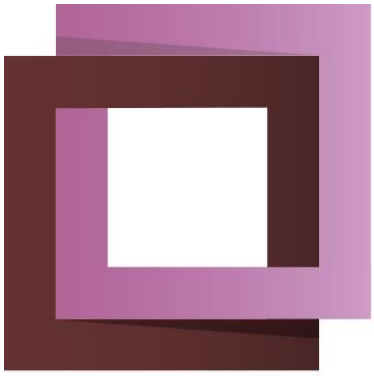

Whole Systems Partnership

Building on the best Programme Evaluation Summary Report July 2018

Publication Date: July 2018

www.thewholesystem.co.uk

Building on the best: Programme evaluation
Summary report
July 2018

1 About this document

This document forms the final report on Whole Systems Partnership (WSP)'s evaluation of the Building on the best (Botb) programme on palliative and end of life care[1] (PEOLC) in acute hospitals in England[2].

WSP carried out the evaluation from May 2017 to June 2018.

The full evaluation report was produced for the Botb project board in July 2018.

2 About the programme

2.1 The programme aims

The Botb programme was designed to build on the strong foundations of the NHS Transform Programme. This programme had already established good practice for end of life care within the National Health Service (NHS) in England[3].

Botb aimed to develop further new areas of focus for improving end of life care initially in 10 pilot sites in England.

[1] This report follows the General Medical Council definition of 'end of life' as including patients who are likely to die within the next 12 months. For the full definition please see www.gmc-uk.org/-/media/documents/Treatment_and_care_towards_the_end_of_life___English_1015.pdf_48902105.pdf

[2] The Botb programme in Scotland is not yet completed and has not been included in this evaluation. A progress report is available from the programme board on the delivery of the programme in Scotland.

[3] The "Route to success" document produced in 2015 as part of this programme is available at www.england.nhs.uk/wp-content/uploads/2016/01/transforming-end-of-life-care-acute-hospitals.pdf

2.2 The policy and service environment

The Botb programme was initiated at a time of significant change across the NHS Health and Care system with unprecedented demand and austerity. The NHS Five Year Forward View[4] and the NHS Mandate[5] both highlight the importance of end of life care.

Our Commitment to you for end of life care: *The Government Response to the Review of Choice in End of Life Care* (2016)[6] set out a clear expectation of the standard of care that everyone should be offered as they approach the end of their life, ensuring care is both high quality and personalised.

Despite the national commitment, many STP's Transformation plans do not include end of life care as a priority[7]. At the same time the new models of care and 7 day services/ Emergency Care Improvement Programmes/ Safety collaboratives have all had a local interface for teams to understand and align.

The programme hypothesis was that the community of practice provided an opportunity to consider ways to develop resilience and to consider change in complex environments.

2.3 Development of the programme

The programme was initially commissioned by Macmillan Cancer Support and developed by the National Council for Palliative Care (NCPC), latterly Hospice UK, working in partnership with Macmillan Cancer Support, NHS England and NHS Improvement.

Colleagues from Macmillan Cancer Support, NHS England, NHS Improvement and Hospice UK were involved in the selection of ten teams to take part in the programme. The participating Trusts are generally referred to as 'sites' or 'local sites' in this report to distinguish them from the central programme team.

2.4 Programme Resources

A small central team was appointed to support the programme delivery and provide quality improvement coaching and support. The team was responsible for the design and all operational management of the programme including development of a logic model, programme management office, event planning, communications, reporting and supporting evaluation.

A community of practice was established as a primary vehicle to support the Trusts' PEOLC clinical teams throughout the delivery phase of Botb and a combination of face to face meetings and virtual web based sessions were facilitated by the team.

3 About the Building on the best (Botb) programme

3.1 Building on the best Programme Vision

Through the combined experience and expertise in end of life care, the partnership between NCPC latterly Hospice UK ,Macmillan Cancer Support and the Participating Acute Trusts will enable the support, knowledge and leadership required so that everyone in hospital approaching end of life

[4] www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[5] assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf

[6] assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/536326/choice-response.pdf

[7] endoflifecampaign.org/wp-content/uploads/2017/10/STP-one-pager.pdf

receives high quality care that respects theirs and their loved ones' personal wishes and needs.

3.2 Programme approach

The basic programme approach is shown in Figure 1.

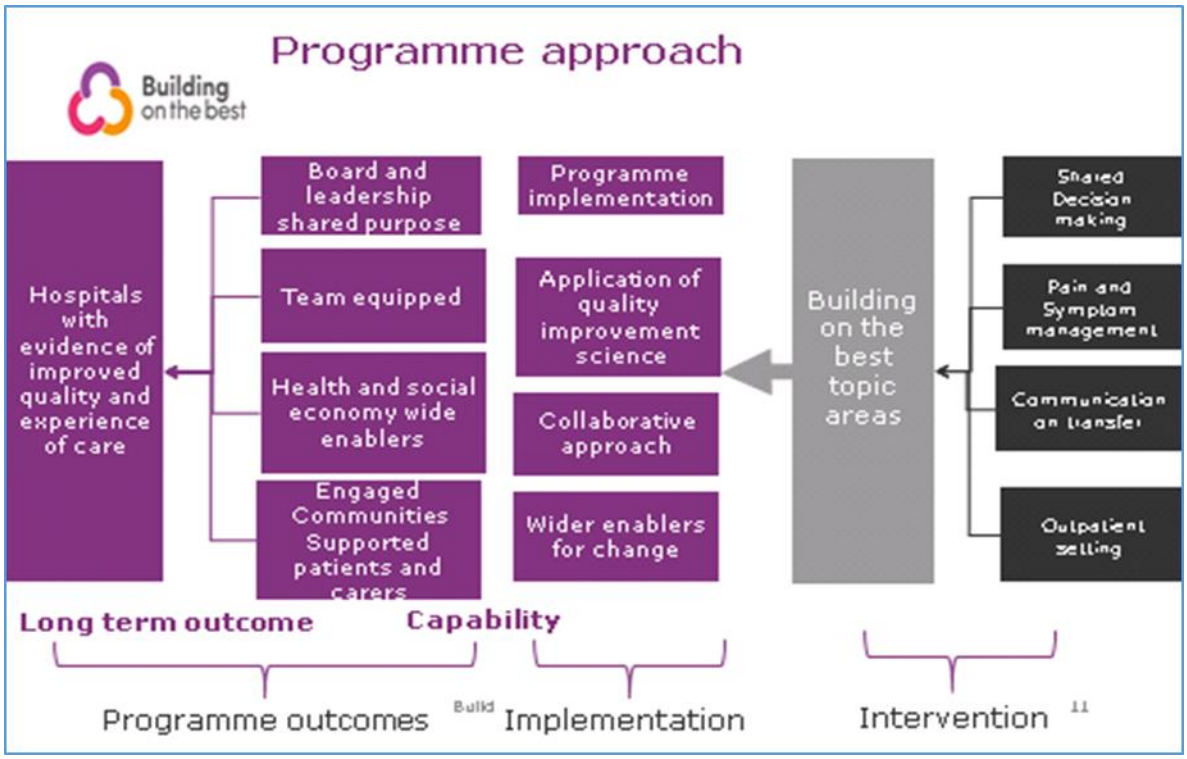

Figure 1: Botb logic model (source: Botb programme team)

3.3 Programme structure

The programme was organised around key themes relevant to end of life care in acute hospitals. These were developed by the delivery team in partnership with a stakeholder group, through a process of scoping the evidence base to identify priority areas likely to have the greatest contribution to improving end of life.

The themes were:

- Shared decision-making
- Pain and symptom management
- Outpatient appointments (in relation to discussions about advance/ anticipatory care planning)
- Handover [8]

3.4 Programme content

The programme comprised a range of events, activities and support functions as outlined below:

- A Community of Practice (CoP) was established from the programme launch. The CoP was supported by:

[8] There was some inconsistency in the programme communications relating to the definition of this theme. However, the design of the programme allowed sites to be flexible and it is therefore unlikely that the inconsistency prevented sites from working on any particular type of intervention. In this evaluation, we have assumed the most comprehensive definition of "handover" applied to the work done under the programme.

    - Provision to the site teams by the HUK programme team of the 'sustainability toolkit' including driver diagrams and action planning;
    - Monthly webinar and then ECHO sessions. Twenty of these sessions were run during the programme.
    - Monthly bulletins issued by the programme team.
    - Support for site teams to identify their priority areas for change. Within the four priority areas, site teams could choose one or more areas as a priority.
- All site teams were visited three times by the programme team. Site visits were timed to ensure that the teams were progressing, were ready for the next steps or during periods when additional support and input may be required. Site team visits included representation from Macmillan regional teams, where they were able to attend;
- Two sets of cluster events were held. Site teams in England split into two / three groups for events.
    - July 2016 – to support teams with their driver diagrams / identify priorities following analysis and diagnostics;
    - October 2017 – for teams to present their emerging case studies and gain peer support and challenge. These three cluster events also included 'resilience and self care' workshops.
- Four face to face events:
    - Programme launch event at Keele University in March 2016.
    - December 2016 - A supportive 'confirm and challenge' day;
    - June 2017 – sharing and swapping of ideas.
    - June 2018 - an event to celebrate being part of Building on the best.
- To support the legacy from the programme, all site teams (including Scotland and Wales) will be given access to Hospice IQ. This is a platform for sharing information, case studies and interventions. It is also a platform for hosting discussion and debate regarding clinical practice.

3.5 Programme completion

The initial Botb programme in England was completed in March 2018.

4 Evaluation aims and questions

4.1 High level aim

What impact has the Building on the Best programme had on improving the quality, experience and outcomes for patients, and their carers, at the end of their lives in acute hospital Trusts across the 10 sites in England and sites recruited across Wales, Northern Ireland and Scotland?[9]

4.2 Project-specific evaluation questions

The partner organisations recognised a number of challenges in trying to directly address the high level aim within the lifetime of the programme itself:

- Firstly, the impacts of the programme on local delivery of end of life care were unlikely to be fully realised by the end of the programme, although it was expected that some changes would have started to take effect.

[9] Source: ***Invitation to Tender for the development of a monitoring and evaluation framework and plan for 'Building on the best'***, NCPC, August 2016

- Secondly, other improvement activity within end of life and palliative care, alongside the transformational changes currently taking place across the health and care system, would mean that attributing benefits directly to the Botb programme would be difficult.

Three more direct and achievable evaluation questions were therefore developed by the partner organisations[10]:

Q1 What interventions have been effective in:

- **Ensuring that the holistic needs and wishes of patients, and their carers, are identified, assessed, recorded and accessible to the staff that are involved in their care?**
- **Supporting patients, and their carers, to become increasingly in control of their care - as much as they want to - with a view to maximising their comfort and wellbeing and focusing on what matters to them as individuals, thereby improving the experience of care in the last months/weeks/days of life?**

Q2 What impact has the Botb programme had on:

- **The adoption of these interventions?**
- **The capability, capacity, and resilience of staff to carry out improvement activity at the front line?**

Q3 To what extent can we demonstrate that the Botb programme has built on the learning from previous End of Life Care Hospital Improvement programmes?

These questions formed the basis of the evaluation framework and have been used as the basic structure for the report.

4.3 Timing of this evaluation and longer term impacts of the programme

It was recognised by the programme team that there were still challenges in addressing the project-specific evaluation questions through an evaluation taking place immediately after the end of the programme itself. This evaluation was commissioned in the context of this recognition.

This evaluation can therefore only provide an initial picture of the long term value of the programme to the system as a whole. It is recommended that the programme delivery partners should consider further rounds of evaluation in future to identify additional local system improvements and the extent to which they are attributable to the programme.

[10] Source: ***Invitation to Tender for the development of a monitoring and evaluation framework and plan for 'Building on the best'***, NCPC, August 2016

5 Framework structure

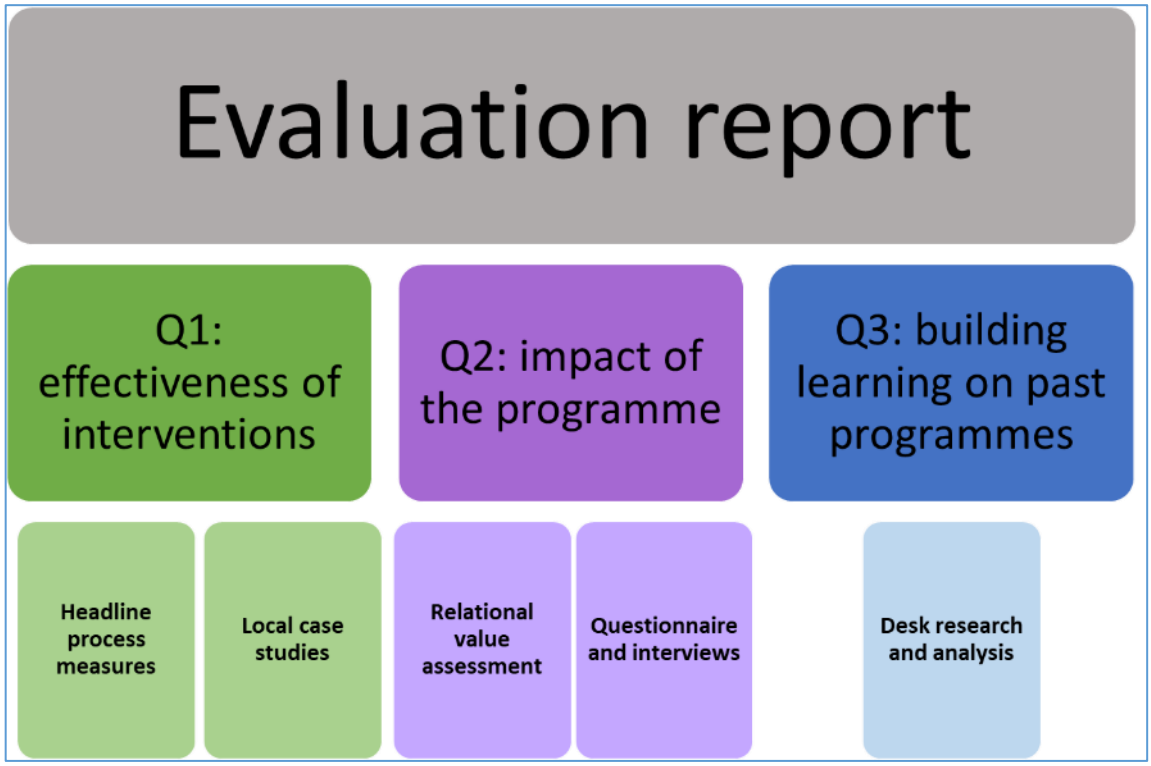

Figure 2: final evaluation framework, June 2018 (source: WSP)

5.1 Evaluation elements

As summarised in Figure 2, there are five elements of the evaluation which were brought together in the report:

- Headline process measures
- Local case studies
- Questionnaire and interviews with local site representatives
- Relational value assessment
- Desk research and analysis

5.2 Confidentiality and data sharing

As the external evaluation partner, WSP agreed and signed a data sharing agreement with NCPC/HUK relating to this work.

All the data provided by individual sites to either the programme team (and subsequently shared by the programme team with WSP) or direct to WSP for the purposes of evaluation (including case studies, interviews, headline measures data and responses to questionnaires) has been treated as confidential.

6 Evaluation evidence - Question 1

What interventions have been effective in:

- **Ensuring that the holistic needs and wishes of patients, and their carers, are identified, assessed, recorded and accessible to the staff that are involved in their care?**
- **Supporting patients, and their carers, to become increasingly in control of their care - as much as they want to - with a view to maximising their comfort and wellbeing and focusing on what matters to them as individuals, thereby improving the experience of care in the last months/weeks/days of life?**

6.1 Data included in Q1 evaluation

- Data collected by the programme team in relation to the headline process measures agreed as part of the evaluation framework
- Case studies from each site about the interventions undertaken as a result of the local plan developed as part of their participation in the programme[11]

6.2 The intervention 'heat map'

Figure 3 below shows the number of interventions identified by sites in their local plans by programme theme and point of impact.

Note that Figure 3 is intended to provide a high level overview of the numbers of interventions associated with the Botb programme that have been assessed as relating to each theme and point of change. It does not take account of the size, ambition or impact of any individual intervention, nor to the extent of crossover between themes or points of impact.

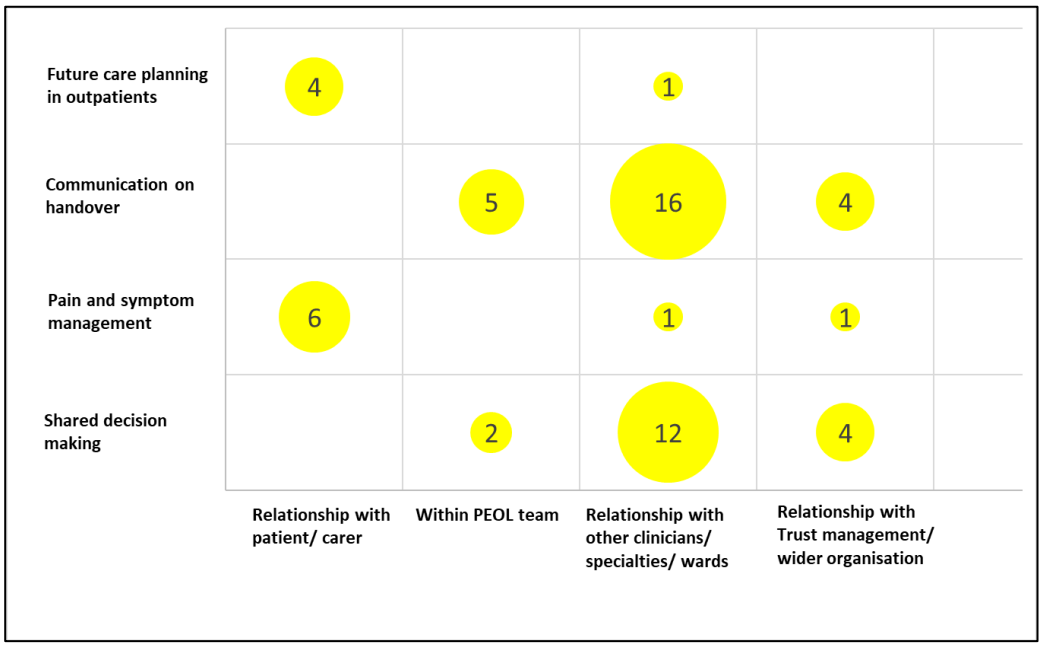

Figure 3: intervention heat map - numbers of reported interventions by theme and point of impact (source: WSP)

[11] Published versions of the posters summarising the sites' case studies are available at www.hospiceuk.org/botb.

6.3 Interventions by site – intentions vs actual

Table 1 shows the number of sites who reported interventions analysed as belonging to each theme, compared to the number who indicated they were intending to work on the theme.

	Site participation (of total 10 sites)				
	April 2016			April 2018	
Programme theme	**Intention to include**	**Intended and interventions made**	**Intended but no interventions made**	**Not intended but interventions made**	**Not intended and no interventions made**
Shared decision-making	7	4	3	2	1
Pain and symptom management	6	4	2	3	1
Outpatients	8	3	5	0	2
Handover	5	5	0	4	1

Table 1: interventions compared to expected participation of sites by programme theme (source: WSP)

6.4 Comments

Although it is high level and does not represent the full complexity of the work taken forward across the participating sites as part of the programme, the heat map does provide some overall indication of the types of interventions that were taken forward under the programme:

- The interventions were almost all outward-facing: only a small minority worked in issues internal to the PEOLC team.
- Of the four themes, handover was the one with fewest sites expressing interest at outset. However, it generated the largest number of individual interventions. As the programme progressed, work evolved including handovers between PEOLC and a wide variety of teams and functions.
- While outpatients received the highest level of expressed interest at outset, few interventions were specifically targeted at this element of the system.
- The largest number related to the relationship with other clinicians within the system, with a twin focus on communications at handover and on supporting improvements in pain and symptom management delivered by other clinicians. Both of these can be seen as having the objective of spreading awareness of PEOLC needs within the wider system and improving the capability of non-specialists to deliver PEOLC support.

6.5 Effectiveness of interventions - needs and wishes of patients and carers

Many of the interventions made within the programme related to identification and in a number of cases quantified evidence was produced of increased levels of recording, including:

- (Site D) A multi-disciplinary programme of awareness raising, education and patient support across the Trust that delivered increases in the level of GSF registration and rapid end of life transfers
- (Site H) New anticipatory care prescribing guidelines and procedures that led to a rise in prescribing levels

- (Site B) Changes to the template for Treatment Escalation Plans indicated a substantial increase (over 300%) in the proportion of inpatients for whom there was a documented treatment escalation plan, reported by the headline process measures
- (Site G) Introducing comfort observations for patients at the end of life which were in place for approximately 50% of reviewed deaths in hospital within 9 months of introduction
- (Site F) A small increase in the proportion of COPD patients with an EPaCCS record (lower than planned due to staffing issues) also reported in the headline process measures
- (Site C) – Increased time in consultations and some evidence of reduced admissions resulting from this
- (Site J) – A focus on training and education leading to increase of 29% in referrals to PEOLC team during the life of the project

6.6 Effectiveness of interventions - supporting patients to achieve increased control of their care

A smaller number of interventions related to improving patient and carer control. The majority of these again aimed to deliver improvements in the way in which non-PEOLC specialties and clinicians engaged with patients identified as at or nearing the end of life.

Examples include:

- (Site C) new ACP promotional materials and patient leaflets in public areas to encourage patients to 'start the conversation'
- (Site F) a patient questionnaire leading to an interview study
- (Site D) Volunteers trained to sit with patients at end of life and support families. This initiative was developed originally by another site and adopted by this site after sharing of information at the Community of Practice.
- (Site A) Reduction in the number of formal complaints made about experience/ care since a new bereavement CNS was put in post and the bereavement survey implemented
- (Site D) A readmission rate of 16% of frail elderly patients with an Anticipatory Care Management Plan (ACMP) compared to the national average of 40-70%, and a small increase in the proportion of patients with an ACMP in place
- (Site G) Reduction in calls to the bereavement office
- (Site G) Audit finding that administration of anticipatory medicine was low due to low confidence. Focused attention and training to support nurses to improve confidence, knowledge and skill with symptom control drugs (has the potential to ensure that patients received the right anticipatory medication at the right time and therefore greater control for patients.)

6.7 Summary of evaluation evidence

- There is limited evidence at this point of which interventions undertaken by local sites under Botb have been effective in delivering improvements in outcomes for patients and carers.
    - Some of this lack of evidence can be attributed to the timing of this evaluation at a point immediately following the delivery of the programme and while the majority of sites are still at early stages of change implementation. This could potentially therefore be addressed by longer term evaluation of the interventions which have been put in place.
    - However, while some gaps in data are due to timing issues, others are attributable to deficits in measurement. Evidence of relevant baseline

measurements and/or robust measurement strategies having been developed as part of the overall improvement plan is variable.

- The developmental nature of the programme has led to wide variation in the nature and scope of work between sites and this consequently provides limited scope for 'side to side' analysis of similar interventions
- There is some evidence of improvements in processes relating to recording of needs in some sites through relatively simple changes including new materials, education and training etc.
- There is some evidence of the programme having an impact on culture and practice change within the acute care system, especially in relation to non-PEOLC specialties. Case study evidence suggests that work to improve PEOLC was welcomed and well received by clinicians and staff in these other specialties. Longer term evaluation would be needed to assess the level to which this wider change becomes embedded within the system.

7 Evaluation evidence - Question 2

What impact has the Botb programme had on:

- **The adoption of these interventions?**
- **The capability, capacity, and resilience of staff to carry out improvement activity at the front line?**

7.1 Data included in this part

In evaluating the programme against this question, two sets of data were considered:

- The programme impact survey
- The programme impact follow-up interviews
- The relational value (R^v) assessment

7.2 Summary of evaluation evidence

- There is evidence that the Botb programme was seen by those participating as having a positive impact on PEOLC quality improvement at the local site level.
- There is evidence that the programme has influenced the planning and implementation of specific interventions to improve PEOLC within local sites, but little evidence at this stage of its influence on embedding change within the system. These findings triangulate with evidence from the case studies examined in section 10.
    - Feedback from local sites provides a resource for future design and implementation of QI work in PEOLC in acute care and (potentially) the wider system of health and care.
- There is good evidence that the establishment of the CoP has been a particularly influential and effective aspect of the programme. Increasingly positive relationships have been established as the CoP has developed across the last 2 years.
    - There is evidence that this has contributed to the successes reflected in other areas of the programme evaluation such as improved relationships within a local site, and between various groups on site that had not previously worked together, shared learning and cross fertilization of ideas.
- There is good evidence that the programme team has created an environment that encourages professional openness, learning from peers, and sharing of both good practice and failures and frustrations.

8 Evaluation evidence - Question 3

To what extent can we demonstrate that the Botb programme has built on the learning from previous End of Life Care Hospital Improvement programmes?

8.1 The Transform programme and Ambitions for Palliative and End of Life Care

It is important to note that the Transform programme fed into the development of a new national framework for local action. ***Ambitions for Palliative and End of Life Care***[12] was produced in 2015 by the National Palliative and End of Life Care Partnership and forms the current overarching context within which NHS Hospital Trusts and others, including the delivery team for Botb, are working.

The framework sets out a clear vision of the future in terms of six ambitions, representing the desired end point of improvement (Figure 4)

Figure 4: the six ambitions (source: *Ambitions for Palliative and End of Life Care*)

[12] Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020, National Palliative and End of Life Care Partnership, 2015

It also lays out eight foundations (Figure 5) which are described as "*pre-conditions for delivering the rapid and focused improvement that [the Partnership] seeks*":

- Personalised care planning
- Shared records
- Evidence and information
- Involving, supporting and caring for those important to the dying person
- Education and training
- 24/7 services
- Co-design
- Leadership

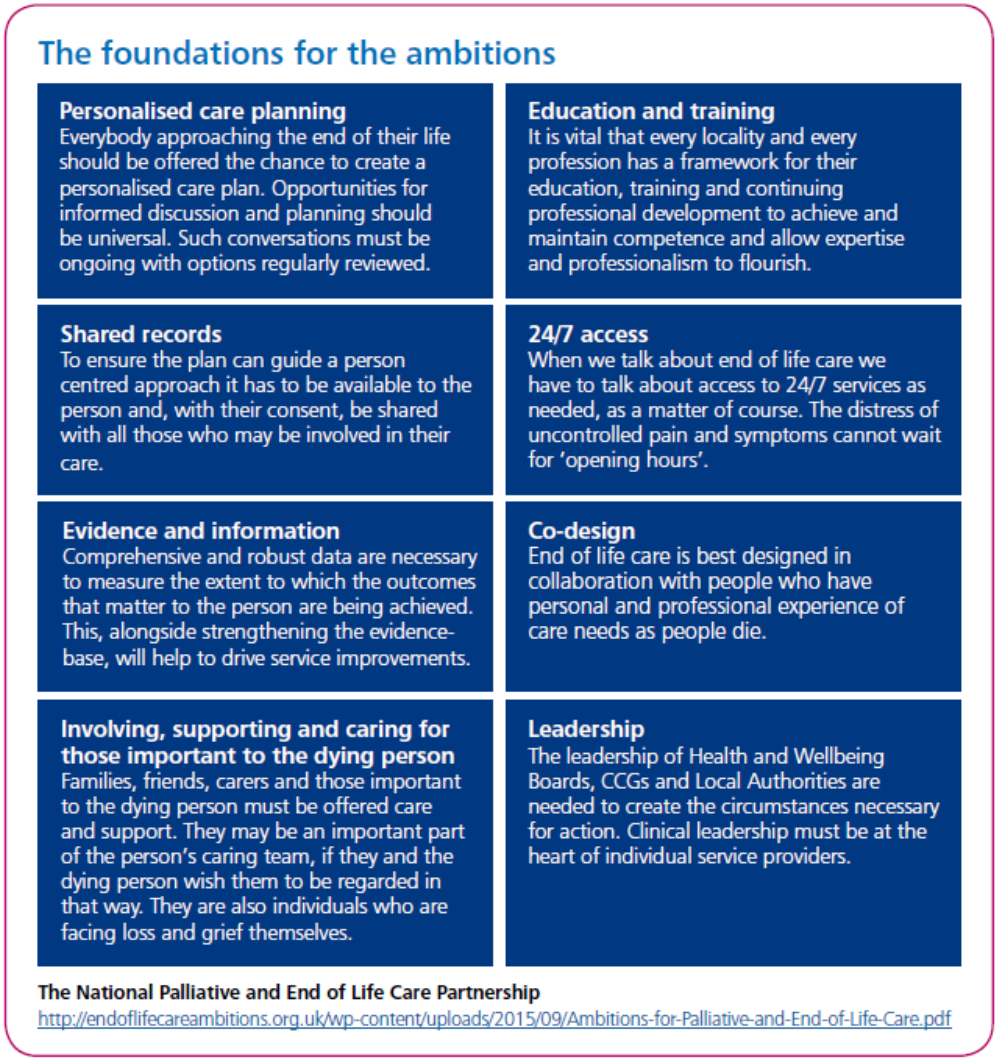

Figure 5: the foundations of the ambitions (source: Transforming end of life care in acute hospitals: The route to success 'how to' guide, NHSE, December 2015)

8.2 Summary of evaluation evidence

- There is good evidence that Botb has built on the learning of previous programmes such as Transform by offering an opportunity for sites to address gaps in their system. It did this by supporting them to implement "tried and tested" tools and interventions that have been elsewhere and which fit within the current framework for PEOLC.
- In particular, there is evidence that it supported sites to spread the remit of their improvement work beyond the boundaries of the PEOLC team.

    - It has been successful in building on previous work in in terms of the deployment of improvement to the wider system of care.
    - It can be seen as having achieved its aim of "establishing new areas of focus" in terms of the scope and reach of PEOLC as a component of good care throughout the acute setting.
- There is no evidence that Botb has stimulated innovation in PEOLC models, but this is to be expected given that it was delivered within the context of an existing framework with identified building blocks for an optimised system.
- There is evidence that the programme set out to build on learning about how to achieve improvement through the tools disseminated as part of the programme. With the exception of measurement for success (where evidence is patchy) this is reflected in the local improvement work to date.

9 Beyond the evaluation - headline messages

This section lies beyond the formal scope of the evaluation which forms the bulk of this report. However, the report authors made a number of observations during their work relating to the Botb programme and the wider area of PEOLC improvement. These are set out below as headline messages.

9.1 Measurement is not an optional activity

This evaluation has been constrained by the availability and variability of data providing quantified evidence of improvement, especially in relation to the potential and actual impact of changes made at local level by participating sites. A number of sites did not access, or develop a strategy to collect, effective baseline data on the starting state of their system to enable them to measure the impact of change. In addition, several of the measures developed over the course of the programme were not effective in capturing change (often because they were at or near 100% before any change was implemented).

It should be noted that at the outset of work on developing an evaluation framework in 2016, site leads identified the need to have evidence of the value of their work which could be used within their Trusts as a priority.

Future iterations of Botb could be more bullish in relation to developing measurement, for example by:

- Requiring participating sites to provide a simple baseline measure related to their expected areas of change as a condition of sign-up (NB as reported in this evaluation, sites' plans did change over time, and so it would be necessary to repeat this throughout the programme as new interventions were planned)
- Requiring sites to develop a measurement strategy as a component of their improvement plan, and providing simple tools and templates for this
- Offering support for teams on basic measurement skills and approaches not requiring the involvement of data specialists or informatics teams
- Providing examples of simple "collect as you go" measures used elsewhere in relation to tried and tested changes
- Supporting teams to present and communicate evidence of change within their own systems (eg to their team, their Trust and their stakeholders)

9.2 There's nothing wrong with the tried and tested

There is no evidence that Botb has stimulated innovation in PEOLC models, but this is to be expected given that it was delivered within the context of an existing framework with identified building blocks for an optimised system.

While Botb has not led to major innovations in PEOLC systems, it has been effective in supporting sites to implement tried and tested interventions that have helped them strengthen the foundations and move closer to the six ambitions set out in the national framework.

Although it was not possible to identify tangible benefits in terms of improved outcomes at this early stage of implementation, our hypothesis is that these benefits are likely to be realised in the longer term.

9.3 Innovation can lie in the where and who as well as the what

Although the interventions deployed within Botb were tried and tested 'basics', the programme supported the participating sites to turn their focus outside the PEOLC team itself and to work with colleagues in other specialties and/or care sectors. This in itself represents a significant shift in approach and a step towards delivering PEOLC as part of an integrated package of care for patient and carers.

The programme was successful in encouraging the engagement of a wider range of stakeholders in the work. A number of sites commented that they had been surprised (in a good way) by the receptiveness of their colleagues in other specialties to working on PEOLC. It requires sustained effort to embed changes in behaviour (changes in materials are easier)

9.4 The Community of Practice has more to offer – if it can be resourced

The CoP has become a valuable tool for its participants and (as a forum for collecting and sharing experiences and ideas) for the wider PEOLC community.

However, to survive and thrive it will need continued investment from a central source in terms of leadership, coordination, and communication tools to foster ongoing team involvement and participation, and to enable further development.

The future CoP will also need continued commitment and support from participating sites (both existing and new). Further thinking around how to communicate the level of commitment needed, and what resources are required, to successfully participate in the CoP and contribute to ongoing shared improvement and development work might also result in any new participants being more fully engaged and thereby increase likelihood of impact.

9.5 There's still lots to do out there

The Building on the Best programme was, as its name suggests, designed to work with sites which were already at the front of the pack in terms of their PEOLC systems and their approach to improvement. These sites were all readily able to identify gaps in their system which could be filled by introducing the tried and tested building blocks discussed above.

If these "best" sites recognised that they had a long way to go, there is clearly significant scope for others elsewhere to work on the basics.

9.6 A change platform, not a change programme

The relationships that local sites developed (and are continuing to develop) within their own systems are critical to achieving improvement. However, Botb was also successful in creating a network that worked between sites. The Community of Practice has been effective in supporting sharing of ideas and encouraging people to "pinch with pride". This probably contributed to the observed shift between what sites planned to do at the start of the programme and what they actually did (as seen in Table 1).

As such, Botb is a successful example of a change platform, as championed by NHSE's Horizons Group:

> *… "change platforms" (approaches to change that allow everyone to have a voice, to connect and collaborate and socially create the future) will lead to the demise of "change programmes" as we know them …*
>
> **Helen Bevan, NHS Horizons, July 2015**[13]

9.7 The barriers to change are "known knowns" – acknowledge them up front

Sites identified a consistent set of factors which worked as barriers to implementing or embedding change in their system.

Elements identified by sites within their case studies as success factors or barriers to achieving the planned improvement included those shown in Table 2:

Success Factors for Improvement	Barriers to Improvement
• Having Board/ senior management support • Using the Botb 'brand' as a catalyst for engaging colleagues • People's willingness to get involved/ being surprised at the level of enthusiasm from other specialties to work on PEOLC improvements • Working collaboratively with colleagues in other areas of the hospital – "it's all about people" • For needs identification/ recording, undertaking a baseline assessment to understand not only eg the level of compliance but also the barriers to recording/ use (eg staff confidence, access to technology, format of electronic forms etc) • Focusing on a small area (eg a single ward, or a small number of OP clinics) but with a vision for how small changes can add up • Embedded, low impact 'collect as you go' data collection to avoid large one-off requests for data • Being able to tell the story of what the change is aiming to achieve • Using a multi-channel approach to training and education, with most sites using a range of activities targeting different audiences but with a single objective (see **Error! Reference source not found.** b elow).	• Lack of management support • Resource constraints • Lack of time • Technological barriers – incompatibility of systems etc • Unhelpful protocols and procedures (eg inflexibility on how long a treatment escalation plan could be valid for) • Large scale organisational change within the Trust

Table 2: identified success factors and barriers (source: site case studies)

[13] http://theedge.nhsiq.nhs.uk/scrap-the-programme-this-is-an-era-for-change-platforms/

None of these are peculiar to Botb or PEOLC and the same list could be identified for virtually any change project in any part of the public sector health and care system since its foundation.

Future iterations of the programme could potentially start from the position that the same issues are likely to recur and address them up front in a number of ways:

- By engaging top level support for the programme providing a line of support for sites via the 'brand value' of Botb
- By developing communications throughout the programme targeted at Trust management to deliver external messages about the value of their site's participation
- Through the programme recruitment/ selection process (eg by reviewing the expected time commitment for the programme for future participants, adding additional requirements for support from Trust management including resourcing of technology/ time for the site to participate)
- Through the programme content (eg by addressing strategies for working with stakeholders on conflicting protocols)
- In particular, by strengthening programme content on measurement strategies (see 9.1 above)

10 Recommendations

10.1 For programme commissioners and planners

- Continue to support the CoP for existing participants
- Roll out the Botb programme as a model of networked improvement, to additional sites (and existing sites if they wish to extend their participation eg into new areas of improvement)
- Strengthen the measurement element of future programmes, and make it a condition of participation, as suggested in 9.1
- Address the known barriers to change as an overt element in the programme
- Consider additional evaluation of the current programme targeted at understanding the impact of interventions being made by local sites and the extent to which improvements have become embedded in local systems
- In addition, a collaborative group such as the CoP may benefit from the use of an 'R^v Tracker', a much simplified relational survey that will track ongoing relational health, give early warning of potential relational issues, and will embed relational thinking into the improvement of care programme
- Communicate the benefits of Botb as a change platform

10.2 For participants

- Keep contributing to the CoP – keep on "pinching with pride"
- Continue work on your existing improvement plan
- Consider how change can best be captured and measured given the resources, tools and techniques available to the team – don't be afraid to do something simple
- Consider how you could roll out the changes you make to other areas of your acute care system (or beyond)
- Expect enthusiasm from colleagues and partner organisations – working with you is valuable to them
- Expect the 'usual' barriers to change and take a proactive approach to managing the risk they pose to achieving improvement

11 Acknowledgements

The authors of this report would like to thank the programme team, notably Anita Hayes, Michelle Barclay and Paul Hayes. Their contributions have been especially valuable in relation to providing information on the context and content of the programme, and in assembling and preparing case study data.

Thanks are also due to local site teams for their co-operation in responding to requests for data, interviews and survey responses throughout the evaluation period.

Whole Systems Partnership
Lucy O'Leary
Heather Wheeler
Peter Lacey
July 2018

Appendix 1 Abbreviations used in this summary

ACMP	Anticipatory Care Management Plan
ACP	Advance Care Plan/ Planning
Botb	Building on the best
CoP	Community of Practice
COPD	Chronic Obstructive Pulmonary Disease
EoLC	End of Life Care
EPaCCS	Electronic Palliative Care Co-ordination Systems
HUK	Hospice UK
NCPC	National Council for Palliative Care
NHSIQ	NHS Improving Quality
OP	Outpatients
PC	Palliative Care
PEOLC	Palliative/ End of Life Care
R^v	Relational Value
SPPC	Scottish Partnership for Palliative Care
STP	Sustainability and Transformation Partnership
WSP	Whole Systems Partnership