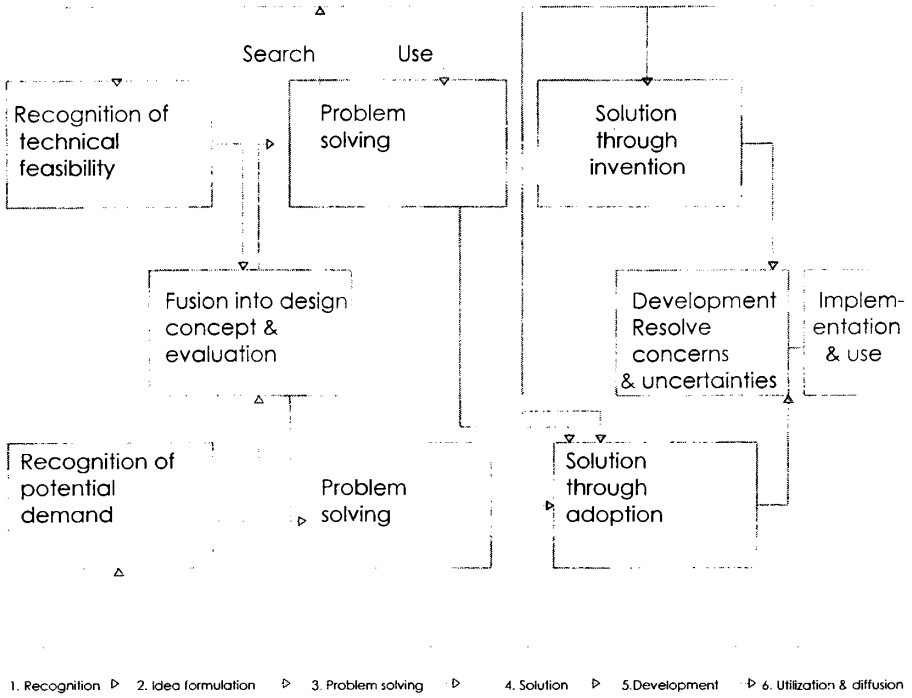
3.2. Andrew Van de Ven (1986) suggests that an innovation is a new idea which may be a combination of old ideas, a scheme that challenges the present order, or a formula or unique approach which is perceived as new by the individuals involved. As long as the idea is perceived as new by the people concerned, it is an innovation, even though it may appear to others as an imitation of something that exists elsewhere.

3.3. The above definition applies to both technological innovations (i.e. new technologies, products and services) and organisational innovations (i.e. new procedures, policies and structures). Many innovations have technical as well as organisational components, for example, the use of lithotripters could not have been introduced without changes in organisational processes. Nick Mays (1994) gives the example of how new technological innovations such as haemodialysis and flexible endoscopes have resulted in a reallocation of tasks, new opportunities for particular groups of staff and a change in doctor-patient relationships.

3.4. Innovations are therefore not entirely dependent upon new inventions; existing services, organisational structures and processes may change gradually bringing about only small improvements, a process described as 'incremental innovation'. Although many people emphasise the 'new' nature of innovation, studies have indicated that process and incremental innovations have an equal or even greater importance in commercial success., (see Tushman and Moore, 1988)

3.5. The model overleaf describes a process of innovation. A successful innovation begins with a new idea which involves recognition of an existing or potential demand and technical feasibility. The next stage is the formulation of the idea into a service or product design as well as evaluation, i.e. making a judgement about committing resources. This is followed by the problem solving stage whereby a solution is invented or adopted from another source. Research and Development input is considered important at this stage. The development stage concerns the resolution of uncertainties about market demand, internal organisational issues and to stakeholder concerns. The final stage is the utilisation, evaluation and diffusion of the solution in the market place.

Model of the Process of Innovation



Source: Adapted from D G Marquis, Innovation Nov 1969

3.6. Barbara Stocking (1991) identifies three main factors that might influence the adoption and diffusion of health innovations:

- the characteristics of the innovation itself;
- the influence of the environment;
- the role of individuals and specific groups.

3.7. D.G.Marquis (Readings in the Management of Innovation, 1988) studied 200 incremental innovations in 50 companies and draws four main lessons from his studies:

- Small incremental innovations contribute significantly to commercial success;
- Recognition of demand is a more frequent factor in successful innovations than recognition of technical potential;
- The training and experience of the people in one's own organisation are the principal resources for successful innovations;
- Adopted innovations should not be overlooked; both original as well as adopted innovations contribute to success.

Conditions for successful innovations

3.8. By definition, innovations introduce change; however evidence suggests that political power structures and groups in organisations often resist change. Professional groups such as doctors, nurses, pressure groups etc. can play a crucial role in either promoting or resisting change. Good leadership and management skills consequently become an essential factor in the process of innovation management in order to carry people along the direction of change and keep them together

3.9. A review of studies of innovations in the public and private sector indicates that for innovations to be successful, the following criteria are important:

- A long term perspective;
- Flexibility at people and organisational level;
- The right internal environment;
- Effective leadership and managerial support;
- Good communication;
- Ability to identify emerging need or create new ways of meeting existing need;
- Acceptance of risk.

4. Findings & Analysis

Literature review

4.1. Information on service developments and innovations was sought from the following sources:

- Journals;
- Papers relating to relevant other work, e.g.
  - the series 'A Study of the Diffusion of Medical Technology in Europe' (King's Fund Centre for Health Services Development, 1991)
  - the Report of the Wessex Institute of Public Health Medicine to the National Standing Group on Health Technology (1995)
  - the Survey of Practice and Service Developments within the Health Care Professions by the University of York;
- Databases (for 1995 & 96) - King's Fund Unicorn
  - Medline
  - Healthstar
  - CINAHL
  - DHSS - Data
- King's Fund Health News (a press cuttings bulletin);

4.2 In addition, the following subjects were also reviewed:

- evaluation methodologies for health service research and development
- the nature or innovation and the management of innovations in the private sector (see references, Chapter 10)

4.3 The literature review highlighted the dearth of publications on service innovations. Papers focus on emerging technologies and innovations concerned with the use of new drugs, treatments or specialised equipment.

4.4 The University of York study did target service and practice developments. It identified developments in the following top ten broad topic areas, but the detailed studies were not available at the time of the review.

1. Community care
2. Rehabilitation
3. Wound healing
4. Mental health
5. Midwifery health services
6. Pain
7. Outpatients
8. Clinics
9. Extending professional roles
10. Cancer

4.5 The CRDC Standing Group on Health Technology agreed priorities for research and development and allocated topics to three categories. A majority of these were largely of a technological nature. The three categories were:

- Band A - topics of high importance to the NHS and for which the Standing Group considers that the return on effort in securing the funding of relevant work will be greatest.
- Band B - topics of high importance to the NHS although the Standing Group does not expect additional effort beyond the usual modes of co-ordination with other research funders and commissioning within the NHS HTA programme.
- Band C - topics which, although of importance to the NHS, are not considered by the Standing Group to be of high enough priority this year to merit funding or expense of effort within the NHS HTA programme. (HTA is Health Technology Assessment)

4.6 The main conclusions that can be drawn from the literature review are:

- there is limited published evidence of initiatives involving patients and users in either the design of services or outcome assessment.
- there are some published reports of initiatives and innovative models of service delivery in mental health.
- most of the published initiatives relating to the extension of primary care focus on polyclinics, resource centres and hospital at home schemes led by community and acute trusts; there are very few published examples of initiatives in general practice involving GPs and practice nurses.
- the changing NHS environment has provided a focus for change and innovation in nursing. 'Extension of nursing roles' provided the largest number of reported initiatives under the theme of the extension of professional roles.
- few initiatives identify dissemination and 'scaling up' strategies.
- considerable information already exists on the nature of innovations, the management of the process of innovation and the factors that lead to successful implementation of innovations. This topic is discussed in greater detail in section 3.
- many innovations are not effectively evaluated despite numerous sources of literature on evaluation methodologies. Section 7 offers a framework for evaluating service innovations.

Responses to the postal survey

4.7 A total of 347 initiatives was notified, 57 by health authorities and 290 by NHS Trusts. The response rates from health authorities and NHS Trusts were 57% and 70% respectively; some provider responses were evidently the result of collaboration with or prompting by local purchasers. Five organisations submitted in excess of 20 initiatives. More than half of the organisations which responded submitted 5 initiatives or less. Of the responses from NHS Trusts, 171 (59%) were from acute/ambulance Trusts and 119 (41%) were from community/mental health/learning disability Trusts; the response rates were 62% from the former and 83% from the latter.

4.8 The number of responses from individual health authorities and NHS Trusts is given in Appendix 3

4.9 Only 6 of the initiatives submitted concerned services in GP practices and only 5 were initiatives taken by voluntary organisations. It was anticipated that health authorities would identify innovations in GP practice as well as NHS Trust settings and that health authorities and NHS Trusts would identify more initiatives in the voluntary sector locally. Whilst one voluntary sector representative was interviewed, there was insufficient data on innovation in general practice on which to base interviews with a sample of GPs. This gap could be addressed in any further survey by targeting the introductory letter and brief questionnaire also at health authority primary care directors, as well as perhaps senior GPs and GP practice managers.

4.10 An index of the database of service innovations established using the information collected from respondents to the postal survey (title of innovation and organisation only) is given in Appendix 6.

4.11 The data from a survey of this kind cannot be regarded as complete or comprehensive; neither can it be regarded as representative of the total data which could theoretically be captured. The data submitted can only be taken to represent itself. That said, as a body of data it is quite revealing. The response forms completed by contributors to the postal survey were coded and sub-coded under three categories - *client group, focus and topic.*

CLIENT GROUP

a Women's health
b Child & adolescent health
c Acute (adult) services
d Services for elderly people
e Mental health
f Primary & community care
g Ethnic minority health
h Services for homeless people
I Services for people with learning disabilities
j Others

FOCUS

a Patient centred care
b Measuring clinical outcomes
c Early discharge
d Admission avoidance
e Guidelines & protocols / care pathways
f Needs assessment
g Information/communication
h Others

TOPIC

a Home care
b Screening
c Rehabilitation
d New & extended professional roles
e Nurse practitioners
f 'Inreach' services
g Primary/secondary/tertiary care interface
h Information & information systems
i 'Outreach' services & clinics
j Integrated care / care packages
k Diagnostics & imaging
l Reduction in bed use
m Day surgery
n Health promotion & education
o Multi-professional & agency working
p Community based services
q Clinical techniques
r Specialist clinics & units
s Others

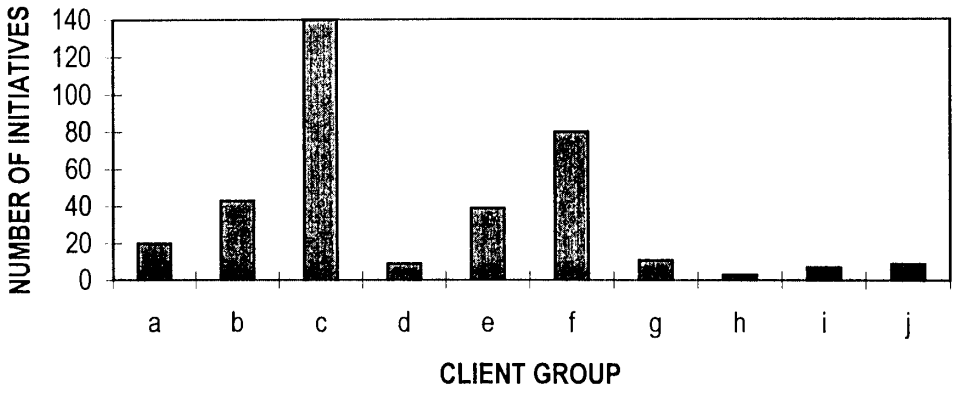
4.12 The process of coding responses revealed a wide variety of initiatives, illustrated in diagrams 1, 2 and 3 overleaf. Diagram 1 shows that the largest number of reported initiatives was in the field of acute (adult) services, with a substantial number also in primary and community care. There were a number in the field of child and adolescent health. Whilst there were also a number concerning mental health services, there were relatively few relating to services for people with learning disabilities, or to homeless people.

4.13 Diagram 2 shows large numbers of initiatives relating to needs assessment and improving information and communication generally.

4.14 Diagram 3 reveals large numbers of initiatives relating to multi-professional and agency working, community based services, new and extended professional roles (especially nurse practitioners), clinical techniques, specialist services and units, health promotion and education, and, to a lesser extent, integrated care, diagnostics and outreach services.

SURVEY OF SERVICE INNOVATIONS

DIAGRAM 1

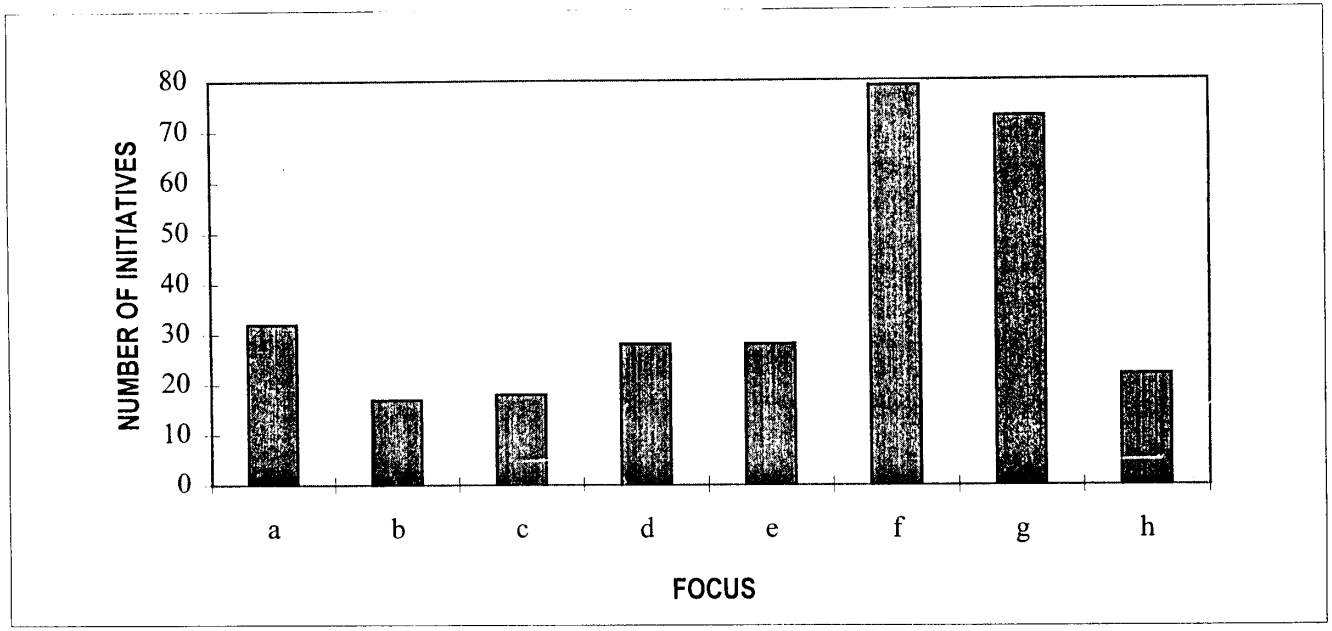


LEGEND

a	Women's Health	f	Primary & Community Care
b	Child and Adolescent Health	g	Ethnic Minority Health
c	Acute (Adult) Services	h	Services for Homeless People
d	Services for Elderly people	i	Services for people with learning disabilities
e	Mental Health	j	Others

SURVEY OF SERVICE INNOVATIONS

DIAGRAM 2

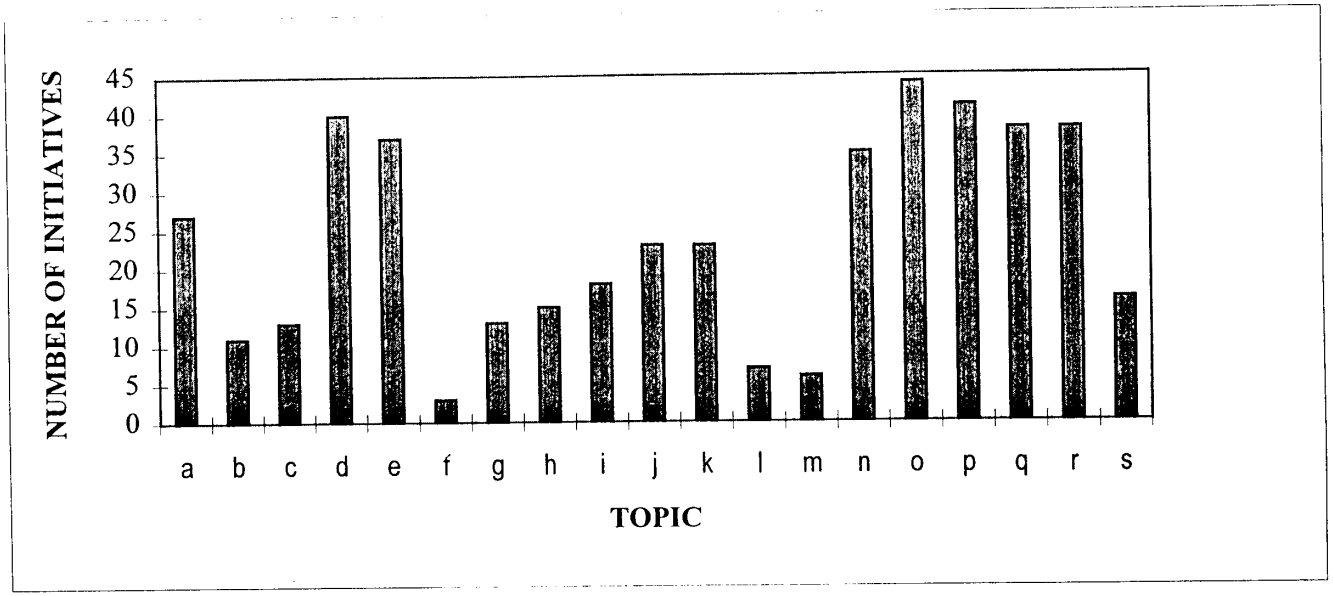


LEGEND

a	Patient Centered Care	f	Needs Assessment
b	Measuring Clinical Outcomes	g	Information/Communication
c	Early Discharge	h	Others
d	Admission Avoidance		
e	Guidelines & Protocols/ Care Pathways		

DIAGRAM 3

SURVEY OF SERVICE INNOVATIONS



LEGEND

a	Home Care	j	Integrated care/care packages packages
b	Screening		
c	Rehabilitation	k	Diagnostic & Imaging
d	New & Extended Professional Roles	l	Reduction in Bed Use
e	Nurse Practitioners	m	Day Surgery
f	Inreach' services	n	Health Promotion Education
g	Primary/secondary /tertiary care interface	o	Multi-Professional & Agency Working
		p	Community based Services
h	Information & information systems	q	Clinical Techniques
i	Outreach' services & clinics	r	Specialist clinics & units
		s	Others

Interview results - broad themes and trends

4.15 Initiatives have a 'natural history', beginning with initial ideas, then perhaps becoming funded projects and perhaps later, fully evaluated innovations. The development of initiatives and their emergence as innovations can take many years. The information given regarding an initiative in response to a survey depends greatly on how and when the survey is carried out. At the time a survey is undertaken some potentially significant innovations may be at a very early stage and may not be recognised by those involved as being innovative; conversely, some initiatives might be regarded at the time as potentially innovative, but may subsequently not realise that potential.

4.16 The survey shows that a great deal of change is occurring across the region and a large number of initiatives was submitted for analysis. The survey response forms and, more particularly, the notes of the face to face and telephone interviews were read and analysed, for the range of service innovations, the broad themes and trends, facilitating and inhibiting factors and the approaches and methodologies used in evaluation.

4.17 The broad themes and trends which emerged are:

- a move towards service provision in the community;
- a wide range of governmental and voluntary organisations working together;
- multi-professional working (and learning), including other sectors (such as Social Services), voluntary organisations, patient and carer groups, etc.;
- a broadening and blurring of roles, within and between professions, including non-professionals.

Interview results - factors which facilitate and inhibit innovation

4.18 Interviews revealed a broad range of facilitating and inhibiting factors. Interestingly, some worked to facilitate in some circumstances and inhibit in others. Thus, a factor facilitating one innovation inhibited another and another factor worked both to facilitate and inhibit during the course of the same initiative. Frequently, absence of facilitating factors acted as a barrier to an initiative's success.

4.19 The facilitating and inhibiting factors which surfaced during the interviews are summarised in Boxes 1 and 2.

Box 1 Factors facilitating innovation

- 50% or more of responses:

  - solve a clinical or service problem, meet a patient/client need
  - have wide ranging support from different groups
  - key people see the need
  - evaluation built in from the start.

- 20% or more of responses:

  - there is a project "champion"
  - key individuals are on board
  - the project involves expanded professional roles.

- 10% or more of responses:

  - training and staff development included
  - links to prestigious projects, national initiatives (providing a rationale and sometimes funding opportunities)
  - serendipity - "the right place at the right time."

- Also mentioned:

  - a culture of being proactive and innovative
  - increased job satisfaction
  - "new blood" appointments
  - good previous experience of innovation/successful pilot
  - effort is recognised/rewarded.

Box 2 Factors inhibiting innovation

- 50% or more responses:

  - vested interests, professional barriers, ideological differences.

- 20% or more of responses:

  - lack of funding, uncertainty about funding, change of funding
  - time (for service provision, for developing the initiative).

- 10% or more of responses:

  - lack of accommodation/facilities
  - patient/community worries
  - restructured NHS (the climate of competition)
  - conflicts with Health Authority priorities.

- Also mentioned:

  - wider context not considered
  - dependency on other agencies
  - lack of information
  - increased workload
  - conflict with Trust's agenda
  - no prior models to guide the project
  - recruitment difficulties.

4.20 Throughout the interviews a number of other issues were raised which, whilst not specifically mentioned as facilitating or inhibiting factors, nevertheless in our view strengthened or weakened an initiative. These are given below.

- The restructuring of the NHS and the review of health care in London gave an impetus for change
- The breaking down of traditional organisational structures, and a greater co-operation between a much wider range of professionals and organisations than before
- The challenging of traditional status and power bases (e.g. doctors')
- A greater sense of accountability and the need for enhanced and more strategic planning
- The (sometimes unexpected or sudden) availability of funding, though funding itself does not necessarily ensure the success of an innovation
- The importance of considering one's image and profile (innovation is a way of "looking good")
- Having a committed and able staff (often taking on an innovation in addition to their normal work load).

The evaluation of initiatives

4.21 Most initiatives were being evaluated in some way, but the quality of evaluation was variable. Methodological approaches ranged from a randomly controlled trial involving 4,000 patients with high levels of quantitative data to a secretary preparing a questionnaire to be handed to patients. The calibre, and hence validity, of some of the evaluations seemed questionable, particularly those of a more qualitative nature. Those involved in leading and managing innovations would gain greatly from help and support in relation to evaluation approaches. Some of the individuals interviewed felt that too much weight is put on evaluation.

4.22 The following pattern emerged in relation to evaluation:

- most respondents said that research expertise is available either within their own team or within the wider organisation (e.g. the quality or clinical audit teams);
- a range of outcome measures is being used in evaluations, together with multiple evaluation techniques;
- qualitative research methodologies are being acknowledged as useful far more now than previously, though the validity of some of the methods being used was questionable;
- there was greater attention to the impact of initiatives on clients and carers;
- there was input from a wide range of professionals and others to evaluation design.

5.0 Evaluating Service Innovations

5.1 The term 'evaluation' is widely used in health services research and development and serves different functions at different organisational levels: that is, documenting that a budget is deserved, control, accountability or a comprehensive assessment relating the inputs and processes to costs and outcomes with the intention of informing future service design.

5.2 Evaluation may be defined as a systematic investigation of the worth or merit of a service or a programme. The key purpose of evaluation should be to inform and assist funding agencies and implementors to make a judgement about continuing a service, modifying it, expanding it or ending it. A key measure should be whether a service is meeting the needs of the individuals it serves.

5.3 Evaluation is increasingly being considered as having two stages: *formative* (on-going) or *summative* (at the end of a programme). Formative evaluation focuses on the on-going development of an innovation with a view to influencing service design, process and delivery. Summative evaluation is concerned with assessing the overall success of the programme at the end, its emphasis being on evaluating the outcomes against success criteria specified at the start of the programme or service.

5.4 The debate on evaluation methodology is ongoing! The approaches range from randomised control trials to pluralistic approaches which assess success from the perspectives of all the key stakeholders in the service utilising both qualitative ("soft") and quantitative measures (see Daly & McDonald, 1992; Smith & Cantley 1985; Guba & Lincoln, 1989).

5.5 The worth or merit of a service can be assessed from several perspectives:

- community access i.e. whether it is available when needed and located in the right place for the appropriate individuals and groups;
- safety i.e. the service is safe and does not lead to adverse outcomes;
- acceptability i.e. it is acceptable to patients and their carers;
- professional acceptability i.e. it is acceptable to the staff providing the service;
- quality i.e. the service is of a high quality;
- cost-effectiveness i.e. how costs relate to outcomes in comparison with the traditional form of the service.

5.6 There is often a tendency on the part of those leading or managing service innovations to assume that all involved will agree on goals and objectives and on the tasks to be undertaken to deliver the service: frequently this is not the case, resulting in ambiguity and conflict. Independent evaluators, who can generate trust and confidence amongst key players, are in a much better position to surface misperceptions, hidden agendas and conflicts and to ensure that multiple perspectives are incorporated in the evaluation.

5.7 Many service evaluations are carried out by in-house staff teams, frequently by the same staff providing the service. This raises many questions about availability of research skills, expertise in research methodologies and especially about the extent to which an unconscious bias may be introduced by staff who have not only developed and nurtured the service, but are at the same time trying to sustain it in the face of all the usual work pressures. It is extremely difficult to expect staff looking after patients, usually a full time job, to take responsibility for data collection as well. Our experience indicates that under service pressures, research and data collection activities are understandably given lower priority and important data can be missed or lost.

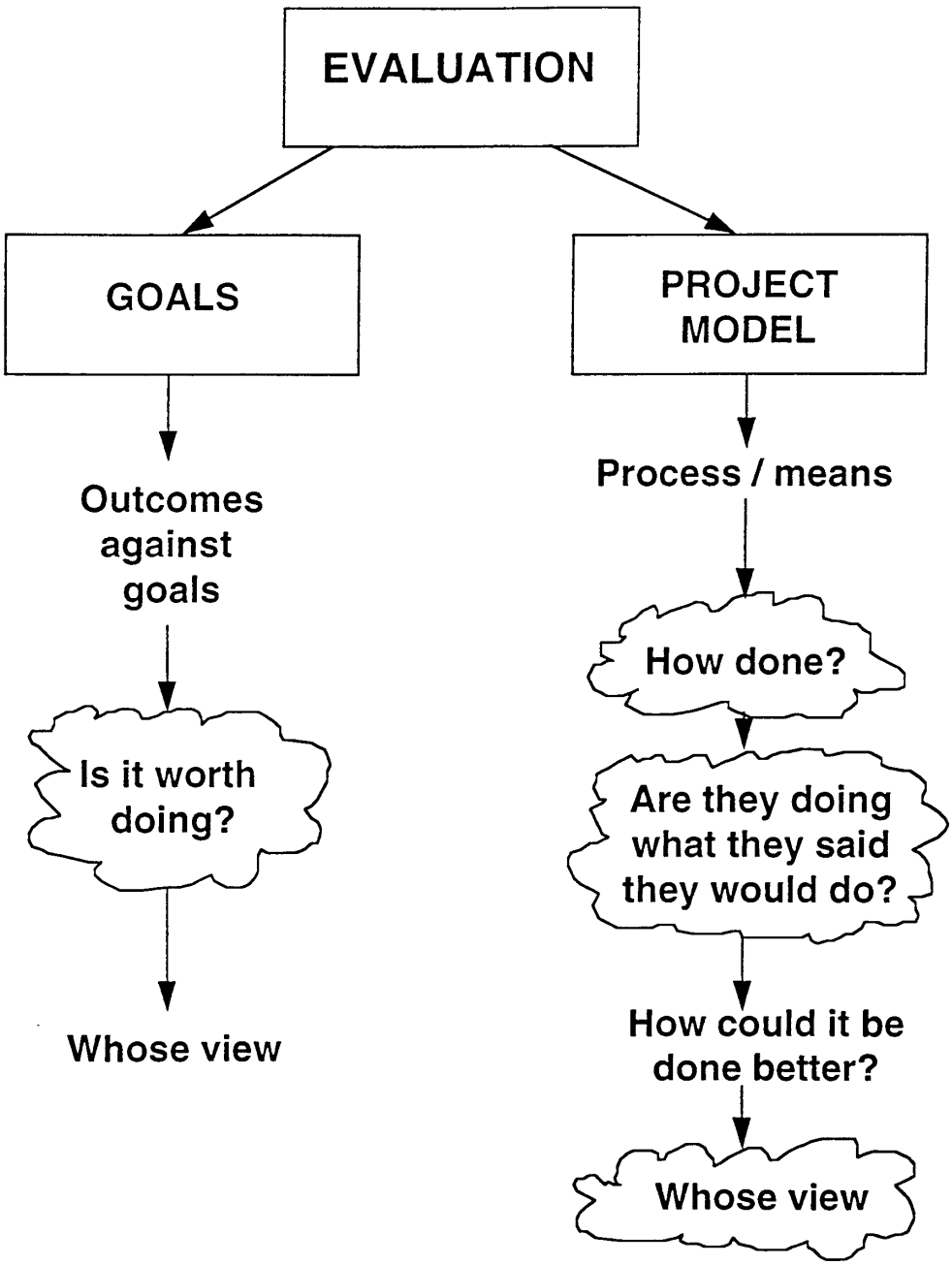
5.8 An approach which combines systematic outcome evaluation and research into process issues is recommended. Outcome evaluation focuses on examining how far the goals identified in the service programme and policies on the one hand, and those identified by other major stakeholders on the other hand, are achieved in practice. Process evaluation examines what contributed to the outcomes in the design and execution of the programmes, such as the relevant conditions, professional capacities, patient resources and other service related pressures (see Diagram 4 overleaf). This approach is described as having an "action research" orientation, which has been defined as " a cyclical process of fact-finding, action and evaluation, following which the process begins again" (Lewen and Ketterer et al, 1980). Such an approach ensures a commitment to using external feedback to assist in developing and improving services on an ongoing basis.

5.9 Our analysis of the evaluation of service innovations in the region is confirmed by the weaknesses highlighted in the recent King's Fund report on the "Evaluation of LIZ Primary Care Projects", reproduced in Box 3 below.

Box 3 Weaknesses in the LIZ evaluation process

- lack of an evaluative framework for considering the impact of the LIZ programme as a whole, either at HA level or for all of London;
- relatively little evaluation across similar projects and relatively little inter-HA working, either to commission evaluations or to learn from them;
- lack of skilled and dedicated resources for evaluative activity leading to confusion between different types of activity broadly labelled as 'evaluation';
- limited interaction between projects, HAs and regional R&D Directorates;
- the fact that criteria for selection of projects for different types of and intensity of evaluative effort were not always clearly identified or consistently applied.

Diagram 4


EVALUATION
GOALS
PROJECT MODEL
Outcomes against goals
Process / means
How done?
Is it worth doing?
Are they doing what they said they would do?
Whose view
How could it be done better?
Whose view

6.0 Discussion & general observations

6.1 There are substantial changes taking place in the NHS today, including those catalysed by various government policy developments, particularly the new emphasis on primary care. Purchasers and providers are considering new models of health care delivery such as Hospital at Home, and the expansion of services in community hospitals, day care centres, general practice and other community settings. Considerable activity relating to the extension of professional roles, the development of integrated care packages and disease management has been penetrated. Our survey discovered that a significant number of innovations focused on new care settings, the development of new relationships and roles, and the extension of professional roles, over half of which related to the extension of nursing roles.

6.2 Initiatives have a natural history beginning with initial ideas, progressing to funded projects and on to fully evaluated innovations. Their development and emergence as innovations can take many years. At the time a survey is conducted, some potentially significant innovations might be at an early stage and might not be recognised by those involved as being innovative or even as having any longer term potential. This is a confounding factor in research into innovations. Also, the extent to which an initiative is regarded as an innovation by those involved depends on their awareness of other initiatives in the same field.. This varies widely and makes for another confounding factor.

6.3 The initiatives reported in this survey were very heterogeneous and ranged from the significantly different, or even seemingly unique, (e.g. the establishment of a completely new service) to the relatively commonplace (e.g. a small scale addition to an existing service).

6.4 Initiatives and innovations may be classified in a number of different ways. The following criteria may be useful:

- who delivers the care. This includes new and expanded staff roles, for example a nurse becoming a nurse specialist, nurse prescribing, or physiotherapist assessment of orthopaedic cases;
- where care is delivered. For example, a shift of care into the community, or facilities specifically made available for a particular care group (such as drug users);
- who is benefiting from care; e.g. targeting particular groups, primary care being made available to non-registered people etc.;
- the way users access services, e.g. introducing self-referral;
- the emphasis of care. Including, for example, a more needs driven service, or a more patient-centred approach;
- organisation or staff mix and patterns of co-operation. Including multi-professional working;
- new provisions for training. Including pharmacists training GPs in prescribing and physiotherapists training orthopaedic surgeons in particular techniques;
- sources of (or more flexibility in) funding. In some instances the funding is the innovation.

It is interesting to note that we were not informed of any unsuccessful innovations. It was not possible, therefore, to draw any learning from "failed innovations".

6.5 In boxes 1 and 2 in Chapter 4 we highlighted the responses given to the questions about the factors which facilitated or inhibited the successful implementation of an initiative. Interestingly, many more of the former than the latter were mentioned. This is probably for a number of reasons:

- People who responded to the survey (and especially those interviewed) were likely to be active innovators (and probably successful ones). The survey methodology was therefore selective.
- Most of the initiatives submitted were well advanced in their natural history. Another survey might discover more about struggling initiatives
- People were selected for interview from the information given on initial survey responses, especially if this suggested much was to be learned about what 'makes for success'. The interview data is therefore based on initiatives that are working.
- We have little data from people who are so burdened with difficulties that they had little time to report their initiative by responding to the survey.
- The survey method entailed selecting innovators for interview on the basis of written responses to the initial brief questionnaire. This seemingly attracted a number of "academic clinicians". Many clinicians are more comfortable speaking about their practice. Some important initiatives being conducted by the latter may have been missed.

6.6 At most a survey such as this can only indicate (1) the findings which were identified through the particular approach it took, and (2) a way of conducting a survey that could be undertaken locally. It should be noted that:

- Any survey is inevitably limited in its scope by how and when it is conducted, and by whom. No survey will ever identify every innovation, nor everything there is to find out about each innovation.

- There is a danger in over-interpretation of the data collected in connection with any survey of this kind.

- This particular survey has provided a model for other surveys. We recommend that similar surveys are undertaken locally to identify initiatives that are successful as well as struggling, partly in order to support initiatives and to help the people involved to identify their strengths and weaknesses, but also to highlight factors locally which are facilitating and inhibiting to successful innovation.

6.7 This survey suggests that, innovation in the health service is rarely about the invention of something entirely new; it is more often about taking an existing service into a new setting or modifying an established process. Whether innovations are of an evolutionary or revolutionary nature, it is essential that they focus on outcomes and are appropriately evaluated in order to validate the change in practice or procedure. An evaluated innovatory process is clearly easier to disseminate and replicate. The Regional Office can assist the process of innovation by contributing to the problem solving and evaluation and by giving key innovations a high profile coverage in the Region.

7. Framework for evaluating service innovations

7.1 As discussed in Section 5, evaluation covers a broad range of activities ranging from a description of the initiative to a systematic process and outcome evaluation to randomised control studies. We believe evaluation methodology should reflect the scope, size of the initiative and expenditure on it, as well as the information needs of the key "audiences". The selection of appropriate methodology is essential if the information is to be used to establish good practice and learning, as well as to inform future service design.

7.2 The following may be a useful classification of innovations for the purpose of evaluation could be:

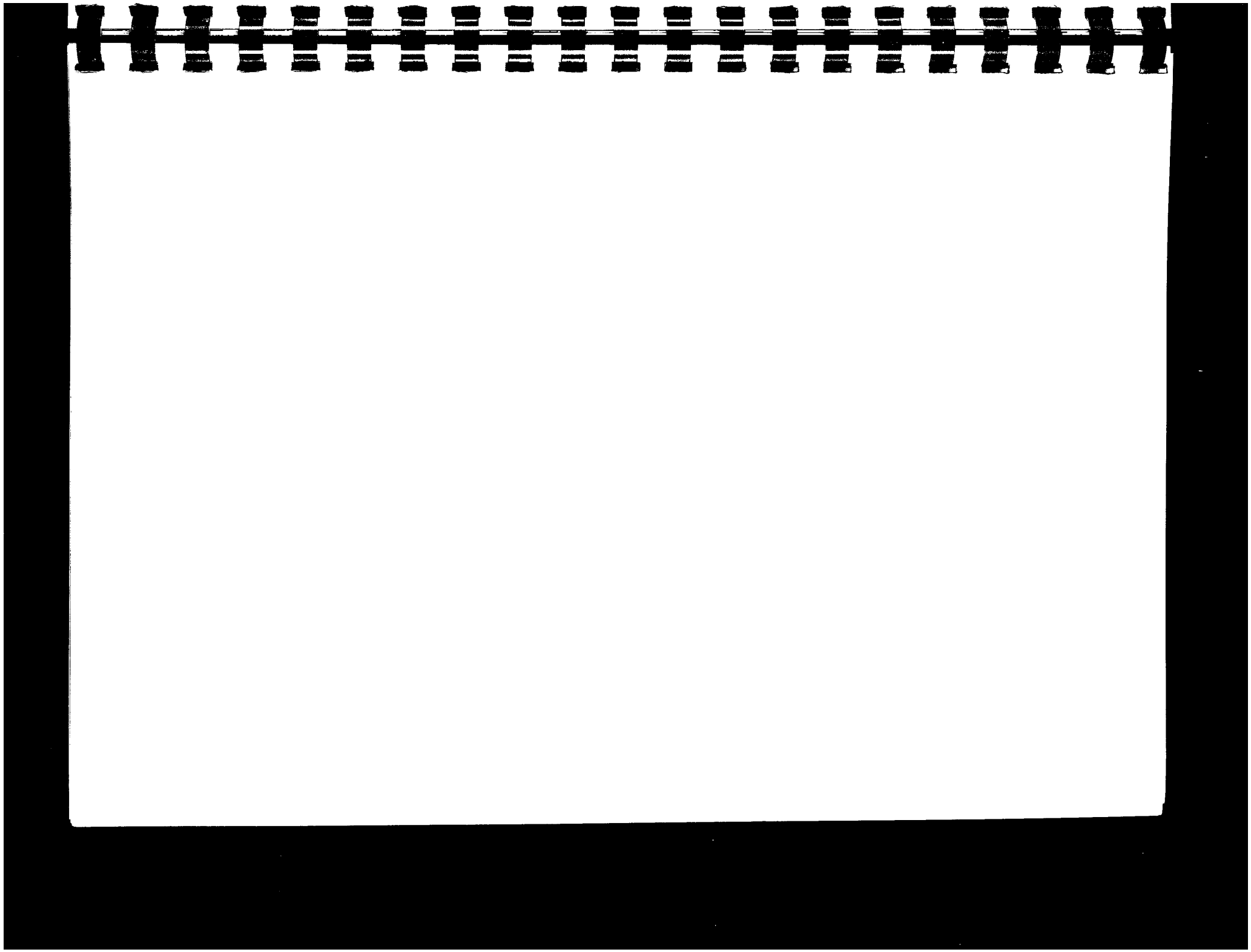
- *initiatives which are significantly different, or genuinely new: they represent a marked shift in practice or behaviour and may be large scale.*
- *initiatives which are incremental: whilst not unique, they have some distinctive aspects and are being successfully introduced locally for the first time.*
- *initiatives with organisational implications, including those involving new and extended professional roles and patterns of working.*

(It should be noted that, whilst the first two categories are mutually exclusive, the third may apply to either one of these first two)

7.3 The classification of innovations is not easy and the application of this classification, like any other, of course, calls for the exercise of judgement as to the nature of individual initiatives. Accepting this, the classification was applied to the initiatives relating to which interviews were undertaken and about fifty others, about which sufficient information had been given to enable judgements to be made. The classification of some of the remaining initiatives called for specialised clinical knowledge which the research team did not possess. Of a total of 113 initiatives, 24 (21%) were classified as 'significantly different or genuinely new'; 89 (79%) as 'incremental'; and 39 (35%) were judged to be initiatives with 'organisational implications'.

7.4 The case studies of innovation in Appendix 5 illustrate the classification.

7.5 Initiatives in the first category would clearly benefit from a systematic evaluation, incorporating both a formative (on-going) element and summative one (judging the merit of the innovation). Those in the second category would benefit from a monitoring process, aimed at assessing the achievement of intended outcomes without needing to collect a huge amount of research data. Initiatives in the third category require a more detailed process evaluation with an emphasis on user and professional perspectives.



7.6 Evaluation following the "action research" approach is recommended for all large scale innovations i.e. those initiatives on which expenditure is significant and which have a wide ranging intended impact. It is important for the evaluator to work with the implementors from the outset ensuring that there is continual, critical reflection on the process of implementation and that the concerns of the key players are addressed at the beginning. This approach uses quantitative as well as qualitative methods. At a minimum, a comprehensive evaluation of a new service innovation should assess the following:

- the existence of a clear unambiguous operational policy, covering inclusion criteria, clinical responsibility and the processes of care and discharge;
- patient activity details, with case mix analysis and clinical outcomes;
- documentation of processes and interventions, to enable quality audits and assessment of safety and adverse outcomes;
- utilisation patterns by general practitioners and hospital medical staff;
- the perceptions of patients and their carers;
- the views of the staff and other key stakeholders;
- analysis of the costs of the 'new' service to enable comparison with costs of the 'old, traditional' service;
- explicit examination of the lessons for larger scale application to appropriate services.

7.7 In an optimal evaluation process for a large scale initiative, independent researchers who understand the innovation should work closely with staff providing the service, ensuring that the development of the service and the design of the research for evaluating the service go hand in hand.

7.8 The independent contribution should focus on:

- conducting some prior research into the context for and size of the new service;
- establishing success criteria with all the key stakeholders;
- ensuring the evaluability of the service;
- defining with the key stakeholders appropriate measures and measurement instruments;
- collecting data or supervising data collection;
- analysing the data;
- collecting and recording patient carer perspectives;
- collecting and recording other key stakeholder perspectives.

8. Conclusions

8.1 An innovation is a new idea which may be a combination of old ideas, a scheme that challenges the present order, or a formula or unique approach which is perceived as new by the individuals involved. As long as the idea is perceived as new by the people concerned, it is an innovation, even though it may appear to others as an imitation of something that exists elsewhere. Innovations are therefore not entirely dependent upon new inventions; existing services, organisational structures and processes may change gradually, bringing about small improvements, a process described as incremental innovation. Although many people emphasise the "new" nature of innovation, studies have indicated that process and incremental innovations have an equal or even greater importance in commercial success.

8.2 The survey shows that a great deal of change is occurring across the region and a large number of initiatives was submitted for analysis. Initiatives have a 'natural history', beginning with initial ideas, then perhaps becoming funded projects and perhaps later, fully evaluated innovations. The development of initiatives and their emergence as innovations can take many years. The information given regarding an initiative in response to a survey depends greatly on how and when the survey is carried out. At the time a survey is undertaken some potentially significant innovations might be at a very early stage and not be recognised by those involved as being innovative; conversely, some initiatives might be regarded at the time as potentially innovative, but may subsequently not realise that potential. This is a confounding factor in any research into innovations.

8.3 The survey targeted particular groups and individuals within the region and utilised particular survey techniques. It thereby attracted particular submissions. If it had been targeted differently or had used different techniques, it is likely that it would have attracted different submissions. As a consequence, the database cannot be regarded as 'comprehensive', 'complete' or even 'representative'; it has therefore not been analysed from a numerical perspective other than for illustrative purposes. The O & M Group and interested others could usefully conduct further and wider surveys to obtain information on other types of initiatives.

8.4 There was a general lack of clarity over expected benefits in terms of measurable outcomes for the organisation or patients. Many of the initiatives involving the extension of the roles of professional groups other than nurses and doctors were small scale and seemed unsupported by senior management in terms of commitment and resources.

8.5 Innovation in health care often requires multiple providers and multiple purchasers in complex multi-agency systems bringing together different professional contributions, whilst paying careful attention to patients' and their carers' views and preferences. It is important that services are subjected to rigorous and systematic evaluation which enhances our understanding of the conditions and processes for and costs of successful implementation and development.

8.6 Innovation is not the enterprise of a single entrepreneur; it is a joint effort that focuses on the creation, adoption and sustained implementation of a set of ideas among people who are sufficiently committed to those ideas to transform them into productive currency. To create an environment where innovation can flourish requires committed organisational leadership as well as support from the wider organisational community, for example, those involved in research and development activities.

8.7 The term 'evaluation' is widely used in health services research and development and serves different functions at different organisational levels: that is, documenting that a budget is deserved, or control, or accountability or a comprehensive assessment relating the inputs and processes to costs and outcomes with the intention of informing future service design.

8.8 Most initiatives are being evaluated in some way, but the quality of evaluation is variable. Methodological approaches range from a randomly controlled trial involving 4,000 patients with high levels of quantitative data to a secretary preparing a questionnaire to be handed to patients. The calibre, and hence validity, of some of the evaluations seems questionable, particularly those of a more qualitative nature. Those involved in leading and managing innovations would gain greatly from help and support in relation to evaluation approaches.

8.9 An approach which incorporates an action research orientation is recommended; this has been defined as " a cyclical process of fact-finding, action and evaluation, following which the process begins again" (Lewen and Ketterer et al, 1980). Such an approach ensures a commitment to using external feedback to assist in developing and improving services on an ongoing basis. It includes both process evaluation and outcome evaluation. Outcome evaluation focuses on examining how far the goals identified in the service programme and policies on the one hand, and those identified by other major stakeholders on the other hand, are achieved in practice. Process evaluation examines what contributed to the outcomes in the design and execution of the programmes such as the relevant conditions, professional capacities, patient resources and other service related pressures.

8.10 At a minimum, a comprehensive evaluation of a service innovation should assess the following:

- the existence of a clear unambiguous operational policy, covering inclusion criteria, clinical responsibility and the processes of care and discharge;
- documentation of processes and interventions to enable quality audits, assessment of safety and adverse outcomes;
- utilisation patterns by general practitioners and hospital medical staff;
- the perceptions of patients and their carers;
- the views and perceptions of the staff and other key stakeholders;
- analysis of costs of the 'new' service to enable comparison with costs of the 'old, traditional' service;
- explicit examination of the lessons from particular initiatives for larger scale application to appropriate services.

8.11 Such evaluations will only be conducted if the service culture is such that it becomes a normal component of management and professional activities. The lack of dedicated resources, knowledge and skills for conducting systematic evaluations has resulted in a loss of useful learning from key innovations and in some innovations not being more widely implemented. The creation of a culture in which purchasers and providers conduct such critical reviews of service innovations will require considerable investment, encouragement and support.

8.12 It is essential to draw together lessons from evaluations and compile them into a format that will give purchasers and providers region wide easy access to evaluated information in order to learn and make informed judgements about implementing similar and new initiatives.

9.0 Recommendations

9.1 Establish a formal mechanism for disseminating information about service innovations in the region; as a start the database should be circulated to all providers and commissioners.

9.2 Establish learning networks to disseminate and share learning and experiences of service innovations and their evaluability. This was also recommended in a recent evaluation of the LIZ primary care development programme.

9.3 All new and significant innovations should be considered by the O&M Group and comprehensive evaluations should be supported in order to draw lessons of general relevance.

9.4 Establish a process for continually updating data using different survey instruments in order to capture innovations of different kinds.

9.5 Make appropriate evaluation a key requirement of all future investment in new service development with guidelines that ensure that evaluation criteria and methods are addressed at the beginning rather than at the end of an initiative.

9.6 Consider the establishment of an evaluation reference and advisory group with expertise on evaluation methodology.

9.7 Encourage and support multi-site evaluation of significant innovations.

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Appendix 1

SURVEY OF SERVICE INNOVATIONS

Postal survey response form

Please use separate form for each innovation/initiative

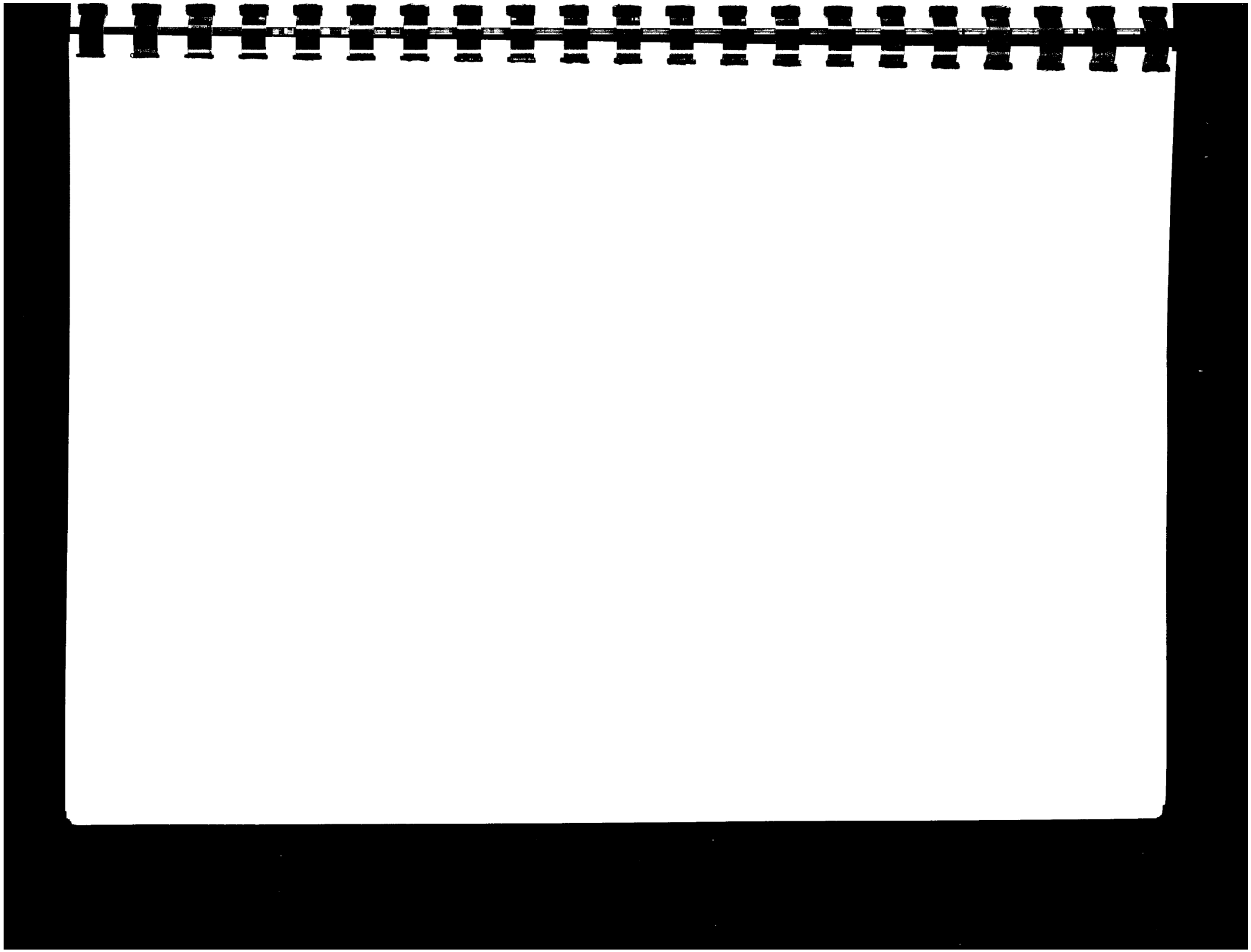
NAME AND ADDRESS OF ORGANISATION

TITLE AND DESCRIPTION OF INNOVATION/INITIATIVE

AIMS AND OBJECTIVES

PLEASE LIST BELOW THE KEY PEOPLE INVOLVED	
Name	**Telephone No.**

Please return to : Sheila Henderson, Kings Fund, 11-13 Cavendish Square, London W1M 0AN



Appendix 2

Semi-structured interview schedule

THE INNOVATION

- Briefly describe the innovation
- Has the innovation been published? If so, please give references.
- What (or who) prompted, or stimulated, the innovation?
- What other internal or external agencies or groups are involved in, or are affected by, the innovation?
- Who is leading the innovation?
- Who is responsible for managing the innovation?

SIZE, SCOPE & TIMING OF THE INNOVATION

- In what ways do you see your initiative as being innovatory?
- How important do you see the innovation for the development of the service?
- Can you express the innovation's size and scope in numerical (or comparative) terms?
- When did the idea behind the initiative first emerge?
- How long did it take for the initiative to get started?
- When do you envisage the initiative being implemented more widely?

PURPOSES

- What is the innovation attempting to achieve?
- What is/are the innovation's main client group/s?
- What other internal or external agencies or groups might benefit from the innovation?

COSTS & BENEFITS

- What do you consider the benefit of the innovation will be to the main client group?
- What might be the benefit of the innovation to others?
- What are the financial costs of the innovation?
- Are there any other kinds of costs? If so, what?
- How has the innovation been funded? Give details of any pump-priming / start-up money and development opportunity time (e.g. release from / cover for service work).
- What mechanism met / is meeting the innovation's start-up costs?

IMPLEMENTATION

- What factors supported / facilitated the introduction of the innovation?
- What factors inhibited its introduction?
- How are the ongoing costs (if any) being (or going to be) met?
- Do you envisage the innovation resulting in any savings?
- If so, how are these savings likely to be used?
- In what ways has the innovation required or initiated new work patterns by health professionals?
- In what ways has the innovation crossed traditional or pre-existing boundaries (indicating whether professional, service, clinical area, managerial, or primary care/community/hospital)?

TRANSFERABILITY

- Is the innovation generalisable and what do you see as its wider significance?
- Where (in what locations and contexts) might the innovation most successfully be replicated?
- What do you see as the barriers to successful implementation elsewhere?
- What prior conditions would be required for successful replication?

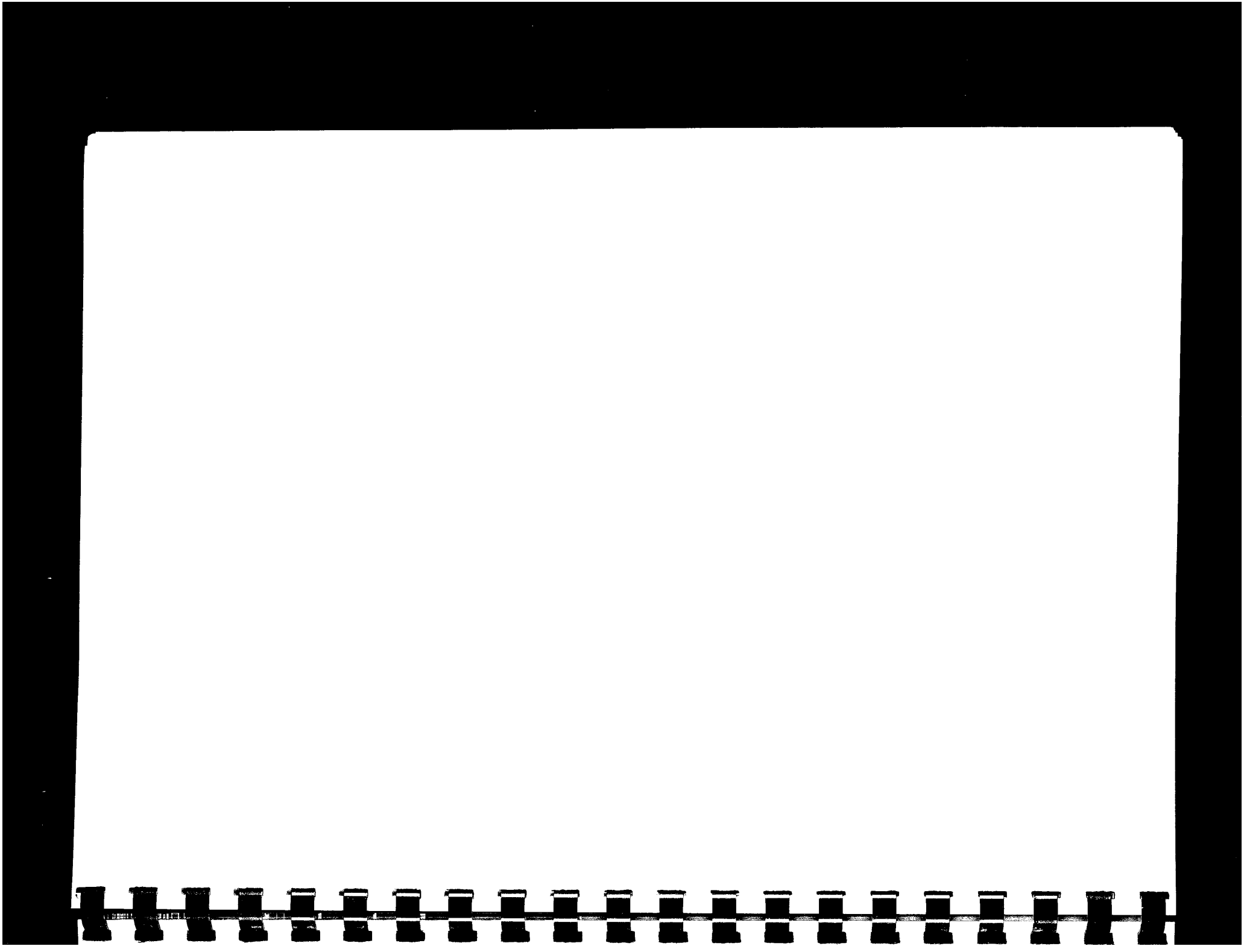
EVALUATION

- Describe how you are evaluating (or intending to evaluate) the innovation.
- Who will conduct (or is conducting) the evaluation?
- What funding is involved in the evaluation and what is its source?
- By what key criteria would you like the innovation to be judged?
- In what ways do you see the innovation as being successful?
- In what ways is the innovation an improvement to the service?
- In what ways are you measuring or observing this improvement?
- In what ways might you modify the innovation in order to make it more of a success?
- If you were starting again, what would you do differently?
- What problems have you encountered and how have they been overcome?
- What lessons have you applied from other initiatives, including failed (or only partially successful) ones?
- Following its evaluation, do you envisage the innovation continuing?

Appendix 3

Numbers of Responses from Health Authorities and Trusts		
No	**Name of Authority/Trust**	**No of Responses**
1	Basildon & Thurrock General Hospitals NHS Trust	2
2	East Hertfordshire NHS Trust	Nil
3	Essex Rivers Healthcare NHS Trust	Nil
4	Mid Essex Hospital Services NHS Trust	Nil
5	Mount Vernon & Watford Hospitals NHS Trust	5
6	North Hertfordshire NHS Trust	3
7	Princess Alexandra Hospital NHS Trust	10
8	St Albans & Hemel Hempstead Hospitals NHS Trust	Nil
9	Southend Health Care Services NHS Trust	8
10	Beds & Herts Ambulance & Paramedic Services NHS Trust	Nil
11	Essex Ambulance Service NHS Trust	3
12	Essex & Herts Community Health Services NHS Trust	10
13	Horizon NHS Trust	1
14	Mid Essex Community and Mental Health Services NHS Trust	2
15	New Possibilities NHS Trust	3
16	North East Essex Mental Health Services NHS Trust	4
17	Southend Community Care Services NHS Trust	25
18	Thameside Community Healthcare NHS Trust	1
19	West Hertfordshire Community Health NHS Trust	4
20	Central Middlesex Hospital NHS Trust	9
21	Chase Farm Hospitals NHS Trust	1
22	Chelsea & Westminster Healthcare NHS Trust	Nil
23	Ealing Hospital NHS Trust	6
24	Forest Healthcare NHS Trust	9
25	Great Ormond Street Hospital for Children	Nil
26	Hammersmith Hospitals NHS Trust	34
27	Harefield Hospital NHS Trust	8
28	Havering Hospitals NHS Trust	Nil
29	Hillingdon Hospitals NHS Trust	5
30	Homerton Hospitals NHS Trust	6
31	Moorfields Eye Hospital NHS Trust	4
32	Newham Healthcare NHS Trust	Nil
33	North Middlesex Hospitals NHS Trust	3
34	Northwick Park & St Mark's NHS Trust	Nil

Numbers of Responses from Health Authorities and Trusts		
No	**Name of Authority/Trust**	**No of Responses**
35	Redbridge Healthcare NHS Trust	3
36	Royal Brompton Hospital NHS Trust	24
37	Royal Free Hampstead NHS Trust	Nil
38	Royal Hospitals NHS Trust	6
39	Royal London Homeopathic Hospital NHS Trust	Nil
40	Royal Marsden NHS Trust	Nil
41	Royal National Orthopaedic Hospital NHS Trust	3
42	Royal National Throat, Nose and Ear Hospital NHS Trust	Nil
43	St Mary's NHS Trust	3
44	University College London Hospitals NHS Trust	1
45	Wellhouse NHS Trust	7
46	West Middlesex University Hospital NHS Trust	Nil
47	Whittington Hospital NHS Trust	8
48	Barnet Healthcare NHS Trust	Nil
49	BHB Community Health Care NHS Trust	Nil
50	Camden & Islington Community Health Services NHS Trust	1
51	City & Hackney Community Services NHS Trust	4
52	Enfield Community Healthcare NHS Trust	20
53	Haringey Healthcare NHS Trust	5
54	Harrow & Hillingdon Healthcare NHS Trust	3
55	Hounslow & Spelthorne Community & Mental Health NHS Trust	10
56	Newham Community Health Services NHS Trust	9
57	North West London Mental Health NHS Trust	1
58	Parkside Health NHS Trust	2
59	Riverside Community Healthcare NHS Trust	9
60	Riverside Mental Health NHS Trust	5
61	Tavistock and Portman NHS Trust	1
62	Tower Hamlets Healthcare NHS Trust	Nil
63	West London Healthcare NHS Trust	Nil
64	Barnet Health Authority	Nil
65	Brent & Harrow Health Authority	Nil
66	Ealing, Hammersmith & Hounslow Health Authority	21
67&68	Hertfordshire Health Authorities	9
69	Hillingdon Health Authority	Nil
70	Kensington, Chelsea & Westminster Health Authority	10
71	Barking & Havering Health Authority	2
72	Camden & Islington Health Authority	6
73	East London & The City Health Authority	Nil
74	Enfield & Haringey Health Authority	Nil
75	North Essex Health Authority	Nil
76	Redbridge & Waltham Forest Health Authority	2
77	South Essex Health Authority	7



Appendix 4

Evaluating Primary Care Development: A review of evaluation in the London Implementation Zone primary care development project

EXECUTIVE SUMMARY

The Government's policies to improve health care in London, set out in *Making London Better* (1993), established as a central objective the development of primary and community health services. Through the former London Implementation Group (LIG), a major programme of investment (in excess of £200 million over the financial years 1993/4 to 1995/6) was launched to support primary care development projects in the London Initiative Zone (LIZ). From the outset, there was a strong emphasis on 'evaluating' these projects, although what was to be understood by evaluation was less clear.

In 1995, the King's Fund was commissioned to review this investment in evaluation. This project was funded by the Department of Health and the aims, which were developed in discussion with North and South Thames Regional Offices of the NHS Executive, were to:

- assess the current status of project evaluation in relation to the LIZ primary health care development projects;
- identify the role which project evaluation plays in the strategic thinking of the 12 inner London Health Authorities (HAs) in relation to future investments in primary care; and
- draw lessons for the inner London HAs in terms of helping them to make better use of project evaluations in future.

From late December 1995 to April 1996 semi-structured interviews were held with representatives from each HA, most usually with those responsible for the management of the LIZ programme, to discuss their plans for evaluating both individual projects and the impact of programme as a whole. Through discussion with HA managers, a range of different types of project in each HA were selected for more detailed data collection. The focus here was on revenue projects aimed at service development.

As a result, a further 36 semi-structured interviews were held with those responsible for leading the evaluation of the selected projects. Quantitative data on the nature of projects and their funding were collected for 1995/6, but the bulk of the data comprises the views and accounts of events provided by the interviewees. In addition, the emerging analysis of the issues raised through the interviews at HA and project level was further developed at two workshops held in June 1996. These brought together,

firstly, those who had taken part in the project level interviews to compare experiences across London and, secondly, those involved in purchasing and primary care development at HA level.

The LIZ primary care development programme (Chapter 2)

The principal objectives of the LIZ development programme can be summarised under the following broad headings:

- *'getting the basics right'*, bringing existing primary care services up to standard - i.e. improving premises and bringing in more core staff (62% of projects)
- *developing innovative primary care* - supporting initiatives that would bring new forms of primary care to the inner city (e.g. extended primary care centres, services for populations with special needs, and primary care in A&E) (25% of projects)
- *shifting services from hospital to the community* - developing the interface between primary and secondary care so that more care took place in the community (e.g. polyclinics, home care) (13% of projects)

The function of evaluation in health service commissioning (Chapter 3)

In theory, each of the LIZ projects is committed to providing some sort of evaluation. However, the vast majority had no earmarked budget and the term `evaluation' was used very loosely. As is the case throughout the NHS, most routine effort concerned with assessment of how well projects attain their objectives comprised monitoring rather than evaluation. A distinction can be drawn between the different types of activity that may be considered as `evaluation' and the different levels at which evaluation can take place.

There is a key difference in approach between *formative evaluation* which aims to provide a stage-by-stage description of the development of a project with some reference to objectives, though these may alter over time, and often in response to the evaluation; and *summative evaluation* which is concerned with learning about the overall effect of a project and is thus focused more on outcome evaluation of the mature project once its objectives have been codified, possibly in comparison with alternative uses of the necessary resources (section 3.1).

Evaluation may take place at different levels, extending from the health system as a whole, the primary care sector, across specific forms of primary care (e.g. out-of-hours care) and within specific projects

(3.2). The amount and nature of the resources available to carry out evaluation is important, although it proved impossible to collect detailed data on the resources available for specific project evaluations (3.3).

The health authority and project level experience (Chapter 4)

Over 60 per cent of LIZ monies have gone into expanding the range and quality of primary care buildings. This was largely seen by HAs as appropriate and, therefore, in need of little evaluation. The interviews at HA and LIZ project levels concentrated on three aspects of evaluation: commissioning and managing evaluation; conducting evaluation; and, the dissemination and use of evaluation findings (4.1).

Commissioning and managing evaluation: An approach to commissioning the evaluation of LIZ projects evolved during the life of the programme. HAs commented on the *ad hoc* approach used in the first year, 1993/94, although, by 1995/96, HAs were commissioning evaluation in the context of primary care strategies and with attention to plans for `pick up' of projects after the end of the programme.

The vast majority of projects were subject to simple monitoring. While a number of projects received more attention, only a handful of studies could appropriately be described as summative evaluations.

The overall management of the LIZ programme, with a short lead- time for setting up projects, limited project design. The vast range and number of projects also had a significant influence on the nature of evaluation (4.2).

Conducting evaluation: Typically, providers interpreted the request for 'evaluation' of projects differently and with varied levels of confidence and competence. The contribution of Public Health Departments to evaluation of LIZ projects also varied greatly from one HA to another. The majority of projects focused on collecting activity data, although a few had begun to look at process measures. To date, there has been little attempt to look at health outcomes or cost-effectiveness in relation to the LIZ projects (4.3).

Use of evaluation: Most project evaluations focused on the development of the individual service and its local benefits. There have been few attempts to share the results of work in progress between trusts

and HAs. At the time of the study, HAs had limited plans for further use of findings although an understanding was emerging that the LIZ primary care development projects provided lessons that could inform future commissioning intentions (4.4). Explicitness in defining the appreciative framework required to shape judgements about future funding under conditions of uncertainty is still emerging.

Evaluation at the regional and national level (Chapter 5)

In each region, the Performance Management Directorate of the NHS Executive Regional Office has played a role in helping HAs to incorporate thinking about monitoring and evaluation into their management of the LIZ programme (5.1). However, there are few examples of successful engagements between those involved in the NHS Research and Development process, and those at HA level in respect of evaluation of LIZ primary care projects (5.2).

Diagnosis and conclusions (Chapter 6)

Both strengths and weaknesses were identified in the LIZ primary care development programme evaluation process.

Strengths included:

- increasing sophistication in the commissioning, management and use of evaluation as a result of the learning which ensued from participation in the LIZ programme, albeit starting from a low base;
- development among staff at project and HA level of a critical evaluative perspective; and,
- increased clarity about the aims, objectives and working methods of projects.

Weaknesses included:

- lack of an evaluative framework for considering the impact of the LIZ programme as a whole, either at a HA level, or for all of London;

- relatively little evaluation across similar projects and relatively little inter-HA working, either to commission evaluations or to learn from them;

- lack of skilled and dedicated resources for evaluative activity leading to confusion between different types of activity broadly labelled as 'evaluation';

- limited interaction between projects, HAs, and Regional R&D Directorates; and

- the fact that criteria for selection of projects for different types and intensity of evaluative effort were not always clearly identified or consistently applied (6.1).

HAs were frustrated by the great speed with which LIZ projects were set up, coupled with the inadequacy of resources to evaluate them properly. Most saw the LIZ programme as a bolt-on, short-term resource, outside mainstream commissioning. Moreover, the emphasis on monitoring the impact of individual projects has not always been related to the size and spend on projects. Subsequently, many HAs have had difficulties placing the project-level evaluation of their LIZ programme within their long-term strategy for primary care development.

If evaluation is a concern, then the LIZ experience does not provide a model of how to organise a programme. On the other hand, it has resulted in considerable and rapid investment in primary care in London. It is now important to examine the overall success of these developments in order to:

- evaluate how well the programme as a whole has achieved its objectives;

- inform the way in which programmes elsewhere may be developed; and,

- share lessons which may be learned both for managing individual projects and for managing a major development programme.

It would also be useful to determine the proportion of LIZ projects which eventually convert to mainstream NHS funding and the factors important in the 'pick up' process (6.2).

Recommendations (Chapter 7)

The recommendations for change and action in the future should not be interpreted as a dismissal of all the good work which has already taken place to evaluate the LIZ primary care development programme and its constituent projects. Particularly at project level, a considerable amount of useful learning has already taken place both in how to do evaluation and how to learn from it. The emphasis on *learning* is particularly appropriate if the LIZ primary care development programme is seen as a 'pilot' for developing new ways of strengthening primary care.

It became increasingly apparent during the course of the interviews that the lack of links between the roles of different parts of the NHS was one of the main things which informants wished to improve. Nineteen recommendations in the main report are directed at different parts of the NHS, including staff in Regional Offices of the NHSE, HAs, project managers and others. The key recommendations for each agency extracted from the longer list in the body of the report are summarised below.

Health Authorities (7.1.1)

A1 *Health Authorities should plan to link the evaluation feedback process to mainstream commissioning*

Hitherto, there has been relatively little use made of the results of evaluation by HAs in commissioning their future pattern of primary care. As HAs' primary care strategies become more refined, it should become easier to use the strategies as one way of assessing the priority which should be assigned to individual projects in the future. Equally, evaluative information needs to be made increasingly available on so called 'mainstream' projects and services.

A3 *Health Authorities should establish formal links with relevant sources of external advice and expertise in health care evaluation*

This external help should include how to commission good quality, useable evaluation as well as the capacity to undertake the studies themselves.

Health Authorities and NHSE Regional Offices (7.1.2)

B1 *Health Authorities and NHSE Regional Offices should develop a regular mechanism for sharing experience and examples of 'good practice' in commissioning, managing and using evaluations of primary care development projects between Authorities and between projects*

The review demonstrated both the current lack of sharing of 'intelligence' between HAs and projects and the value of such mutual learning. The exchange of 'intelligence' needs to include not only examples of 'good practice' and the findings of studies, but also how to obtain and use evaluation for practical decision-making.

Regional Offices of NHSE (7.1.3)

C1 *Regional R&D Directorates, in conjunction with the Primary Care Support Force, should explore the scope for developing research networks linked to multi-site evaluations, focusing on key themes or major groups of projects in the LIZ programme*

Given the project-specific, local nature of much of the evaluative activity on the LIZ programme to date, there is a strong case for more generalisable, larger scale, thematic evaluations focused on areas of the programme which have received major investment, where important learning for the future may be possible and/or where the financial consequences of development may be considerable. The benefits of such research would extend beyond the current LIZ programme.

C2 *Regional R&D Directorates, working with HAs, should build on their recent experience of more proactive styles of working (eg attempts to increase the skills available in primary care research) by developing more widely a 'brokerage' model of commissioning R&D in relation to the LIZ programme*

In situations where innovative projects are still developing and research expertise and interest is not necessarily in place, there is a strong case for R&D funders to use part of their resources for 'brokerage' between researchers, projects and purchasers. The aims of this would be to shape frameworks for evaluation relevant to health services commissioning, identify appropriate research questions and methods, identify suitable settings for evaluation,

identify interested professional researchers, facilitate research collaborations, obtain support for evaluation among service providers and contribute to the development of projects so that they can be assessed summatively and the results used in future commissioning decisions.

C3 *Regional Offices should develop a range of mechanisms designed to assist HAs to make judgements when comparing the costs and benefits of projects in different areas of their LIZ programmes and also between 'mainstream' and LIZ services, so that decisions about take-on funding can be made in an informed way*

The need expressed by purchasers was for ways of developing the findings of individual evaluations into useable 'intelligence' which would provide an informed basis for making the tricky judgements necessary to discriminate between the claims of fundamentally different types of projects under conditions of considerable uncertainty. While a comprehensive, rational decision-making model is likely to remain unattainable, a starting point might be to provide easily accessible summaries of different technical methods for thinking about and making priority decisions. However, this should be accompanied by experiments in more interactive and comparative approaches to better decision-making in which research evidence, local 'intelligence', the views of experts and professionals, HA views, the perceptions of the public, the objectives and targets in their primary care strategies and other inputs to the process have to be weighed in combination with one another.

Department of Health, NHSE, Primary Care Support Force and Regional Offices (7.1.4)

D1 *A programme-wide evaluation of the impact of the LIZ primary care development programme should be developed and undertaken as soon as possible*

Given that the vast bulk of the evaluative activity surrounding the LIZ programme has been project-specific rather than concerned with the overall effects of the programme as a whole and given the scale of the investment, there is increasing interest in being able to assess the effects of the LIZ programme within the context of longer term and parallel trends to improve the quality of primary care in London. Three aspects are particularly important: the impact of LIZ capital spending; the uses to which the additional staff funded through the programme have been put; and the geographic and socioeconomic equity implications of the programme.

Appendix 5

CASE STUDIES OF SERVICE INNOVATIONS

Group A: Initiatives which are significantly different, or genuinely new: they represent a marked shift in practice or behaviour and may be large scale.

1. IMPACT

Organisation: Hammersmith and Fulham MIND

A new, non-statutory, community based multi-disciplinary mental health team, supported by Riverside Mental Health Trust and funded under the Sainsbury Mental Health initiative for three years. Eight practitioners and an administrator form an outreach team approach with no individual case loads, for up to six clients with long term serious mental health problems with whom other mental health services have failed. The service provides clients with comprehensive mental health care, social care and support as well as housing and community advice.

The initiative is innovative because it attempts to provide comprehensive local mental health services through an independent, non-statutory agency, and is targeted at a neglected client group. Some of the roles and responsibilities within the team are generic, with specialist roles reflecting particular skills and experience. A key worker approach is not adopted.

The cost is approximately £800,000, met by the Sainsbury Centre for Mental Health for three years, to be picked up by Ealing, Hammersmith and Hounslow Health Authority and Social Services as part of the community care plan.

Benefits of a pro-active outreach service include building relationships with other agencies (e.g. housing and smaller voluntary sector groups), an alternative route into mental health services, and a holistic approach to patient/client care.

Evaluation has been commissioned by MIND from the university of the West of England, and covers qualitative interviews with service team and other organisations, impact on clients, user satisfaction, and contract monitoring.

2. An ambulatory care project

Organisation: West Hertfordshire Community Health (NHS) Trust

This is a randomised controlled study of transferring patients back to their own environment at an earlier than discharge date. The project transfers patients (over 55 years) home once they no longer require the resources of a hospital, and involves caring for them in their own environment. The service is managed by the hospital as a continuation of the acute episode, and clinical responsibility remains with the hospital consultant in elderly care medicine. The home health care team comprises a medical registrar, project manager, generic workers, physiotherapists, occupational therapists, community nurses, and social services. Patient care is documented using integrated care pathways (ICP). The project involves the acute hospital, district nursing, social services, and general practitioners.

The initiative is innovatory because patients are managed in the most appropriate setting, and follows integrated care pathways resulting in a constant standard of service. It is important because it reduces pressure on acute beds, and involves collaboration with the Community Trust.

The project benefits patients because they are managed and supported at home, and because ICPs provide patient focused care. For the hospital, the project releases beds, and provides documented care following the ICP format. The costs of the project involve £100,000 received from the health authority for 15 months and consultant time which is funded by the acute sector.

Evaluation, funded by the purchaser, is being conducted by an internal team with advice from the London Health Economics Consortium. The key criteria include patient outcomes, length of stay, costs

of home care versus acute care, and audit of ICP. A randomised control trial methodology is being adopted.

3. Alternative contract currency

Organisation: Enfield Community Care NHS Trust

This is the implementation of a care package as a unit for defining health care provision, and hence to offer "package" as a method of contract currency. It aims to reduce variants in the cost/price relationship, to clarify service provision, and to provide patient focused care, rather than service cost focused care. It is, then, the development of an alternative currency for contracting for community care since "full consultant episodes" is a poor measure of care in community settings. The "care package currency" is based on protocol directed care.

The initiative is innovative because it facilitates change via a clinical focus, and improves care and efficiency whilst developing a new currency for contracting purposes. The organisation sees this as important for developing contracting in their setting.

The benefits of this initiative to patients included them receiving a treatment plan (removing uncertainty and fear), better co-ordinated care, and (potentially) improved clinical interventions. For the professionals, the benefits of the project include clear outcomes and care processes (which could be audited continuously) and easier planning for current and future service provision. For the purchasers and managers of the provider Trusts, the initiative has the following benefits: the care packages are clearly identified and costed; there is clear information on the services provided; the service is easier to cost. The cost of the initiative (provided by the health authority for three years) is £300,000. The professional's time in developing care plans has been met from existing resources. The project also has "cultural costs" which require a commitment from the whole organisation.

There is no explicit evaluation process in place. However, the following validation procedures are in place: project board meeting reviewing project's progress; purchaser monitoring compliance with contracts; internal teams auditing packages of care.

Group B: Initiatives which are incremental: whilst not unique, they have some distinctive aspects and are being successfully introduced locally for the first time.

1 Care at home scheme

Organisation: The Hillingdon Hospital Trust

The project employs community based staff working with patients pre-admission and post-discharge within the context of an integrated care pathway which extends from primary sector to secondary and back to primary. The IPC is carried by the patient. The project aims to provide more appropriate care, initially to people having had joint replacement, by discharging them early, and by care being provided by a specially trained team of nurses, therapists and health care assistants.

The initiative is innovative because it deals with the linkage between different service elements, including social care. It incorporates a great deal of multi-skilling, reducing the number of professionals going into the home. The innovation is core to the development of acute services, and other services to which it could be extended in the short term include stroke rehabilitation.

The total annual cost of the project is £145,000, and in the first instant releases 6-10 beds. The benefit of the project is to provide better quality care and choices at the same cost as now or less, with possible savings in the future.

The project is being evaluated externally by Brunel University involving daily living assessment, patient satisfaction questionnaires, review of ICP variances, reviews of the use of hospital resources, monitoring infection rates and pressure sores.

2. Development of joint department of psychological therapies

Organisation: Hounslow and Spelthorne Community and Mental Health Trust

This project brings together psychology and psychotherapy services in the Trust. It aims to provide an integrated service to clients with a broad range of existing services under a joint department to ensure that the right psychological expertise is available without duplication. The service is integrated to include psychotherapy, clinical psychology, psychiatric nursing, and counselling. The projects was prompted through inappropriate GP referrals, duplication of training and supervision, and the need to provide a "quick response" service to reduce waiting times.

The project is innovatory because it provides a single point of entry to the psychological therapies and a quick response outreach service. It is important because the Trust's isolated services have come under a single organisation with a multidisciplinary group developing a standard set of assessments. It provides a health centre based outreach assessment service from which patients can be referred on, and pools the resources of the various psychological departments to achieve value for money and efficiency.

The benefits to the patient/client include a quick response service, single point of entry, a seamless service, and an appreciation of the psychological problems of the "worried well". The benefits to the Trust include reduced waste of resources, joint training and research, and education of GPs leading to more appropriate referrals. There are no figures for the cost of this project, which is funded from an underspend from other departments.

Evaluation of the project has been funded (£7,000) to employ a research assistant to audit the services (in collaboration with Imperial College). They key criteria used include response rate, speed of response, and outcome of treatment.

Group C: initiatives with organisational implications, including those involving new and extended professional roles and patterns of working.

1. Structured nurse consultations in hospital outpatients

Organisation: Wellhouse NHS Trust.

This initiative forms part of the treatment for acute asthma where at least one consultation is held with a specialist respiratory nurse for advice on self-management, which uses a six-step asthma consultation involving assessment, education, advice to change medication, and instruction on inhaler technique. The project aims to reduce asthma morbidity by improving patient self-management in acute attacks, leading to reduced symptoms, improved lung function, less time off work, and fewer consultations with health professionals. This is a collaborative multidisciplinary initiative.

The project is innovative through the adoption of a structured nurse consultation, requiring nurses to extend their professional role, with more decision making and action taking, together with accepting greater accountability The innovation is important to the development services and could contribute to the introduction of nurse specialists in other services.

The benefits of this initiative are to reduce asthma morbidity by improving patient self-management in acute attacks, leading to reduced symptoms, improved lung function, less time off work, and fewer consultations with health professionals. Nurses were funded initially by the National Asthma Campaign and by pharmaceutical companies. It is now supported by mainstream contract funding.

Evaluation is through multidisciplinary audit, to include numbers of patients seen, treatment changes, and health outcomes. It is anticipated that the key criteria by which the initiative will be judged is where the patients feel their asthma and lives have improved, that is in minimising the effects of asthma on patients' lives.

2. Joint management of paediatrics for the children of Hounslow

Organisation: Hounslow and Spelthorne Community and Mental Health

This project involves the joint management of children's services in Hounslow, integrating acute, secondary and primary care. It was prompted by a national shortage of trained medical , nursing and therapy staff, as well as by resource cuts in local authority funding, the reduced need for inpatient admission for children, and the
patients' charter. It involves the purchasers, acute trusts, GPs, community and mental health trusts, and Hounslow local authority. The initiative began in September 1995 and the three year pilot stage is envisaged. It aims to clarify and agree guidelines for targeted packages of care, and to improve continuity of care by deploying staff across community and acute settings.

The initiative is innovatory because is uses a disease management approach, a partnership between acute and community trusts, is ambulatory, is client focused, is managed by a joint board, and involves changed roles of the professionals involved.

The main benefit of the initiative is to reduce the length of stay in acute care, to provide integrated care (potentially leading to better outcomes), and encouraging evidence-based practice. Current funding of the project is from internal resources, though it is recognised that training will require £22,000 for which a proposal has been submitted. Currently funding is by the two trusts involved.

An internal evaluation is being conducted by the project management board. Criteria include: integrated care plans, health outturns, and stakeholder views of the initiative.

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150	Ealing, Hammersmith and Hounslow Health Authority	Health Care Sessions For Homeless People.
151	Ealing, Hammersmith and Hounslow Health Authority	The Mosque Project, Health Sessions
152	Ealing, Hammersmith and Hounslow Health Authority	Implementation Of A District Wide Clinical Management Diabetes Register.

153	Ealing Hammersmith and Hounslow Health Authority	Impact Project
154	Redbridge and Waltham Forest Health Authority	CPA As Contract Currency
155	Ealing Hospital NHS Trust	Use Of Hospital At Home Scheme In Conjunction With Colo-Rectal And General Surgery Procedures
156	Ealing Hospital NHS Trust	Occupational Therapist Based In Accident And Emergency
157	Redbridge Health Care Trust	Anaesthetic Nurse Practitioner
158	Parkside Health NHS Trust	Back Clinic - Marylebone
159	Essex and Herts Community NHS Trust	Podiatry Service
160	Redbridge and Waltham Forest Health Authority	Greg Close - Six Place Intensive Residential Support Scheme.
161	Ealing, Hammersmith and Hounslow Health Authority	Integrated Care Pathway (Diabetes) In Primary Care
162	Ealing Hospital NHSTrust	Accident And Emergency Primary Care Unit
163	The Hillingdon Hospital	Provision Of Specialist Nurse In Urology To Provide Nurse Led Prostate Clinics As Well As Providing Counselling For Patients Diagnosed With Carcinoma Of The Genito/Urinary Tract.
164	The Hillingdon Hospital	Integrated Acute Back Pain Service
165	The Hillingdon Hospital	Care At Home Scheme
166	Horizon NHS Trust	Collaborative Care Planning Based On The Horizon Care Model
167	Riverside Mental Health Trust	Home Treatment Team
168	Riverside Mental Health Trust	Admiral Nurse Service
169	Harefield Hospital NHS Trust	Artificial Heart
170	Harefield Hospital NHS Trust	Surgery With Chemotherapy For Non-Small Cell Lung Cancer
171	Riverside Mental Health Trust	Westminster Intensively Staffed House (ISH)

172	Riverside Mental Health Trust	Community Support And Rehabilitation Service (CSRS)
173	Harefield Hospital NHS Trust	Inititiation Of Thorascoscopic Ligation Of Patent Ductus Arteriousus In Infants And Young Children
174	Harefield Hospital NHS Trust	Cardiomyoplasty/Mortomyoplasty
175	Harefield Hospital NHS Trust	Use Of Live Donors In Lung Transplant Surgery
176	Harefield Hospital NHS Trust	Hospital At Home
177	Harefield Hospital NHS Trust	Local Provision Of Specialist Pacing.
178	Harefield Hospital NHS Trust	Comparison Of Pharmacological And Non-Pharmacological Methods For Controlling Ventricular Rate In Patients With Artial Fibrillation (AF)
179	Forest Healthcare NHS Trust	Adolescent Walk In Counselling Service
180	Forest Healthcare NHS Trust	Support Groups For Professionals Undertaking Therapeutic Play/Counselling With Children And Young People.
181	Forest Healthcare NHS Trust	Sleep And Behavioural Management Clinics
182	Forest Healthcare Trust	Midwifery Assistants In The Community
183	Gerhard Wilke	Identifying Blocks To Implementation Among GPs
184	Medical Advisor Directorate, Barking & Havering Health Authority	Shared Treatment/Care Guidelines
185	Forest Healthcare Trust	Massage Therapy Service For People With Learning Disabilities
186	Royal London Hospital	Nurse Led Pelvic Radiotherapy Clinic.
187	Royal London Hospital	The Introduction Of New Assessment Documentation In An Outpatient Setting
188	Royal London Hospital	Multidisciplinary Patient Held Notes
189	Royal London Hospital	Radiotherapy Nurses Quality Group

190	Royal London Hospital	Journal Club
191	North Middlesex Hospital	Implementation Of Consultant Appraisal Throughout The Trust.
192	North Middlesex Hospital NHS Trust	Setting Up Network Of Ophthalmology
193	North Middlesex Hospital NHS Trust	Preparation Of Evidence Based Protocols In Paediatives Between Trust And GP Surgery
194	Arts Therapies Team, North East Essex Mental Health Trust	The Arts Therapies: An Introductory Course
195	Child & Family Consultation Service	Solution Oriented Therapy Project
196	Essex and Herts Community NHS Trust	Independent Living Centre and Joint Equipment Store
197	Ealing Hammersmith and Hounslow Health Authority	Formulary Development
198	H.O.S.T. (Hillingdon Outreach Support Team)	Creative Outreach
199	H.O.S.T.	Money Management Service
200	H.O.S.T.	Positive Labels
201	Ealing Hospital NHS Trust	Midwifery Led Maternity Care Involving Named Midwife Providing Continuity Of Care And Permanent Named Link With Each GP Practice.
202	Ealing Hospital NHS Trust	Cardiology Chest Pain Clinic
203	Ealing Hospital NHS Trust	Cardiology Coronary Rehabilitation Programme
204	Redbridge Health Care Trust	Urology Nurse Practitioner
205	Redbridge Health Care Trust	Minor Injuries Unit
206	Camden and Islington Health Authority	Development Of NVQs For Health Care Assistants In General Practice
207	West London Health Promotion Agency	Community Health Educators - Southall (Ealing)
208	Ealing Hammersmith & Hounslow Health Agency	Pilot Project To Investigate How To Set Up Ethnic Monitoring In General Practice.
209	Ealing, Hammersmith & Hounslow Health Authority	Alcohol Training In Primary Care

210	Ealing, Hammersmith & Hounslow H.A.	Nurse Practitioner Service In General Practice
211	Ealing Hammersmith & Hounslow Health Authority	Child Health Promotion Policy
212	Ealing Hammersmith & Hounslow Health Authority	Evaluation Of Pharmaceutical Care Transfer
213	Ealing, Hammersmith & Hounslow Health Authority	Needle Exchange Scheme. Evaluation Of The Scheme
214	Ealing, Hammersmith & Hounslow Health Authority	Medicine Counter Assistants Training
215	Ealing, Hammersmith & Hounslow Health Authority	Evaluate The Impact Of Pharmacy Audit Facilitators On Community Pharmacy.
216	Ealing Hammersmith & Hounslow Health Authority	Pilot Of The Local Menu
217	Ealing Hammersmith & Hounslow Health Authority	Intensive Health Promotion In The Community Pharmacies.
218	London Brook Advisory Centre Outreach and Development Team	Brook Outwest
219	Ealing, Hammersmith & Hounslow Health Authority	Total Pharmaceutical Care South Fulham Pilot
220	The Hillingdon Hospital	Re-Engineering Pathology
221	Moorfields Eye Hospital	Community Children's Clinic Run By Orthoptist And Optometrists
222	Moorfields Eye Hospital	Use Of Multimedia In Education Of Patients.
223	Moorfields Eye Hospital	Shared Care: Doctors And Optometrists Working Together In Shared Care For Glaucoma Patients.
224	Moorfields Eye Hospital	Nurse Led Glaucoma Follow Up Clinics.
225	Central Middlesex Hospital NHS Trust	Creation Of Nurse Led Units Within An Existing Accident And Emergency Department
226	Central Middlesex Hospital NHS Trust	Short Stay Unit Surgery And Medicine

227	Central Middlesex Hospital NHS Trust	Assessment Unit Fast Track From Accident And Emergency
228	Forest Healthcare NHS Trust	Developing The Public Health Role Of Community Nurses
229	Forest Healthcare NHS Trust	1. Identification Of Post Natal Depression./2. Coping Strategies of Mothers with Post Natal Depression
230	Thameside Community Healthcare NHS Trust Mental Health Service	The Introduction Of Complimentary Therapies To Acute Psychiatric Services.
231	Royal Brompton Hospital	Minimally Invasive Surgery - Video Assisted Thoroscopic Surgery.
232	Royal Brompton Hospital	Neoadjuvant Chemotherapy In Operable Lung Cancer./Neoadjuvant chemotherapy in Marginally Operable Lung Cancer
233	Royal Brompton Hospital	Bronchial Stenting In Airway Obstruction
234	Royal Brompton Hospital	Lung Volume Reduction Surgery
235	Royal Brompton Hospital	Cardiomyoplasty
235	Royal Brompton Hospital	Artificial Heart Devices
235	Royal Brompton Hospital	Live Donor Lung Transplantation.
238	Royal Brompton Hospital	Minimally Invasive Cardiac Surgery
238	Royal Brompton Hospital	Transmyocardial Laser Revascularisation
240	Royal Brompton Hospital	Endovascular Surgery
241	North East Essex Mental Health Services Trust	North East Essex Mental Health Servicestrust - Critical Incident Review Process
242	Haringey Healthcare NHS Trust	Biomechanics Clinic
243	Haringey Healthcare NHS Trust	Acute Ingrown Toe Nail Clinic
244	**Duplicate**	

245	Central Middlesex Hospital NHS Trust	Rapid Referral Service For Orthopaedics And Rheumatology.
246	Royal Brompton Hospital	Pleuroperitoneal Shunts In Malignant Pleural Effusions.
247	North West London Mental Health NHS Trust	Crisis Intervention/Admission Diversion Service
248	North East Essex Mental Health Services Trust	Single Screening Of Deliberate Self Injury Clients In The Accident And Emergency Department At Night.
249	Haringey Healthcare NHS Trust	Home Treatment And Support Service (HTSS)
250	Camden & Islington Health Authority	Home Vision Service From Optometrists Practices
251	Wellhouse NHS Trust	Anticipated Recovery Pathways In The Medical Directorate (ARP)
252	Wellhouse NHS Trust	Structured Nurse Consultations In Hospital Outpatients
253	Wellhouse NHS Trust	Practice-Based Dietetic Services
254	Wellhouse NHS Trust	Physiotherapy Outreach Services
255	Wellhouse NHS Trust	Occupational Therapy Outreach Services
256	Wellhouse NHS Trust	Minor Accident Treatment Services (Mats)
257	Wellhouse NHS Trust	Urology Practitioner
258	New Possibilities NHS Trust	Access Citizenship Today
259	New Possibilities NHS Trust	4U Employment Agency (Supported Employment)
260	Mount Vernon Hospital NHS Trust	Multi-Cultural Satisfaction Project
261	Mount Vernon Hospital NHS Trust	Home From Hospital Scheme
262	Mount Vernon Hospital NHS Trust	Introduction Of A Lecturer Pracitioner For Cannulation Training
263	duplicated	
264	duplicate	
265	Haringey Health Care NHS Trust	Gay Men's Services Development Project

266	City & Hackney Community Services NHS Trust	Mermaid Ward - Women Only In-Patient Unit + Mother And Baby Unit
267	Newham Community Health Services NHS Trust	Project Worker For "Making It Happen" Public Health Project
268	Kensington & Chelsea and Westminster HA	Community Arts Centre
269	East and North Hertfordshire Health Authority	Link Miu With A GP Branch Surgery Development
270	West Hertfordshire Health Authority	Integrated Diabetic Care Model
271	The Whittington Hospital NHS Trust	Weight Management & Obesity Clinic
272	Newham Community Health Services NHS Trust	Health Advocates In Health Visiting Teams
273	Newham Community Health Services NHS Trust	Cardiac Rehabilitation
274	Haringey Healthcare NHS Trust	Child And Family Support Team, North Tottenham
275	Newham Community Health Services NHS Trust	The Shrewsbury Centre
276	Newham Community Health Services NHS Trust	Community Mental Health Teams (Adults)
277	Newham Community Health Services NHS Trust	Bi-Lingual Co-Workers In Physiotherapy For Children
278	Newham Community Health Services NHS Trust	Leg Ulcer Nurse Practitioner
279	Newham Community Health Services NHS Trust	Newham Support Network
280	Newham Community Health Services NHS Trust	Bi-Lingual Co-Workers In Speech And Language Therapy
281	Hertfordshire Health Authorities	To Look At The Appropriateness Of Paediatric In-Patient Admissions In The Four Paediatric Units In Hertfordshire
282	Hertfordshire Health Authorities	Implementation Of Research Evidence On Anticoagulation Therapy In Primary And Secondary Prevention In Stroke
283	The Whittington Hospital NHS Trust	Community Gynaecology Liaison Nurse
284	The Whittington Hospital NHS Trust	Continence Nurse Specialist

285	The Whittington Hospital NHS Trust	To Establish Comprehensive Day Care Needs For Both Paediatric Surgical And Medical Patients
286	The Whittington Hospital NHS Trust	Paediatric Play Service
287	The Whittington Hospital NHS Trust	Paediatric Emergency Clinic
288	The Whittington Hospital NHS Trust	Breast Feeding Workshops
289	Tavistock & Palmer NHS Trust	The Tavistock Monroe Community Project
290	City & Hackney Community Trust	Rowhill Family Support Project
291	Kensington & Chelsea and Westminster HA	Uk Coalition Of People With HIV/AIDS Advocacy Project
292	Kensington & Chelsea and Westminster HA	Free Condoms
293	Kensington & Chelsea and Westminster HA	Market Management Protocol
294	Kensington & Chelsea and Westminster HA	Elderly Home Treatment Team
295	Kensington & Chelsea and Westminster HA	Flexi-Carers
296	Hammersmith Hospitals NHS Trust	One To One Roll Out
297	Hammersmith Hospitals NHS Trust	BMT Treatment For Complex Haemoglobinopathies
298	Hammersmith Hospitals NHS Trust	Picture Archiving & Communication System (PACS)
299	New Possibilities NHS Trust	Chestnut Grove
300	Kensington & Chelsea and Westminster HA	Nurse Practitioner In A&E
301	Kensington & Chelsea and Westminster HA	Direct Access Services
302	Hammersmith Hospitals NHS Trust	Treatment Of Oesophageal Cancer Using Metallic Shunts
303	Hammersmith Hospitals NHS Trust	Telemedicine For Foetal Care
304	Kensington & Chelsea and Westminster HA	Medical Advice To Part III Accommodation
305	Kensington & Chelsea and Westminster HA	Joint Commissioning And Tendering
306	Hammersmith Hospitals NHS Trust	Diabetic Retinopathy Screening Clinic
307	Hammersmith Hospitals NHS Trust	Introduction Of A Discharge Pathway By The Multidisciplinary Audit Group

308	Hammersmith Hospitals NHS Trust	Provision Of Reconstituted Cytotoxis For Use At Home
309	Hammersmith Hospitals NHS Trust	Use Of Magnetic Resonance Imaging And Spectroscopy In Neonates
310	Hammersmith Hospitals NHS Trust	The Installation Of A Teleradiology Link Between Hammersmith And Charing Cross Hospital
311	Hammersmith Hospital NHS Trust	Treatment Of Intracranial Aneurysms By Percutaneous Occlusion Using Detachable Coils
312	Hammersmith Hospitals NHS Trust	Review Of Procedures Which May Be Suitable To Be Undertaken As Day Cases
313	City & Hackney Community Trust	Core Arts
314	City & Hackney Community Trust	Further Education Seminar For Users And Ex-Users Of Mental Health Services
315	Hammersmith Hospitals NHS Trust	Baby Massage
316	Hammersmith Hospitals NHS Trust	Early Pregnancy Assessment Unit
317	Hammersmith Hospitals NHS Trust	Bone Densitometry And Body Composition Measurements By Dual-Energy X-Ray Absorptiometry (DXZ)
318	Hammersmith Hospitals NHS Trust	Pre-Implantation Diagnosis
319	Hammersmith Hospitals NHS Trust	Re-Use Of Patients' Own Medicines And Review Of Discharge Medication.
320	Hammersmith Hospitals NHS Trust	Nursing Home Ward
321	Hammersmith Hospitals NHS Trust	Provision Of A Comprehensive Civa Service Including PCAS
322	Hammersmith Hospitals NHS Trust	Positron Emission Tomographic Camera
323	Hammersmith Hospitals NHS Trust	Development Of 2 Satellite Haemodialysis Facilities
324	Hammersmith Hospitals NHS Trust	Radiological Placement Of Hickman Central Lines And Dialysis Catheters
325	Hammersmith Hospitals NHS Trust	Medicines Help-Line

326	Hammersmith Hospitals NHS Trust	Tele-Radiology Service
327	Hammersmith Hospitals NHS Trust	Treatment Of Pulmonary Arteriovenous Malformation By Embolisation
328	Hammersmith Hospitals NHS Trust	Investigation Of Gastrointestinal Bleeding By Visceral Angiography And Treatment By Embolisation
329	Hammersmith Hospitals NHS Trust	Contrast Enhanced Power Doppler
330	Hammersmith Hospitals NHS Trust	The Management Of Retinopathy Of Prematurity (ROP)
331	Hammersmith Hospitals NHS Trust	Immunoadsorption In Patients Awaiting A Renal Allograft
332	Hammersmith Hospitals NHS Trust	Adolescent Reconstructive Surgery For Congenital Malformations Of The Genital Tract
333	Hammersmith Hospitals NHS Trust	Percutaneous Transcatheter Ablation Of Arteriovenous Malformations
334	Hammersmith Hospitals NHS Trust	Molecular Diagnostic Facilities
335	Hammersmith Hospitals NHS Trust	Comprehensive Service For Amyloidosis
336	Hertfordshire Health Authorities	County Wide Consensus Guidelines For The Treatment Of Leg Ulcers
337	Hertfordshire Health Authorities	Implementation Of Care Guidelines On Back Pain Management Through Introduction Of A Physiotherapy Led Service
338	Hertfordshire Health Authorities	North Herts Community Nursing Leg Ulcer Project
339	Hertfordshire Health Authorities	North Herts Community Nursing - Hospital At Home
340	Hertfordshire Health Authorities	Continuation Of Cardiac Rehabilitation
341	Hammersmith Hospitals NHS Trust	LDL Apheresis For Severe Familial Hypercholesterolaemia (FH)

342	Whittington Hospital NHS Trust	Multidisciplinary Community Based Parenthood Education Course
343	Chase Farm Hospital	Leg Ulcer Service
344	IMPACT, Hammersmith & Fulham MIND	Impact Is A Community Based Multidisciplinary Mental Health Team Funded Under The Sainsbury Mental Health Initiative For 3 Years.
345	Royal London Hospital	Nurse Prescribing Of PC4
346	Southend Health Care Trust	3D Planning System
347	Southend Health Care Trust	Electron Applicator
348	Central Middlesex Hospital	Bridging Team For Care Of Elderly
349	Central Middlesex Hospital	Floating Ward
350	Central Middlesex Hospital	Critical Care Facility
351	Central Middlesex Hospital	Low Dependency/Pre-Discharge Ward
352	Central Middlesex Hospital	ACAD Ambulatory Care & Diagnostic Centre