

ISBN 1-84544-918-5 ISSN 1477-7274

Volume 11 Number 1 2006

Clinical Governance

An International Journal

**Fine words into action: learning
from the first five years of the NHS
Clinical Governance Support Team**

Guest Editors: Aidan Halligan and
Ron Cullen



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ISSN 1477-7274

Volume 11
Number 1
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Fine words into action: learning from the first five years of the NHS Clinical Governance Support Team

Guest Editors

Aidan Halligan and Ron Cullen

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Clinical governance: assuring the sacred duty of trust to patients

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Abstract

Purpose – To hammer home that clinical governance is the defining heart and inspiration of quality in the NHS and to expand on its implementation by all concerned.

Design/methodology/approach – Lists the ideal aspects and attributes of clinical governance.

Findings – Finds that clinical governance is a *sine qua non* and mandatory lever for achieving quality in the NHS and that whatever changes are necessary must be fully carried out.

Originality/value – Arguably, coming as it does from the top of the hierarchy, this posits the most soul-searching advocacy of clinical governance's importance for the NHS so far presented.

Keywords Clinical governance, National Health Service, Quality

Paper type Viewpoint

It didn't seem like an explosive situation. The audience had been quietly attentive. I had finished a talk and asked for questions. Then, out of the crowd, I noticed one angst-ridden face. That happens sometimes – the listener's face seems to gather all the power of a message and reflect it back with a galvanising passion: "I can't stand the feeling of disempowerment – the power base here sits with several individuals who can be nastiest and shout the most." This was said by a respected and senior clinician and the question was implicit. It had an electrifying effect on the audience. You could hear a pin drop!

What I have learnt is that clinical governance is communicated most effectively in those authentic unchoreographed moments which influence by winning time in overloaded lives and linger in the memory: because people remember the flash of the moment, the mental click and recreate the emotion just by thinking about it. These moments are what bring a change of heart.

So much is written and said about clinical governance and so little is truly understood. And yet, despite incomplete understanding, by general agreement, clinical governance has entered the spirit of the NHS and offered a light in the darkness.

If you pause and think of the NHS, the chances are that you will think of service and people, rather than structures and processes. Healthcare pervades the media and often our personal lives. Mention of it captures attention and makes the audience linger. We respect its practitioners and voluntarily place our lives in their hands. Clinical governance reflects this privileged relationship and seeks to assure our sacred duty of trust to patients. It does this by providing:

... a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Scally and Donaldson, 1998).

Clinical governance is here to stay. The brand, with its implicit promise of patient-centred, accountable care has put down roots in our healthcare culture. Despite the initial perceptions of threat and challenge to organisational and clinical autonomy sometimes flagged up by the phrase, it has become part of the vernacular of the NHS.

Clinical governance is the framework through which organisations influence the informal psychological and social functioning of their staff. Its delivery will result in every clinical team putting quality at the heart of their moment-to-moment care of patients. To achieve this objective, we need to communicate with staff so that when asked to define clinical governance or to give practical examples of its application, they will be able to respond authoritatively and effortlessly. We need, too, to ensure that clinical governance is more widely explained so that it isn't a mystery to the patients and carers who are the direct beneficiaries.

The meaning of a word is its use in action. Where clinical governance has worked, it has been as a result of acts of individual leadership. That leadership hasn't always emanated from the usual suspects – rank and title don't necessarily come with character and vision. When these individuals treated patients and colleagues as they would want to be treated themselves, when they put patients' needs ahead of their own, when they didn't avert their gaze and instead of blaming ensured learning, when they did these things and 100 other things both big and small, they led by example and reflected what we all recognise as the best in the sort of professional we want to be.

What we, in the Clinical Governance Support Team, have learnt over the past five years is that although health systems are vast and complex, individual leaders, including patients and carers, can make a real difference. The essence of leadership, within the context of clinical governance, has been to offer hope, and to show those involved that change is possible.

Properly implemented, clinical governance will remove the fragility around what is traditionally considered to be the "soft" end of the quality spectrum. It is a transforming initiative, which designs-in the necessary cultural levers to make safe, high quality service not just achievable, but inevitable.

"We don't see things as they are – we see them as we are." Implementing the framework of clinical governance helps both clinicians and managers to see clinical concerns as concerns for everyone in the organisation rather than professional and personal ones. Clinical governance has been described as the simple and singular purpose that unites all healthcare professionals and patients in a powerful manner. The absence of that unity leads to a subtle and pernicious withdrawal of enthusiasm.

When pressed, the majority of healthcare professionals emphasise that they learn best by doing. What has become clear is that much of the work in health cannot be subject to mass standardisation and doesn't respond to command and control. Asking a top-down bureaucracy or "management" to deal with this won't work. No matter how laudable the decree or policy and how worthy the intent, the reality can only be made possible through translation into meaningful action and behavioural change at local level. Understanding this perspective leads to the inevitable conclusion that at the heart of change is a change of heart. The most effective form of control is self-control. We need inspired, creative healthcare professionals fully engaged in reforming, designing and developing the healthcare of tomorrow. This philosophy has been at the centre of all the work the Clinical Governance Support Team has carried out.

We have learnt that influence is achieved less through analysis, which alters thinking, than through offering a truth, which affects feelings. At the core of all the work we have carried out over the years has been the principle of “holding up a mirror”, getting groups and individuals to agree that the image reflected is a truth that they can relate to, and helping them to move from where they are to where they want and need to go. That has been the basis of our “RAID” change model (Review, Agree, Implement and Demonstrate), a model that is only truly complete when it includes those who experience our healthcare as patients and carers; so often it is their perspective that fuels and enriches the will to improve.

To support this philosophy of change, we developed individual, specialised programmes, which offered support to multidisciplinary frontline teams, to dysfunctional teams, to boards, to enable a safe culture, to help develop leaders, to inform large group change and to facilitate failing organisations in turning around.

For many, clinical governance is seen as the organisational conscience, and, at its most idealistic, the “beating heart” of care. At the level of the clinical team, the DNA of clinical governance is that it enables the vocation and motivation of healthcare professionals and patients by giving their personal energy a voice: allowing them to meaningfully and continuously improve the culture they are a part of. It encapsulates an organisation’s statutory responsibility for the delivery of safe, high quality patient care and it is the vehicle through which that accountable performance is made explicit and visible.

Clinical governance, in point, in pith, and in comprehension far exceeds any other attempt to define quality in healthcare. The thousands of delegates that we have worked with from the NHS have given us priceless information about how to enable clinical governance to be at the heart of our health service. It is incumbent upon us to build red flag mechanisms that turn that information into information that cannot be ignored. There is so much we know about good practice and so little connection between that and what we actually do.

We seem to stare down at the NHS through the wrong end of the telescope – overestimating the impact of guidance coming from above, underestimating the local power to transform healthcare delivery, unaware, almost, that the very definition of success and of failure could be shaped by local ownership.

We are much more aware than ever before of the gap between what healthcare could be and what it is. Clinical governance in this context is an idea whose time has come, and there is a need, now, to make it visible and concrete in every corner of the NHS. None of what has happened or is about to happen would have been possible without the fundamental commitment and courage of so many frontline staff.

What we have learnt, more than anything else, is that if clinical governance gains purchase in the hearts and minds of frontline staff and is built up from the bottom, then the strength of that frontline mandate is unstoppable.

Reference

Scally, G. and Donaldson, L.J. (1998), “Clinical governance and the drive for quality improvement in the new NHS in England”, *British Medical Journal*, Vol. 317 pp. 61-65.



Being patient-centred: creating health care for our grandchildren

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Abstract

Purpose – To provide an overview of the learning from four practical programmes that explore different aspects of patient participation in healthcare provision.

Design/methodology/approach – To describe the origin and rationale for each project or programme, and to summarise the learning from it.

Findings – At a variety of levels, involving patients in the design of care services can provide new insights, and leads to more patient-focused and locally appropriate solutions. Engaging patients appropriately is not a trivial exercise, and those that are engaged need appropriate support, but the resulting solution is often more widely applicable than is first anticipated and can be cost-neutral.

Originality/value – The active participation of patients in the design and provision of care is a widely voiced public and professional aspiration, but is genuinely realised only rarely. The paper describes the principles, benefits and learning common to four practical expressions of that aspiration.

Keywords Patients, National Health Service, Team working

Paper type General review

Introduction

“The experience is the outcome”. For many healthcare professionals, this is a truism; they joined the health service to treat and care for patients, working with each to deliver the best possible outcome for them. But for the NHS as a whole, an explicit policy focusing on improving the patients’ experience of care is a relatively new departure and demands a different relationship with patients and their families:

There is a crucial role for informed patients and carers to play, beyond consultation and democratic participation, both of which are vital, but cannot substitute for active presence



inside the system. That role is in essence the same as any other member of the team in question, with one simple but important difference: everyone else on NHS teams is there to represent a professional perspective. It is a function that I hope will spread across the NHS: the skilled informed and experienced advocate whose voice is not simply data to be considered, but as much a part of the design and delivery of services as the medical, nursing, allied health professional or management perspective (CGST Patient Affiliate).

The idea of involving patients and the public in dialogue about health care planning and delivery has been around for many years. In practice most healthcare organisation Chief Executives could give evidence that their organisation had consulted the community on the latest plans for service reconfiguration, and most clinicians would genuinely believe that patient involvement happens on every occasion in the consulting room. Unfortunately, as these examples suggest, patient, carer and public involvement is often assumed or simply misunderstood. For many in healthcare, the leap may not always be made to the underlying reason for involvement, which is to develop a partnership that enables dialogue about choices; choices which in turn lead to the best possible experience of health care (What is the evidence that choice results in better health care outcomes?)

Organisational strictures often militate against the development of this dialogue. One of the biggest challenges is ensuring that the organisational and team cultures that surround the relationship between patient and healthcare professional actively support the principles of partnership. These cultures need to continue to nurture the practice of compassion and engagement with patients and carers for all healthcare staff in their training, ongoing professional development and daily practice:

Patient and Public Involvement (PPI) isn't a thing that you do, it's a way that you do whatever else it is that you do (CGST Patient Consultant).

Understanding these organisational and professional cultures, the mechanics of cultural change, and the relationship these have with the quality of health care has been a key focus for the Clinical Governance Support Team (CGST) since its inception. The Patient Experience Team (PET), an integrated team of patients and clinicians, emerged within CGST partly to ensure that the principles of patient involvement were present across the whole range of CGST's programmes and support services. As the principles of patient involvement have gained wider political and professional momentum, NHS managers have found themselves addressing the tensions of performance management whilst ensuring that the quality of care is evaluated and improved through active patient and carer participation. The Patient Experience Team has therefore also sought to act as a source of active support, learning and expertise on patient involvement for front line NHS staff. As a result PET has variously collaborated on, sponsored and managed a number of patient involvement projects and programmes, offering analysis, diagnosis, training, facilitation, story telling, change management and bespoke consultancy services as required. This paper reflects on three such projects, with the intention of illustrating the practical reality of patient and carer involvement, and highlighting the general learning from a variety of interventions.

Mastering patient communication programme for doctors

A woman in her mid-30s sits in a busy Accident and Emergency department on a Saturday afternoon. This wasn't her first miscarriage, but that was making it no easier

to bear. A young doctor appears, concerned and keen to help. He has a few questions, simple questions, and the shock comes with the last one: "can you sign the consent form please?". "Consent to what?" she asks. "To remove the products of conception" he replies, without callousness, but also without awareness: for him, "products of conception", for her, her baby.

CGST patient story

It is of course self-evident that the patient experience of health care is very heavily influenced by the way healthcare professionals communicate with them.

In August to December 2003, the Patient Experience Team piloted a "Mastering Patient Communications" (MPC) programme in two UK Strategic Health Authorities in the South-West of England. The programme was delivered the Cognitive Institute, an Australian commercial enterprise specialising in communication skills training in clinical environments. MPC provides doctors with the opportunity to gain patient feedback on their interactions with patients through the "Doctors' Interpersonal Skills Questionnaire" (DISQ). DISQ presents 12 questions on the interaction between doctor and patient, and patients provide a rating on a five point scale from 1 (Poor) to Excellent (5). MPC participants then attend a one day workshop where they can reflect on their patient feedback, share and discuss emerging issues, learn some of the theory of communication and actively rehearse specific communication skills. These skills include:

- greeting and welcoming;
- ability to listen;
- explaining information;
- eliciting patient concerns and fears;
- ability to reassure patients;
- time given to the consultation;
- consideration of the patient's personal context;
- respect for the patient; and
- concern for the patient's privacy and dignity.

In the weeks following the workshop, the DISQ patient feedback exercise is repeated to provide a comparison with pre-workshop performance. Three independent MPC workshops were run, covering 33 hospital and primary care doctors and in excess of 2000 DISQ returns from patients. A total of 25 doctors completed the workshop and pre- and post-workshop DISQ assessments.

Figure 1 presents mean pre- and post-workshop patient ratings for each of the 12 DISQ elements for the 25 fully participating doctors.

A more complete review of the pilot programme is available in Greco (2004), but overall, post-workshop DISQ patient ratings were significantly higher than pre-workshop assessments ($p = 0.009$, $n = 25$, Wilcoxon matched pairs analysis) for these 25. Only 28.6 per cent of patients gave their doctors full marks on the DISQ assessment prior to the workshop, but this rose to 37.6 per cent after the workshop.

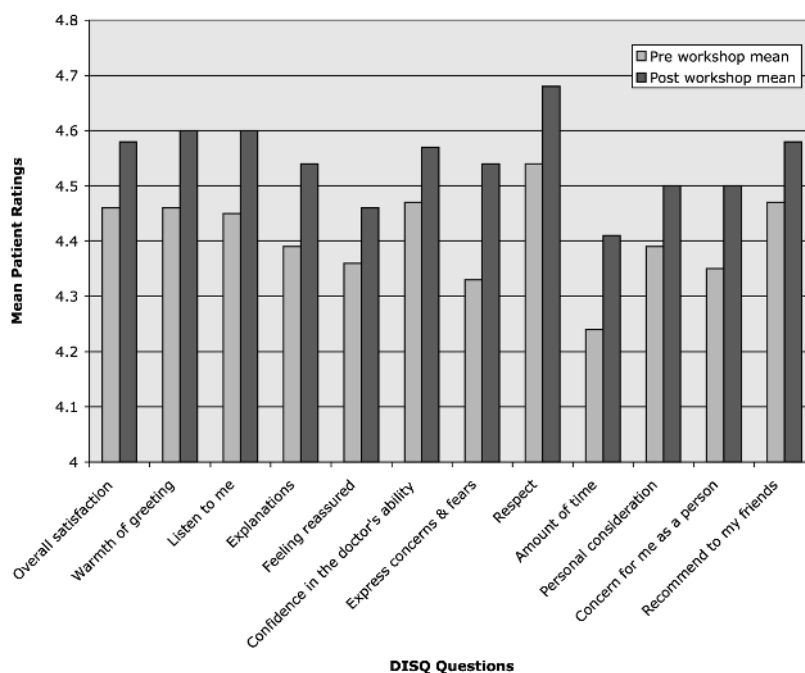


Figure 1.
Pre- and post- workshop mean ratings

Patients as teachers

Of course, patient involvement in the sense it is used in the summary of the Mastering Patient Communications programme is essentially reactive: patients are given the opportunity to pass comment on the service presented to them, rather than actively participate in the shaping and design of those services.

The “Patients as Teachers” model is one that seeks directly to incorporate the patient experience and perception into service design and professional education and training. The concept of patients acting as teachers and mentors to healthcare professionals is not new, indeed it is well established in the teaching of physical examination skills, history taking and communication skills (Wykurz and Kelly, 2002).

In 2004, The Patient Experience Team facilitated a “Patients as Teachers” project at Bradford Teaching Hospitals NHS Trust as part of their wider Patient and Public Involvement (PPI) strategy. This project focussed on efforts to ensure that the Trust’s Rheumatology Department was addressing the needs of ethnic minority women patients; women of a South Asian origin constitute a significant proportion of the local population, but staff in the department felt that they were not fully meeting their needs.

The project proposal included two key elements:

- (1) A facilitated focus group attended by female patients with a particular condition.
- (2) An educational meeting where patient representatives from this focus group teach “good practice” from their perspective to clinicians and staff and make

recommendations for service improvement. Nominated staff take forward specific actions on each of these recommendations, according to an agreed plan.

A project team was formed under the leadership of a Staff Nurse from the Rheumatology department, but comprising staff from across the Trust and including, crucially, a Patient Advice and Liaison Officer who was an Urdu and Punjabi speaker. The project team first planned the patient focus group, carefully designing it to engage Asian women and a letter of invitation was then issued to approximately 60 Asian women who had attended the Rheumatology service for a clinical consultation. The letter provided specific reassurances intended to increase the chances of attendance. These included:

- That the group would meet in the local community, using a recognised local community centre.
- That only women would be present when they met.
- That familiar and appropriate Halal and vegetarian food would be available.
- That interpreters would be available.
- That the meeting would be followed up by a phone call in Urdu or Punjabi to address any issues arising.

Twenty two women agreed to attend the meeting, though in the event 11 actually attended. The attendees were split into three groups, each working with an interpreter and a Rheumatology nurse facilitator to address specific questions about the service they had received and possible improvements to it. Then groups responses were collated, in English, on flip charts. Evaluations showed that the participants enjoyed the two and half hour focus group and, in total, they generated some 16 service improvement proposals, including the attendance of interpreters in clinics, provision of pictorial signposts, community based exercise and patient support groups.

For the second element of the “Patients as Teachers” model, two English speaking representatives from the patient focus group volunteered to present the ideas to a regular Rheumatology Multi-Disciplinary Team (MDT) meeting. Ultimately, these representatives declined to present, but attended the meeting to answer questions on an agreed presentation delivered by the project lead. The MDT meeting was chaired by the project lead and Patient Experience Team facilitator, who both held a brief to ensure that patient rather than professional views were the focus of the meeting. The MDT agreed to take forward 14 of the 16 focus group proposals, each one being assigned to a named member of the team.

The MDT proved very receptive to the patient proposals and suggested that around half of them would benefit all Rheumatology patients irrespective of patient age, sex or ethnic background. The conclusion of the project team was that “Patients as Teachers” offered a generic model for integrating patient views into planning and development of Trust services.

A review of progress six months after the MDT meeting confirmed that around half of the proposals had been achieved, while more complex projects, such as the provision of multilingual information audio tapes, were still in progress.

Several of the proposals were applicable across the Trust, and a number of Trust wide improvement initiatives have been developed as a direct result.

Patients accelerating change programme

The Patients Accelerating Change PAC programme provides a logical extension to the involvement of patients in service design by promoting on-going patient participation in specific improvement projects. PAC was created in response to concerns that there were few readily available solutions to issues repeatedly identified by the UK National Patient Survey Programme. PAC places emphasis on:

- Selecting improvement projects in response to sources of local patient feedback, including surveys, focus groups, suggestions box inputs and complaints, but particularly from the analysis of local data from the National Patient Survey Programme.
- Sustained and active membership of patients and carers in project teams or advisory panels.
- The identification of an Executive or Non Executive Director able to maintain the profile of the programme at Board level.
- Individually and locally designed approaches to problems.
- A systematic approach to running improvement projects.

The programme is jointly run by the Patient Experience Team and the Picker Institute Europe. It involves a series of national training and learning days, regional workshops for PAC project leads, the sharing of tools and techniques for public and patient involvement, and active advice and support from a national PAC support function within the Patient Experience Team.

The first two years of the PAC programme, involved 53 NHS acute Trusts from across the UK. Nine Trusts participated in the pilot phase (May 2003-April 2004), and were free to select their own improvement project. Forty-five Trusts were involved with the second phase, with the choice of project constrained to one of three options identified from an analysis of national survey results:

- (1) Information handed out to patients leaving hospital.
- (2) Explanation and management of test results.
- (3) Information concerning medication.

Two thirds of Trusts chose to focus on the first of these areas, issues around discharge, and a case study typical of these is presented below as an example of a PAC project:

*When the elderly leave hospital: supporting carers with improved discharge information
Wrightington, Wigan and Leigh NHS Trust*

The project benefited greatly from the wholehearted support and enthusiasm of stakeholders to improve the service. Despite encountering some difficulties, clear progress was made on key issues, including the allocation of funding for the introduction of an electronic patient record system to facilitate rapid dissemination of information to GPs, due to go live in Spring 2005. The steering group, with input from a lay panel, produced a card providing helpful contact details for newly discharged patients, including the ward number in the event of any concerns about their condition.

The success of this project is attributable to the involvement of patients and carers as partners in the initiative, the enthusiasm of stakeholders, and direct patient feedback obtained via the video diaries.

Background: To address concerns regarding inadequate discharge information at in a sub-acute hospital catering largely for older people.

Process: Survey results, information from PALS, complaints and patient comments, revealed that poor communication when patients left hospital was an issue affecting the Trust as a whole. The steering group decided to focus upon a particular category of patient, the elderly. Such patients often have complex requirements which impact heavily upon their carers.

The group initiated two surveys. One was implemented within the hospital, obtaining feedback from patients via one-to-one interviews, the other was an independent survey by the PCT Patient Forum, who contacted local GP practices for feedback concerning current discharge arrangements and whether they adequately met patients' actual needs.

An especially innovative method of engaging patients and carers in discussions was the introduction of a video diary project, led by the PALS Information Officer and the PPI Coordinator, with a view to examining issues for those relatives into whose care patients would be discharged. The project was well advertised and relatives were asked to comment on videotape about positive aspects of the patient's care and of their visits to them, as well as what might be improved; also whether a contact information leaflet might be of use when the patient left hospital. Ward staff and patients also became involved in giving their views. The results of this direct feedback were produced on videotape and DVD and shared with the Chief Executive and others.

Given the diversity of the projects, an aggregated analysis of the impact of PAC is difficult, though Sweeney *et al.* (2005) present results of a survey of PAC pilot participants and report that most PAC participants were encouraged by the positive results emerging from their projects.

Nevertheless it is possible to identify a number of recurring themes from PAC project experience:

- It is ultimately local project teams, incorporating sustained input from patients and carers, that deliver effective change projects, but there is a clear need to provide external support to Patient Advice and Liaison Service (PALS) representatives and Patient and Public Involvement (PPI) leads. This support takes the form of advice on techniques for recruiting patients and maintaining their involvement, and on running the projects that emerge from their input.
- Solutions often need to be locally devised or adapted, in few situations does an external solution apply perfectly to a local problem. Often these changes are simpler than anticipated, and in many cases can be cost neutral, and small scale projects tackling a specific issue often bring a greater chance of success, leading to wider adoption across the organisation.
- PAC projects have consistently demonstrated that NHS Trusts can sustain patient participation in service improvement projects.

Conclusion

We have selected and summarised three patient and carer involvement projects drawn from the Patient Experience Team's programme of work. Together, they are representative of some key learning from front-line NHS experience, learning that can be applied to a wide range of future patient, carer and public involvement projects.

Healthcare organisations are now more likely than ever to seek patient, carer and public feedback about the quality of the services provided, though, inevitably perhaps, there is some attendant scepticism about the value of some of these exercises. While it is true that patient surveys, focus groups and forums can have limited impact in and of

themselves, the projects cited above reinforce the assertion that patient involvement, in various forms, can make a substantial contribution to the quality and progress of service improvement, but there are some important observations to be made about this central assertion:

- Obtaining input from patients is not a trivial or ad hoc exercise. As the above example of the “Patients as Teachers” model demonstrates, patient feedback exercises demand careful thought and planning, and often access to specialist or community specific knowledge, particularly if the exercise is focussed on minority segments of the population.
- Organisations embarking on such projects need explicitly to support those charged with executing them by properly protecting time and facilitating access to specialist knowledge.
- One clear indicator of this should be executive level sponsorship in the form of a named and interested board member; this was a key determinant of success for many PAC projects.
- The PAC programme also demonstrated that while such projects need to be locally owned and driven, those running the projects benefited from an external support function, in this case the Patient Experience Team, provided access to peer networks, advice and a series of tools and techniques.
- Patients and carers, too, may need a degree of support if they are recruited to participate in project teams or work alongside clinicians in any capacity. As the Patients as Teachers example demonstrates, exercises such as patient participation in team meetings require careful facilitation and briefing to ensure that patients are comfortable in their role and that their input is effective.
- PAC projects often succeed by first concentrating on a small, limited area of the service or population. Frequently, the issues and lessons that arise from these small beginnings are found to be more widely applicable, as in the case of service needs of South Asian Women in Bradford; whatever the outward appearance, the reality is that human beings are fundamentally more similar in their needs than is often appreciated. Small, successful initiatives discover generic learning, and their early success often prompt wider adoption within the organisation.
- The purpose of patient and carer participation must be clear and well communicated in every instance, and when patient feedback is sought, it should be with a view to how susceptible the care system is to reacting to its findings. Often, the response to patient feedback, and the terms of patient participation, is to effect structural change, providing new materials or facilities, perhaps through revised processes. Yet what determines much of the perceived quality of care is the attitude and behaviour of health service workers, and their relationship with their patients: the greater goal for health service reform is cultural. Too often, cultural change is seen as a distant aspiration, but the Mastering Patient Communication programme serves as a reminder that, if culture is characterised as “the way we do things around here”, then it is susceptible to some degree to well designed and executed, but essentially conventional, patient-centred educational interventions.

At least in the UK NHS, and probably beyond, the trend in healthcare is towards greater patient choice and increasing organisational accountability for the quality of care. In this environment, successful providers will be those that remain sensitive to the needs and preferences of patients and carers, and which honour the trust that patients place in them. For those providers, patient feedback and participation will become a necessity rather than an option, and projects of the sort we have described above will become operationally routine:

I would like to see the model of having patient consultants and affiliates repeated throughout the NHS. This will mean that every job that everyone does, from clinicians to managers, to board members, to administrative staff, will begin with the question “what will the patient or carer think of this?”. In 20 years time, I know that my grandchildren will take this new way of working for granted (Patient/Carer Consultant).

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The Expert Patients Programme

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The Expert
Patients
Programme

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Abstract

Purpose – To describe the purpose, establishment, work and achievements of the Expert Patients Programme (EPP) of the NHS Modernisation Agency's Clinical Governance Development Programme.

Design/methodology/approach – The Expert Patients Programme (EPP) is one initiative of the Clinical Governance Support Team (CGST) which provides support for health professionals in implementation of the NHS Clinical Governance Programme arising out of the early work of the Patient Experience Team (PET). "Expert patients" are those with experience of self-management of long-term conditions and the programme centres on developing a model of peer support for patients with similar conditions. The EPP team has built on work at Stanford University in the USA where patients and their carers provide peer advice and support – an initiative termed "lay-led self-management". The EPP team developed a six-week course facilitated by trained lay people based on the Stanford "Chronic Disease Self Management Course" (CDSMC). This course was incorporated in a pilot study which ended in 2004 and in which the NHS collaborated with accredited voluntary organisations. A total of 98 per cent of Primary Care Centres in the UK took part. The methodology and benefits of the support programme are outlined.

Findings – Evaluation by questionnaire confirms data from other countries on showing improvement in patients' conditions and a decrease in their use of health services. Access to the EPP programme is to be widened and will be available throughout the NHS by 2008.

Originality/value – An account of the formation, activities and outcomes to date of the EPP programme are provided.

Keywords Patients, Diseases

Paper type General review

There are many opportunities for patient, carer and public involvement (PCPI) in health and social care. Although PCPI has long been recognised as a cornerstone of clinical governance, even the most well thought out plans for involvement can have little real impact on the behaviour of health professionals who for various reasons that are well documented elsewhere are unable to really identify with the patient and carer experience of health and social care.

The EPP is a programme that at its heart seeks to empower everyone, health professionals, carers and patients alike, by supporting all parties to develop more productive working partnerships for the self-management of long-term conditions. The programme has had a powerful impact on thousands of people with long-term conditions in many ways, none more so than on some of the health professionals who have experienced the course as a participant.

A paramedic told us about her experience of the Expert Patients Programme which she had undertaken as a participant. She had gained an enormous amount from the course in learning how to self-manage her own long term condition. However she was



so energised by the programme that she went on to train as a tutor and also returned to work. She describes the powerful impact the experience has had on her attitudes towards her patients:

I realised, being on the course, how much patients and carers are not listened to by the professionals . . . through looking at examples of the people in the group and the ways they had been dealt with by professionals and the health system. And now that I'm recovered, I'm back at work, I just feel that I want to help be a voice for someone so that their opinions are listened to and their feelings are thought of. Because I did realise that I was, like many, treating the illness, not the patient. And that is the most important thing. We learn about all those illnesses in the textbook, but it manifests in different ways in different people, and they are not all the same. I mean, you've really got to listen either to the patient or their carer, because they live with it 24/7 and they know the best ways of managing, so we've really got to listen to them.

This story demonstrates one of the many ways the EPP can have a powerful effect in breaking down the psychological barriers that so often separate patients, carers and health professionals. By truly beginning to understand the patient experience this one health professional and many others like her will take extra care in her work to ensure that she listens, understands and works more collaboratively.

Introduction

Since 1 April 2004, the Patient Experience Team (PET) from the National Clinical Governance Support Team, in partnership with the Department of Health (DH), has provided operational and strategic management to support the development of the Expert Patients Programme (EPP)[1] as a mainstream NHS service.

Background

For a number of years many primary and secondary healthcare organisations and voluntary groups have informally engaged people who have different long-term conditions (and their carers) in providing peer support to others with similar conditions. This work has helped people with many long-term conditions such as diabetes, asthma and coronary heart disease whose quality of life depends largely on their ability to self manage their condition(s). However this kind of support was often unstructured and the availability very varied across different localities. Designing and evaluating a structured programme of support which could be delivered by peers rather than health professionals was first tested in the 1980s at Stanford University in California (Lorig *et al.*, 1986). Lorig found that outcomes were as good as those from programmes led by health professionals. This approach had the added bonus of the programme leaders acting as effective role models for the participants. The approach has been termed lay-led self management.

This approach was initially undertaken specifically for people with arthritis but the Stanford research team, recognising that there were common issues faced by all people with long term conditions, such as fatigue and anxiety, developed a generic programme called the "Chronic Disease Self Management Course" (CDSMC) which was successfully tested in the 1990s (Lorig *et al.*, 1999).

EPP in the UK

Voluntary sector organisations including leading charities such as Arthritis Care, the British Liver Trust and the Manic Depression Fellowship pioneered the use of this generic, structured lay led self-management across the UK during the 1990s.

The success of this was recognised by the DH, culminating in the Chief Medical Officer's report, *The Expert Patient: A New Approach to Chronic Disease Management in the 21st Century* (Department of Health, 2001) which set out a vision for lay led self-management courses being a part of standard NHS provision in England. The pilot NHS Expert Patient Programme was subsequently set up by the DH.

The Expert Patient Programme is based on the CDSMC and is essentially a six week course facilitated by trained lay people which helps people with long term conditions to develop their self-management skills.

From 2002-2004 the EPP was piloted in 98 per cent of PCTs in England through a license agreement between Stanford University and the DH. Throughout this time the DH have worked in partnership with a number of accredited voluntary organisations in the UK who are also licensed to run the Stanford based course. This has been co-ordinated through a partnership with the Long Term Medical Conditions Alliance (LMCA), who support a large number of voluntary organisations for people with long-term conditions. Through this partnership a Quality Assurance framework that incorporates training and assessment is currently being developed and implemented across the voluntary sector and the NHS.

The Secretary of State launched the NHS Improvement Plan in 2004, which confirmed that the EPP would be available through all PCTs within four years: "The Expert Patients Programme will be rolled out throughout the NHS by 2008 to enable thousands more people with long term conditions to take more control of their health."

Monitoring and evaluation

The pilot phase of the EPP in England came to an end in the autumn of 2004. By this time 98 per cent of PCTs had been involved in the EPP pilots and 191 PCTs (out of a survey of 250) reported either undertaking or having courses planned post pilot. Monitoring data gathered in November 2004 showed that the work of the pilot has resulted in a network of over 80 trainers established round the country (2 wte for each SHA). They have trained 803 volunteer tutors who had delivered 1300 programmes to approximately 17,000 people with long term conditions.

Analysis of a range of questionnaire data from 963 participants (245 courses) from both before and after the course has shown some emerging trends. These non-standardised measures indicate that the EPP courses have resulted in significant changes in levels of confidence that the participants can self-manage symptoms such as pain, tiredness, depression and breathlessness.

These self-reported data also indicate more effective use of health services following EPP courses in that:

- GP consultations have decreased by 7 per cent;
- A&E attendances decreased by 16 per cent; and
- outpatient appointments decreased by 10 per cent.

There have also been increases in the use of pharmacies (18 per cent) and 33 per cent of the participants report feeling better prepared for consultations with health

professionals. The information from the pilot also suggested we may expect improved compliance with medication and other treatment regimes, resulting ultimately in improved health outcomes and better value-for-money. Many comments about the programme have been made on the evaluation forms, enabling a range of qualitative data to also be collected.

Although these findings should only be considered as emerging trends and at this stage cannot be directly attributable to the programme alone, they indicate possible outcomes and compare favourably with data from other countries where similar programmes have been run (e.g. Fu *et al.*, 2003). Confirmation of any such trends will only be possible after the results of an independent randomised controlled trial (RCT) currently underway and an economic analysis are published in 2006.

Recent new developments

In 2005 other important developments to widen access to the programme include:

- *Expanding language coverage:* The EPP handbooks, which accompany the six-week course; have been developed in six different languages other than English. These are Greek, Chinese, Gujarati, Hindi, Urdu and Punjabi. Courses have been delivered in Greek, Bengali and Chinese. To enable this to happen there has been considerable work with the communities to understand how they want their courses delivered and to recruit bilingual trainers. Handbooks are also available in audio, large print and Braille.
- *Availability to sensory-impaired people:* The programme is looking to develop course material for people with sensory impairments including a DVD version available in British Sign Language.
- *Online availability:* A national pilot of an on-line version of the programme is due to commence in 2005.
- *EPP Newsletter:* A quarterly newsletter, "EPP Update" and a website provide up to date information about the programme: www.expertpatients.nhs.uk

Future direction

The Strategic Management Board of the EPP chaired by Harry Cayton (Patient Experience and Public Involvement lead from the DH) has identified three clear priority areas:

- (1) communications, in order to publicise the programme;
- (2) increased delivery; and
- (3) widening access to everyone with a long-term condition.

Since the autumn of 2004 we have been working to establish and support a new operational management team that is now fully functional. This team includes a new programme manager and administrator, communications manager and two new project managers for developing quality assurance and the internet version of the EPP; the EPP Online. One important aspect which has been essential to the success of the programme is the nurturing of a positive team spirit and commitment to take the programme forward and meet the challenging strategic aims of the programme.

The first EPP conference was held in April 2004 and we are planning another in the Autumn of 2005. The broad aim of this conference will be to promote the EPP with PCTs.

Lessons learned

The story at the beginning of the article demonstrates the power of enabling a health professional to appreciate the “patient experience” and indicates how this insight is likely to have a significant change on her professional behaviour. This is truly clinical governance in action.

For those of us involved in supporting people with long term conditions it also illustrates the importance of the work that needs to be done to enable all health professionals to gain this understanding if we are to support effective self-management. Empowering patients is only one half of the equation.

Note

1. The EPP won the Guardian Public Service Award for Diversity and Equality in November 2004.

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The Essence of Care in clinical governance

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Abstract

Purpose – To review progress of the Essence of Care Programme of Clinical Governance. To describe its development and highlight its achievements.

Design/methodology/approach – The background to the programme is outlined and the methods adopted by the Clinical Governance Support Team (CGST) and NHS personnel involved are described.

Findings – At the heart of commitment to improve quality of health care lies Essence of Care to which the fundamental needs and comfort of patients are paramount. This provides a benchmarking tool for national standards of practice across health and social care which is applicable across medical specialties and relevant to all health professionals involved in caring for patients. Fundamental aspects of care were identified based on concerns of patients and professionals; these include communication, personal hygiene, food and nutrition. Standards are agreed between patients, carers, user groups, health care professionals, professional bodies and NHS departments. Systems for feedback and monitoring ensure continual improvement. Wide dissemination has ensured that Essence of Care is embedded in the NHS.

Originality/value – This review summarises the aims, objectives and progress of the work of the Essence of Care Programme of Clinical Governance since its initiation.

Keywords Clinical governance, Case studies, National Health Service

Paper type General review

Essence of Care in action

Patients attending Christie Hospital, England, for bowel investigations (colonoscopy) went directly to the theatre department. They were often older people with complex health needs. The two days of bowel preparation beforehand, and being “nil by mouth” on the day, meant some patients already felt weak and physically fragile when they arrived. By the end of their investigations, which included the additional impact of sedation, the Consultant, mindful of their condition, often admitted them to hospital. Planned as outpatients, they were in no fit state to go home.

The authors would like to thank Christie Hospital NHS Trust, Manchester and the Learning Disability Service at Chesterfield PCT for their consent to include case studies of their Essence of Care work.



A nurse from surgical theatres initially thought that being part of a multidisciplinary group focusing on food and nutrition benchmarking at the hospital (part of an Essence of Care toolkit for best practice in healthcare) was of no relevance to her department. However, following discussion with the group, it became apparent it was: A surgeon thought of a simple way to help alleviate the long term problem and shared her idea with the theatre nurse. The nurse representative told the group and they decided to put the proposal forward to the NHS Trust Board, which supported its implementation.

A £3 voucher for a hot drink, soup and a sandwich is given to patients having bowel investigations. After the procedure, patients can sit in the recovery room to get over the effects; time to have a bite to eat and get some strength back. This seems simple. It is, but it has made a huge difference to the hospital and to the patients. Figures showed that within a sixth month period there was a saving of approximately £8,000. More important for patients is that fewer are admitted to hospital after their colonoscopies and they can stick to their plans to go home afterwards.

The above case is one example of many improvements in patient care that have occurred across the NHS in England, and beyond, since February 2001, when Essence of Care was launched. “Essence” is a benchmarking tool designed to help practitioners take a patient-focused and structured approach to sharing and comparing practice across health and social care settings, to improve the quality of patient care. It supports the measures to improve quality set out in *A First Class Service* (Department of Health, 1998). Indeed, it has been described as the bedrock of clinical governance, with clinical practice benchmarking connecting the concepts of quality, clinical effectiveness and evidence-based practice. The importance of Essence of Care, as a resource to support frontline professionals implementing clinical governance at local levels in NHS organisations was acknowledged in May 2002, when it was integrated into the NHS Clinical Governance Support Team’s (CGST)[1] portfolio of national programmes and teams, as part of a tripartite arrangement between the Department of Health, Commission for Health Improvement and the office of the Health Ombudsman.

The background to Essence of Care

The drive to promote consistent, high standards of care has been a major stimulus evident in recent healthcare policy and reform (Department of Health, 1998, Department of Health, 2000). These reforms clearly highlighted that there are fundamental aspects of care that are central to the patient’s experience. The *NHS Plan* (Department of Health, 2000) reinforced the importance of “getting the basics right” and upholding principles that put patients at the heart of reforms.

Essence of Care was developed from a commitment in the national nursing, midwifery and health visiting strategy, *Making a Difference* (Department of Health, 1999). This put clinical governance at the centre of its plans for quality improvement. The document highlighted an example of clinical practice benchmarking in the North West of England, where it was successfully used to compare and share practices across paediatric care. Exploring the benefits of benchmarking was cited as one way in which the nursing, midwifery and health visiting professions could re-focus on the fundamental and essential aspects of care; making standards explicit; monitoring practice and seeking to improve quality. Following publication of the report, patients, carers and professionals worked together to agree and describe good quality care and

best practice, identifying a range of “aspects of care” benchmarks, fundamental to the patient’s experience.

Developing the “aspects of care”

The Essence of Care identifies nine “fundamental aspects of care”, each with its own set of benchmarks: the most recent (April, 2003) focuses on communication between patients and or carers and healthcare personnel:

The fundamental aspects of care[2] are:

- communication;
- continence and bladder and bowel care;
- personal and oral hygiene;
- food and nutrition;
- pressure ulcers;
- privacy and dignity;
- record keeping;
- safety of clients with mental health needs; and
- principles of self-care.

Concerns around these interrelated aspects of care were initially highlighted through patient complaints, ombudsman reports and professional concerns.

The evidence used to establish the benchmark standards included:

- consensus agreement involving over 2,000 patients, healthcare professionals and user group representatives;
- patient stories derived from the Leading an Empowered Organisation (LEO)/ Royal College of Nursing Leadership Programmes;
- Allied Health Professionals Leadership Programme development;
- lessons learnt in relation to humanity of care, from Commission for Health Improvement clinical governance reviews; and
- national guidance and policy.

Patients’ and carers perspectives were paramount to the process of identifying the benchmark standards: availability of the evidence was balanced with their expectations about what constituted “best practice” and what aspects of care were fundamental to them. As such the benchmarks, and their continued development, reflect those areas of care that actually matter to patients and their carers.

What’s in the toolkit?

The Essence of Care toolkit contains the following:

- an overall patient-focused outcome for each of the nine aspects of care (see above); and
- a number of factors that need to be considered in order to achieve the overall patient-focused outcome.

Each factor consists of:

- a benchmark of best practice for each factor;
- a continuum between poor (E) and best practice (A);
- indicators for best practice that support the attainment of it;
- guidance section on how to use the benchmarks; and
- forms to document and chart activity.

In the context of the food and nutrition aspect of care (the focus of the two case studies in this article) the patient-focused outcome is:

... patients are enabled to consume food (orally) which meets their individual needs.

Food and nutrition has ten factors which include, for example, “Factor 9 – Monitoring”. The benchmark for this has a continuum from E to A (see Figure 1).

The set of indicators for best practice include, “patients, carers, practitioners or professionals complete the food and fluid chart.” Discussion can be stimulated around the evidence produced to support the indicators, and experiences of different groups can be compared. Additional indicators can be added to reflect the uniqueness of particular patient or client groups. This process allows healthcare practitioners to review aspects of care, identify where to focus practice development, and plan what they need to do to their service to reach the highest standards.

Communication and dissemination

During 2000, in preparation for the launch of, what were then “new” aspects of care benchmarks, eight regional facilitators were trained to use the initial Essence of Care toolkit. These regional facilitators supported local facilitators in each NHS acute and primary care trust to take training forward in their own organisations. Copies of the toolkit were then sent to each regional office across England in February 2001 (Department of Health, 2001).

Essence of Care has always been subject to ongoing review and amendment in line with users’ comments. For example, whilst “communication” was an integral part of each of the initial eight aspects of care, it was felt important enough to merit inclusion as a stand alone “aspect” in a revised 2003 Essence of Care. This move was a direct response to requests from participants involved in using the first version of the toolkit

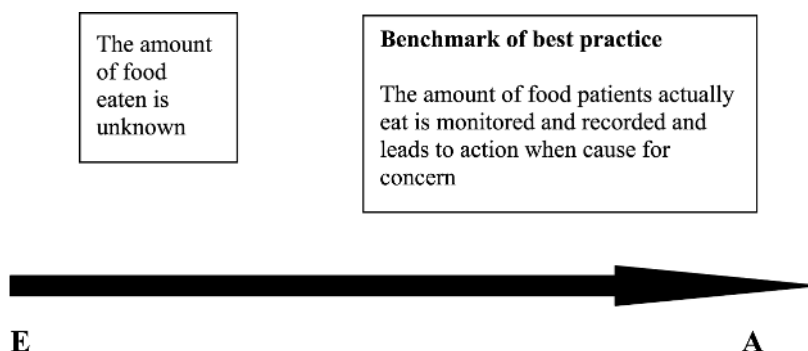


Figure 1.
Factor 9: monitoring

(Department of Health, 2001). In addition, the format of the original benchmarks was simplified because users had difficulties in applying it to their local, variable, circumstances: intervening steps on the E (poor practice) to A (best) continuum were removed. The focus shifted therefore from rating practice, towards more emphasis on stimulating discussion among the benchmarking comparison group.

The revised 2003 Essence of Care was sent out to all NHS organisations; copies were also sent to universities, prison healthcare services and to key stakeholders. Since then the regional and local facilitators have worked in partnership with practitioner leadership programmes, the CGST and the wider NHS Modernisation Agency, to embed it within NHS organisations' clinical governance arrangements across the country.

To satisfy demands for this revised toolkit from the UK and beyond, a downloadable version was posted on the Essence of Care programme pages on the CGST web site (www.cgsupport.nhs.uk).

In Essence, what are the benefits?

The benefits of the toolkit include:

- It is a multidimensional tool with a generic format that can be used in different healthcare settings, with patient and/ or carer groups, and regardless of clinical specialty.
- The focus is on the patient and the patient's journey rather than on any one professional perspective.
- There is an opportunity to collaborate through integration of organisational, management and professional approaches to delivering quality of care.
- It provides a forum for practitioners to take part in informal clinical supervision where participants can discuss issues beyond the benchmarking area being considered.
- Professional development: practitioners have integrated their activities into professional portfolios, demonstrating the effectiveness of an underlying philosophy which sets out to share and develop best practice.
- The benchmarking process can lead to improvements in other related areas, emphasising, for example, the importance of ensuring systems are in place to address the needs identified, and the necessity of connecting work into local, regional and national strategies (for example National Service Frameworks) to ensure synergy with delivering clinical governance.

The example below demonstrates another potential benefit from working through the Essence of Care process: staff who are well supported and empowered to look at their own practice, are more likely to identify the solutions and take ownership and responsibility for making changes.

Ensuring what you want is what you get Concerns

A learning disabilities team from Chesterfield PCT reviewed their service by working through the Essence of Care Food and Nutrition benchmark. They were concerned about patients who misunderstood menus and were unable to communicate what they wanted to eat. When meals arrived, they were not always what the patients expected; sometimes there was food they didn't like.

Action

Two care support workers came up with an idea to improve the care of these patients. They used pictures of real food (e.g. peas, carrots) to build up a visual menu, cutting out and laminating each picture and sticking Velcro on the back. Then the pictures were divided into sections in a file i.e. soup page, main course, vegetables, pudding page, fruit page, etc. Finally, strips of Velcro were added to plastic plates.

Improvement

A patient ordering food can show what s/he wants by selecting pictures from the file and “sticking food on their plate”, to build up a meal. Patients are happy, as they know what they are getting. They no longer have the frustration of trying to communicate what they want, only for this to be misunderstood.

The “picture plates” idea has spread to other departments: it is being used for stroke patient care; in older people’s services; and to aid other patients with communication problems. There is huge potential for helping any patient who experiences language difficulties.

The above example also shows, in a small way, the value of sharing good practice beyond one’s own specialty or service, as so often ideas from one area are transferable to others. Internal benchmarking therefore, can also encourage inter-departmental networking: this is particularly important where staff in specialist areas feel isolated. Spreading this benchmarking exercise further afield can allow for a “compare and contrast” of current practice across different types of organisations (e.g. between mental health and acute trusts). Sharing good practice and learning from the examples of others is something that NHS organisations have not always been good at (Commission for Health Improvement, 2003), but that Essence of Care benchmarking encourages.

Supporting success

Integrating Essence of Care into the work of the Clinical Governance Support Team was a crucial step in ensuring that fundamental care was addressed in all NHS organisations, and with the advent of commissioning, in private sectors of care.

Healthcare practitioners have been able to identify a critical path of sustained improvement; from the point of contact with patients and their carers, through to the boardroom, ensuring that addressing fundamental care issues is not only on NHS Trust Boards’ agenda but is visible within Board Directors’ objectives and those who have responsibility for the delivery of high quality care.

Over the past five years, the CGST has learnt that NHS Trust Board commitment is essential to effective delivery of clinical governance. It has proved an essential part of the Essence of Care process; the Board can not only reinforce the value of delivering the fundamentals of care, but directly address issues or concerns raised by key stakeholders through benchmarking activity, ensuring that issues are taken to the right people across the organisation. Board teams have also come to understand that effective use of the tool can provide evidence that the established standards for NHS care provided for patients in England are being met (Department of Health, 2004a)

The 28 Strategic Health Authorities across England have also been supportive in facilitating “celebrations of good practice”, a sharing of knowledge, and approaches to improvement at local level regarding the nine benchmarks covering the fundamental aspects of care. This has culminated in NHS staff being recognised in *Nursing Times*

awards for their approach to Essence of Care and the impact it has had on patient care at a local level (Davis, 2002 and Sandiford, 2004)

Conclusions

Nationally, organisations in NHS primary, secondary and tertiary care, and across the private sector, have embraced the principles of the Essence of Care as fundamental to the implementation and delivery of good clinical governance. The application of the benchmarks to practice can result in a real difference to the quality of patient care delivered (Oxtoby, 2003 and 2004; Gilbert, 2005; Harvey, 2004)

Contrary to the history of Essence of Care, the toolkit is not “just for nurses”: it is relevant to all healthcare personnel to explore the benefits of benchmarking activity, undergoing a process by which best patient-focused practice is identified and continuous improvement sought through comparison and sharing.

Development of the Essence of Care benchmarks has provided a valuable opportunity to challenge and break down traditional boundaries between professional groups, organisations and sectors and replace them with an integrated patient focus. Good leadership however, is critical to maintaining the drive and direction of healthcare teams that seek to deliver practice improvements using the benchmarking process. Such teams also have to balance the drive to demonstrate evidence-based practice, with the demonstration of care practices that patients and carers have identified as “of the essence”.

With the appointment of a successor organisation to the NHS Modernisation Agency, of which the CGST has been a part, and the launch of a new national organisation to support the implementation of clinical governance in 2005 and beyond, Essence of Care is to continue its contribution to NHS improvement and modernisation by being locally rather than centrally based. This move will facilitate regional ownership and continued evolution of the benchmarking tool, ensuring it remains relevant and practical to local communities. Underpinning this is the message, delivered by agencies such as the National Patient Safety Agency (NPSA) and the Healthcare Commission (Healthcare Commission, 2004), both of which recommend using Essence of Care, stressing its relevance and value as a key mechanism for driving continuous quality improvement in patient care.

Notes

1. The Essence of Care programme is no longer hosted with CGST – it is now with the Department of Health.
2. The public health policy document, *Choosing Health* (Department of Health, 2004b) makes every patient contact with the NHS a health promoting contact. To support this, a “Health Promotion” benchmark has been commissioned.

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Supporting clinical governance in primary care

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Abstract

Purpose – To report on the clinical governance work of the NHS Clinical Governance Support Team's, Primary Care Team.

Design/methodology/approach – The review describes the formation of the NHS Clinical Governance Support Team's Primary Care Team and the development of a range of national clinical governance activities, drawing on a case study example.

Findings – The Team have been developing appraisal, and revalidation for general practitioners across the UK, supporting front-line staff in primary care to improve patient experience by embedding principles of clinical governance into day-to-day practice, and are providing an online education and training programme to develop primary care managers. It has established links, and worked collaboratively with a range of partners in its activities.

Originality/value – The article provides a summary of the activities of the Primary Care Team and its activities to date. An example of supporting clinical governance in primary care is given in a case study of facilitating an influenza vaccination campaign.

Keywords General practice, Primary care, Performance appraisal, Clinical governance, National Health Service

Paper type General review

Introduction

Clinical governance aims to raise patients' expectations about the quality and safety of their care, to improve collaborative relationships and efficiency within and across clinical teams; to make clinicians more accountable for their actions; to increase job satisfaction for professionals; to improve clinical outcomes and reduce significant incidents and errors (adapted from Gerada and Cullen, 2004). The remit of the Primary Care Team at the NHS Clinical Governance Support Team (CGST) is to work towards embedding clinical governance firmly in primary care. Much of the work of the CGST Primary Care Team is strategic, helping to embed clinical governance at all levels of Government policy.

The three main strands of the Primary Care Team's diverse work programme are:

- (1) working with partner organisations to build on the development of appraisal, and to strengthen revalidation;
- (2) supporting frontline primary care to embed clinical governance and improve the patient experience; and

The authors would like to give thanks to Sandy Gower and all at the Bennetts End Surgery, Hertfordshire for their help with the case study.



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- (3) providing an online education and training programme to develop primary care practice managers (and those aspiring to be practice managers).

Supporting GP appraisal, and revalidation

Supporting a healthy process of doctor appraisal goes to the heart of what clinical governance is trying to do, not least as effective appraisal has been shown to have a positive impact on patient care (West *et al.*, 2002), but also because it can be a catalyst for continuing personal development and learning (Conlon, 2003a).

In 2002 appraisal for general practitioners (GPs) was introduced in England, with most GPs having their first annual appraisal in 2003. Prior to this, the Department of Health commissioned the CGST to develop a programme to train a cohort of GPs in appraisal skills in England. The programme took place between March and November 2002, prior to the formation of a Primary Care “team” at the CGST in 2003/2004.

Delegates received a one-day course of training in groups of twelve, led by two facilitators. Over 92 training days, 952 GP appraisers underwent training, achieving at least one appraiser in all but two primary care trusts (PCTs) nationally (Wall *et al.*, 2002). An evaluation by GP delegates who attended, showed it to be a positive experience: the opportunity to participate in “real” appraisals with each other and receive feedback from GP peers observing by video was viewed as a particularly important part of the programme learning. (Conlon, 2003b).

After completion of the “Training the Appraisers” programme, future funding was devolved to university postgraduate deaneries so that GP appraisal training could be developed and supported at local level, with the CGST coordinating a national appraisal network. Progress towards linking appraisers so that they could share experiences and learning, and have access to news articles and documentation about appraisal, came to fruition in April 2003, when the CGST launched its GP Appraisal e-group at www.gpappraisal.nhs.uk. A monthly email bulletin was also produced to update members about discussions on the website’s forum and identify current appraisal news. By October 2005, the appraisal website had over 1650 registered members and over 1500 visitors a month.

In addition to the national programme and website the CGST has produced a framework for the quality assurance of appraisal for doctors. This work, commissioned by the NHS Appraisal Steering Group, and produced through the efforts of a UK-wide groups of experts in appraisal, was completed in August 2005 and is published on the CGST website (NHS Clinical Governance Support Team, 2005).

Revalidation

Appraisal and how it relates to revalidation (see below) is the subject of much debate in primary care (Conlon, 2005):

Appraisal, and revalidation: a summary

Appraisal

A formative and developmental process of facilitated self-reflection, which takes place in a confidential, supportive setting and without a pass-fail element.

Revalidation

A summative and public process where doctors provide evidence and data to support their case for revalidation of their licence, demonstrating they remain “fit to practise”.

The CGST has been working to promote a revalidation process which combines supportive appraisal, with objective measurement of the doctor's performance by the PCT. Revalidation itself is being reviewed by the Government in light of publication of six reports into the criminal conduct of GP Harold Shipman (The Shipman Inquiry, 2005). The CGST intends to continue to make positive contributions in the light of this review.

The Primary Care Team is also supporting the strengthening of revalidation by working with the Royal Colleges to develop a robust and verifiable set of criteria for standards and evidence. This work has been progressing since May 2004, when the CGST was asked by the NHS Appraisal Steering Group to convene an expert group to identify examples of evidence that could be used in a set of minimum requirements for revalidation of doctors working in primary care. The expert group considered this task and was instrumental in producing a key document on the revalidation process: *Defining the Evidence for Revalidation: Supporting the Royal College of General Practitioners* (NHS Clinical Governance Support Team, 2004a). This document was the basis for the RCGP's own consultation on the minimum evidence requirements from GPs for revalidation. (Royal College of General Practitioners, 2004).

In a complementary exercise to the above, and with a view to aiding the process across the medical profession as a whole, the CGST Primary Care Team has mapped the equivalent documents from other specialist Colleges against the evidence set devised for GPs, to see how they compared. The views and recommendations expressed to the RCGP (NHS Clinical Governance Support Team, 2004a) were refined into a generic framework that could translate across to other disciplines. This work supports the Colleges in their task to define an appropriate evidence set for revalidation for each of their disciplines. The Academy of Royal Medical Colleges is preparing a report on progress to the General Medical Council.

Primary care is more than just doctors; the Primary Care Team is also developing proposals for general practice accreditation. This would include establishing a quality-driven framework around the whole practice team, bearing in mind that it is the inter-relationships between team members which determines the quality of care that the patient receives.

Supporting GPs and front-line staff: a case study

All members of the Primary Care Team spend time with front line staff in primary care. In doing so they are helping to bridge the gap between clinical governance policy and implementation within primary care organisations. The following case study recognises that public health is not just "academic" and doctor led, it is something that most people working in primary care practices do every day. The need to prevent flu in the vulnerable and elderly is a key concern of general practice and leading an effective vaccination campaign requires integrated team work and activities that encourage involvement of the local community.

With many influenza campaigns under their belt, the team at a general practice in Hertfordshire decided they wanted their 2004/05 campaign to be a different experience for the 18,000 patients and staff. The Managing Partner invited the Primary Care Team to look at how the campaign might be structured and delivered in the local community.

In June 2004, the surgery's Management Assistant, and a member of the Primary Care Team experienced in working with large groups facilitated a workshop for about 40 people who worked across primary care. Everyone was included: health visitors, GP registrars, receptionists, secretaries, health care assistants, practice nurses, and district and MacMillan nurses. The weekly training slot was extended so the whole team had two and half hours protected time to come together.

Staff were updated on the previous year's vaccination results and their current flu targets. They were asked what it felt like to work in the practice and to reflect on the previous year's flu campaign. Group discussions addressed how the practice could "do things differently" and everyone could support the campaign. A project plan was then developed.

Various facilitation techniques were used to engage different members of the practice team in the campaign: one of the tools used was a giant "The Health of our Flu Campaign" thermometer. This was placed in the staff coffee area so each team's contribution was visible to all. Another tool was a large poster in the shape of a wine bottle where staff could leave Post-it note feedback as "messages in a bottle". These simple, visual tools stimulated debate and helped to keep the topic and the activity upbeat. There was a good sense of collegiality among the primary care team. Comments included:

Tremendous team spirit, all of us working towards a common purpose of vaccinating as many people over 65 and at-risk patients as possible.

A quality, not just a quantity service this year – a job well done.

Actions to help reach the flu targets included:

- A campaign launch by the Mayor, with local media support;
- A flu vaccination posters competition;
- Healthy Communities "Super Flu Saturdays" at the surgery; and
- A new style newsletter designed by a local school pupil.

Putting the "public" in public health

Local community awareness of the flu campaign was raised when an enthusiastic receptionist made the link between the practice and a local school. A competition was arranged. Year 6 children were asked to design posters to spread awareness of the importance of flu vaccines to vulnerable elderly people and people with coronary heart disease. The posters were judged by the surgery's primary care team and the winners attended the Mayor's campaign launch at the surgery. They were presented with book tokens and photographed by the local press. The media attention at the event spread coverage of the flu campaign further into the local community. The winning posters were displayed in the main reception of the surgery which kept flu as a "hot topic" among patients.

Healthy Communities "Super Flu Saturdays"

In 2003, the large turnout to a single flu vaccination Saturday left patients and staff alike, exhausted. The 2004/05 campaign was different. Two Flu Saturdays were held

and every member of staff, whether clinical or non-clinical, worked on one of the mornings. Over 1200 patients attended flu vaccination appointments which included, where appropriate, the time for a pneumococcal vaccination, blood pressure reading and medication and chronic disease management checks. Even local police were on hand to assist with the extra traffic in the surgery car parks. The number of patients receiving flu vaccines in 2003/04 was 2,700. Thanks to a whole team effort, 3,100 patients were vaccinated in 2004/05. What's more, the programme was more enjoyable for all concerned.

Carers' clinic

The practice team was also sensitive to the needs of carers registered with the surgery. They were invited for a 20 minute appointment at a special carers' clinic. As well as a flu vaccination with the nurse, each carer was offered a mini "health check". The carers' support worker and Age Concern were available for advice. This work contributed to the surgery team winning a Silver Carer Aware Award from the Princess Royal Trust for Carers in December 2004.

A team approach to quality

At the Hertfordshire practice, work is ongoing to gain a truly integrated team approach to quality care. For example, in 2005, the practice worked with the district nursing team to deliver an earlier flu vaccination to housebound patients in the community. A more personal approach to encouraging vaccinations has been adopted too. Instead of sending vaccination letters to patients through the primary care trust, invitations have been put on prescriptions, patients telephoned, and the reception team personally remind patients of the need to book vaccination appointments.

During the June workshop, some receptionists expressed an interest in further training and development. The practice nurse team facilitator is training receptionists who are interested in health care assistant roles and in taking blood pressures. Receptionists have already paired up with nurses and GPs to assist with data entry on Flu Saturdays.

Using facilitation techniques in primary care not only opened this team up to a different experience of delivering their public health flu campaign, but gave the practice a greater focus on the quality of service it delivers to patients. Staff accepted the challenges of whole team engagement, and quality care is high on the practice agenda:

The practice partners feel it is essential to invest in quality and I believe that where you have quality, rewards will follow-not just financially, but in healthier, happier patients and better team working (Sandy Gower, Practice Managing Partner).

Primary Care Management Development Programme

As a group, practice managers often miss out on training and education opportunities. Even if funds are available, they can be too busy to be released from their work place. As a result, gaps in their skills and knowledge may develop, such as in delivering public health policy, human resource issues, practice finances and aspects of clinical governance such as risk management.

In March 2004, 300 GP practice managers attended a national conference to talk about clinical governance in primary care and their professional development needs as practice managers. Their lack of training and educational opportunities was confirmed and prompted the Primary Care Team to join with a wide range of agencies to address the professional development needs of this group.

The Primary Care Team has developed, in partnership with the National Primary Care Development Team (NPDT) and other agencies[1], a set of e-modules, based on and mapped across to, the new General Medical Services (GMS) contract and major public policy initiatives, such as the public health White Paper, *Choosing Health* (Department of Health, 2004). These modules are linked to core (and optional developmental) competencies, and are the basis of phase one of a three phase Primary Care Management Development Programme.

The Programme was launched at a national conference in April 2005. By November, over 300 registered participants were embarking on their first online module.

The programme is targeted at managers who have had very little formal training in practice management, but is also applicable to pharmacy and dental practice managers and to managers in primary care trusts. Training is supported by a series of local action learning sets, facilitated by a network of local facilitators. The programme is delivered via primary care trusts' education and training structures and will have links to other areas through clinical governance networks.

The three phases to the Management Development Programme are:

- (1) *Phase One*: introductory module and nine online modules; core competencies with interactive self assessment.
- (2) *Phase Two*: a service improvement project (in development).
- (3) *Phase Three*: vocational training scheme with integrated work across care sectors (in development).

Once established, the Programme should begin to meet the demand for clinical governance support in primary care practices and trusts and improve the competencies, knowledge and skills of practice managers. Hopefully, it will also improve the capacity for joint working across different managers in a particular area, as well as begin to establish a cohort of senior managers who will liaise with the CGST and the Department of Health and help the Primary Care Team deliver on future policy initiatives.

Dentistry and pharmacy

The Primary Care Team are also linking with dentistry and are supporting the British Dental Association (BDA) and the dental policy branch in the Department of Health to help them develop their clinical governance systems. Revalidation is inevitable for all healthcare professionals and the team are supporting the BDA to define their own standards of criteria and evidence for revalidation.

As a response to the findings of The Shipman Inquiry (2005), the team are working with pharmacists (particularly supporting pharmacy supplementary prescribers and nurse supplementary prescribers) to address clinical governance issues, and the

storage and use of controlled drugs. A clinical governance pharmacy toolkit has also been developed and is available on the CGST web site.

Summarising the work of the team

A specialist Primary Care Team has been functioning for three years as part of the CGST. In this time, and despite two members continuing work as GP Principals, the team has embarked on, and in some cases completed, a wide range of projects, interacting with over 15 key stakeholders on the way. More projects are coming on stream. The following is a summary:

- Co-ordinating the initial training of appraisers for GP appraisal; and developing an appraisal support website and a Quality Assurance Framework for doctors' appraisal.
- Developing evidence for GP revalidation, including being instrumental in shaping the Royal College of General Practitioners Revalidation documentation (NHS Clinical Governance Support Team, 2004a, Royal College of General Practitioners, 2004).
- Mapping other specialist Colleges' documents against the evidence set devised for GPs, to see how they compare and translate across to other disciplines.
- Helping to define the roles and responsibilities of clinical governance leads in primary care trusts (Gerada and Cullen, 2004).
- Working in partnership with the NHS Alliance and commissioning them to develop and deliver a clinical governance network; part website and part network meetings.
- Working with the National Clinical Assessment Authority to develop its role within clinical governance, specifically around the development of a clinical governance toolkit and controlled drug use.
- Ongoing work on a quality and outcomes framework related to clinical governance.
- Workshops on Essence of Care in Primary Care[2]. Three workshops were held across the country to share good practice among primary care trusts that had implemented "Essence".
- An online Primary Care Management Development Programme is up and running.
- Working with others around the Government's response to, and implementation of, the recommendations in the reports from the Shipman Inquiry.

Conclusions

The CGST Primary Care Team is supporting the process of clinical governance across all aspects of the NHS, providing an interface between health, social services and voluntary organisations. It is supporting those devising policy; it is supporting primary care clinicians at the front line who are delivering the agenda and seeking to improve the quality and safety of patient care through their clinical practice.

The value underpinning the team is that of clinical governance itself: that all aspects of the service must be in balance, in order for quality to emerge: accountability balanced with autonomy, scrutiny with support, the provider's needs with the patient's

needs. The complexity of primary care means this balancing process is an enormous challenge, but one that the Primary Care Team faces with relish.

Notes

1. Organisations and agencies involved in the Practice Management Development Programme include the Royal College of General Practitioners, the NHS Alliance, the National Clinical Assessment Authority (NCAA) and the British Dental Association. Primary care managers and representatives from primary care organisations have also had input.
2. Essence of Care is a flexible clinical governance benchmarking tool for improving patient care.

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Further reading

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The role of an NHS Board in assuring the quality of clinically governed care and the duty of trust to patients

The role of an
NHS Board

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Abstract

Purpose – To provide an overview of the change to NHS Clinical Governance Support Team's Board Development Programme.

Design/methodology/approach – The background to the programme, the methods adopted by the Board Team and lessons learned are outlined. Commitment and active support at Board and senior levels are known to be essential for organisational change and, in order to help translate aims into strategic priorities and to implement these into improved services, the Clinical Governance Board Support Team was formed in 2000 as part of the overall NHS Clinical Governance Support Team (CGST). Its members provide advice and support to NHS personnel who are involved in improvements to health care services.

Findings – The team worked initially with Boards of acute NHS Trusts and later with Primary Care, Ambulance and Mental Health Trusts. Among the lessons learned from their own work and the increasing body of research-based evidence is the importance of the leadership role of the Board in fostering a positive culture of change, enthusing and empowering staff. Other factors are the effectiveness of communication with external organisations, scrutiny of all points of contact with users of the services and involvement of users – patients and carers – at all stages. The Team evolved during the programme, strengthening its clinical base and introducing patients and carers as associates. In order to meet demand and increase capacity of the Team, learning materials have been developed and these and their experiences widely disseminated. An example of success is demonstrated by the progress made by a pilot cohort of Primary Care Trusts.

Originality/value – This review summarises the aims, objectives and progress of the work of the Board Development Programme.

Keywords Clinical governance, Boards, Culture (sociology), Directors, National Health Service

Paper type General review

The Clinical Governance Support Board Team has worked with the Boards of more than 250 NHS organisations, including Acute, Ambulance, Mental Health and Primary Care Trusts, as well as with the Boards of Cancer Networks and those of Strategic Health Authorities. We have had the opportunity therefore, to work with and to learn from more than 3,000 Executives, Non Executives and Clinical Leaders who, on a day to day basis, govern the complex and interconnected system that is the National Health Service. Some of the key learning from this work is set out below.

It is clear from all of our engagement that an informed, passionate and lived commitment to clinical governance from the Chair, CEO and Board of an NHS organisation is a necessary precondition to the sustained safety and quality of patient-centred care and the discharge of the duty of trust.



However, commitment from a Trust Board can never be sufficient, of itself, to generate and sustain high quality provision. For this to occur, the Board's commitment must be translated into strategic priorities and focussed, project managed and monitored implementation plans that actively engage all staff in persistently addressing each of the constituent elements of clinical governance. It is what happens at the clinical "coalface" which is the hall mark of clinical governance. One acid test for any organisation's governance is therefore the lowest standard of care that is tolerated. Another is the extent to which clinical excellence is relentlessly pursued. Both of these express themselves through the lived culture of an organisation.

We have learned that to make an informed judgement of a Board's strategic leadership capability and commitment to the clinical governance agenda it is important to take two things into account.

The first is that, as the original guidance on clinical governance made clear, clinical governance needs to be understood as "a ten year journey". In reaching a robust and valid judgment on a specific Board and its leadership of the clinical governance agenda it is clearly essential to take account of how long the Board has worked together as a corporate entity. In any complex inter-connected organisation the only thing that can be changed quickly is rhetoric. To translate even the best Board level vision, aspiration and strategy into an embedded reality across the geographically dispersed and professionally differentiated "community of practice" of, for example, a Primary Care Trust is, inescapably, the work of some years:

There is considerable variation in states of readiness for the development of clinical governance and it should be seen as a medium to long-term development objective (Department of Health, 2000).

Evidence of imperfect clinical governance across an organisation is not necessarily evidence of poor Board leadership – though the absence of a clear emphasis upon the safety and quality of care and of strategy and prioritised and monitored actions to embed clinical governance, would constitute such evidence (except in the most recently formed of Boards).

The second factor is the "degree of complexity" with which a specific organisation and its Board are required to deal. This "degree of complexity" is a complex compound of a number of factors. Amongst the most important are the organisations its history, its "life stage", its financial and clinical inheritance, the range and the scope of the clinical services that it provides, the extent of the social deprivation and the specific demography of the community that it serves. Additionally, the overall health and well being of the health and social care economy/ies within which it is embedded is as important as any of these "intra-organisational" and demographic factors. All of these conspire to create a "degree of governance difficulty" that is unique to each specific NHS organisation.

To exemplify this, as part of our work with the Boards and Professional Executive Committees (PECs) of Primary Care Trusts in 2003, we asked Board and PEC members to make a judgment of the progress that had been made in embedding clinical governance and all of its constituent elements across the PCT. On a scale that ran from 0 = No Progress to 10 = Fully Implemented, the 63 participating PCTs recorded an average score of 5.5 (range 3.4 to 7.1). On the basis of direct follow up work with the PCTs at the top and bottom of the range, both of these very different self assessments

appeared to be appropriate and soundly evidenced. Superficially, therefore, it might seem that we were working with one organisation that enjoyed excellent strategic leadership of the clinical governance agenda and one that did not. This was not the case.

The difference in their progress was not attributable to differences in their Board or PEC performance. It was the overwhelmingly consequence of their different life-stage, their inheritance from predecessor organisations and their context.

The highest scoring had existed, at that time, for almost three years – in other words, like all PCTs, a relatively young organisation. However, it was part of a stable rural health and social care economy that was in financial balance. It had enjoyed a positive inheritance from the two high performing Primary Care Groups from which it had been formed and it had no difficulty in attracting staff to an affluent and attractive part of England. The lowest scoring, by contrast, served the one of the UK's most disadvantaged and ethnically diverse communities in an inner city. Like the health economy of which it was part, the PCT was beset by historical financial deficits, it had inherited a chronic shortage of general practitioners and other key clinical staff and was desperately short of senior and middle management capacity. It had existed for a little over a year.

A key element in our work with this organisation, as with the highest scoring, was to help them to identify and to celebrate the progress that they had made and to celebrate the fact that both benefited from talented and energetic Boards and PECs. In each case the Board and PEC had shown a passionate commitment to the well being of their local communities and understood the implications of their duty of trust. In one case the challenge centred around building upon a solid inherited foundation and taking those proverbially difficult steps from the high plateaus of good practice to the summit of sustained excellence; in the other, on creating solid foundations upon which future clinical governance progress could be based.

In both of these cases and in every other high performing organisation with which we have worked, the Executive had worked collaboratively and energetically alongside the clinical staff to promote an explicit commitment to safety and quality at every level in the organisation, and to embed empowered clinical leadership within all locations and across all teams.

Because, inescapably, it is front line staff (both clinical and support) who translate strategy, intention and aspiration into concrete quality of care, in our experience high performing Boards also pay sustained attention to staff well being and morale, so that front line staff feel valued, empowered and supported in their caring tasks. Only in this way will an organisational culture evolve in which risk is minimised and learning and innovation are prioritised, so that “excellence can flourish”.

We have found it useful, in our work with Boards, to draw upon the Japanese concept of the “*Gemba*” – a word that describes points of contact between an organisation, its staff and its service users – in other words, in the NHS context, the countless occasions and locations where patients and clinical and other staff come face to face and/or interact. It is here that quality is manifest. This concept makes clear the vital importance of those who work “in the *Gemba*” and deliver “care” (whether they are receptionists, porters, nurses, junior doctors or consultants). The concept also makes clear that the key task of all other members of the organisation (whether they are Non Executive Board Members, CEOs, finance or human resources staff) is to

“support the *Gemba*” – that is, to make it as easy as it can be for patient-facing staff to deliver sustained quality of care.

We have also learned how important it is – as the precepts of clinical governance emphasise – that staff work collaboratively together not only across professional and intra-organisational interfaces but also across organisational boundaries, since it is not merely the quality of discrete episodes of care but the overall seamless co-ordination of the patient journey that guarantees the safety and the appropriateness of the total patient experience – not least for those living with (often multiple) long term conditions. We have learned that the best Boards proactively foster collaborative partnerships with other NHS bodies – and with the local social, voluntary sector and wider business community. In other words, Board must create the conditions in which, at the strategic level there is a clear focus upon the overall health and well being of the community. At the same time, if they are to improve the “here and now” quality of care for specific clinical conditions they must mandate clinicians, managers and administrators to engage in a discourse with colleagues from other organisations and sectors. When these discourses also actively engage the patients and carers they hold in common, we have learned what a powerful lever this can be for concrete service transformation and a whole system exercise of the duty of trust. In other words, clinical governance in action requires collaboration and partnership at all levels within NHS organisations and between them – from the grass roots to the Board room.

We also know from the experience of successful private sector companies, how important it is for Boards to remain strategic, outward looking and future focussed. Our work with NHS Boards has reinforced how important this is for them – but how difficult it is to achieve in the face of short term targets and a proliferation of urgent short term pressures. Notwithstanding these pressures, successful Boards look forward in order to deliver sustainable quality and needs led service provision. In any rapidly changing external environment organisations that do not adapt cannot thrive and (arguably) will not survive. In the UK the public sector reform agenda is even now gathering greater pace. This agenda promotes greater devolved power to front line organisations, alongside “contestability” and the promotion of “customer choice”.

The advent of ever more Foundation Trusts (which have greater commercial freedom and more devolved and earned autonomy from Department of Health direction) alongside a significant growth in private sector provision of NHS care (likely to represent in the region of 15 per cent of all provision by 2008) in itself represents a fundamental shift in the health care environment. Allied to profound technological advances in information management and bio-technological advances in treatment possibilities these changes will have fundamental consequences for the patterns, locations and models of care. If NHS organisations are going to continue to provide flexible, patient centred and high quality care within such a rapidly involving environment, they will need to be imaginative and forward thinking in their attention to clinical and overall governance. As the CEO of the NHS commented recently “make no mistake, NHS Boards are facing real challenges to improve their governance”. A key element in our work with Boards has therefore been to work alongside them in understanding what it will mean to be “fit for purpose” as we all work collaboratively to deliver best value to local communities and to the public purse through *Creating a Patient Led NHS* (Department of Health, 2005).

The origin of the Board Programme

The Board programme was initially developed in 2000 to complement and support the early work of the Clinical Governance Development Teams. Their efforts to generate concrete improvements in the quality of care within specific clinical areas quickly encountered organisational obstacles and resistance to change that could only be overcome with the active support of senior Executives – and of the Board itself.

In other words, the overall clinical governance support team learned that to effect sustainable improvements in care three things are essential:

- (1) the active commitment and engagement of grass roots clinical and support staff who alone can deliver “clinical governance in action”;
- (2) a positive and sustained commitment to clinical governance from the Board to foster within the staff community a positive and empowered culture in which commitment to patient safety and commitment to innovation co-exist and mutually support each other; and
- (3) a sustained commitment from the Board to assure that patients, carers and local communities are actively involved in the planning, delivery and evaluation of all aspects of the organisations work.

“Clinical governance” will only become embedded in an NHS Trust or PCT where all of those who exercise both Executive and Non Executive authority understand and act upon the duties and responsibilities that it entails:

Good leadership empowers teamwork, creates an open and questioning culture, and ensures that both the ethos and the day to day delivery of clinical governance remain an integral part of every clinical service (Halligan and Donaldson, 2001).

The Board Team initially focused upon work with the Board’s of acute NHS Trusts. Much early emphasis needed to be placed upon the creation of clinical governance policies, committees and lines of reporting and accountability so that safety and quality of care were managed down through the organisation and reported up to the Board. A Board’s scrutiny and strategic leadership of the safety and quality of care demands more than a superficial or rhetorical commitment to clinical governance. Its implementation within a complex and inter-connected health care system requires thoughtful and persistent attention to each of its constituent elements and to the inter-relationship and interconnection between these elements. In other words, there needs to be a clear strategy and focussed implementation plan (derived from and reflecting the Trusts overall clinical priorities) in relation to, for example, clinical audit. There also need to be mechanisms in place to ensure that lessons learned from audit are acted upon and that (where appropriate) they inform and improve the identification and management of clinical risks and that each of these in turn informs education and training priorities for clinical staff.

In the face of the many co-incident pressures upon them, it was clear that relatively few Boards had had the opportunity to devote sustained time to the consideration of the elements of clinical governance – and to ask themselves how they could be “reasonably assured” that each of these elements was in place and was delivering evidence to them of the safety and the quality of the patient experience. This issue is given even greater prominence by the requirement placed by the independent Healthcare Commission upon all NHS Trust Boards to complete, by October 2005, a

Draft Statement on Compliance with each of the “core” elements across the seven domains of the national “Standards for Better Health” (Department of Health, 2004a). It is clinical governance systems and processes that should generate the evidence that will underpin these declarations.

Finally, an ever growing body of first hand experience of working with NHS Boards alongside a developing research based literature on governance (and governance failures) in both the public and private sectors highlighted the need to give explicit attention not only to the “structural architecture of clinical governance” but to the culture and behaviour of the Board itself as a corporate entity.

The characteristics and culture of NHS Boards

It is worth noting that the composition of NHS Boards is, in many respects, different from those found in some parts of the private sector and in the majority of the UK voluntary and independent sectors. NHS Boards have a non-executive chairperson and a majority of non executive Directors – but these non Executives share overall clinical and other governance responsibilities with Executive director colleagues in one indivisible and corporate Board. The way in which the Board “hold the Executive to account” for the discharge of Board policy, strategy and prioritised action in relation to the clinical governance of care is therefore complex and has within itself elements of ambiguity which need to be consciously recognised and skilfully managed. A prerequisite for the resolution of this ambiguity into a healthy and productive tension (as opposed to an arid or fractious polarisation) is the emergence (over time and on the basis of experience and evidence) of “informed trust” between the two sub-groups. In our experience this can only occur when there is a clear, explicit and common recognition of the unique, legitimate and distinctive contribution that each constituency makes. Only then can a culture emerge within the boardroom that maintains an appropriate balance between trust and challenge.

Building upon the NHS CEO’s “three bottom line requirements for all NHS Boards” and upon the research on effective governance of Sonnenfeld, Nadler and others reported in the Harvard Business School, the CGST Board Team have developed a style of engagement that enables Boards to reflect upon their own composition, role, core functions and cultural norms so that they can thereafter keep under constant review their own “fitness” for their exercise of the “duty of trust” that clinical governance implies.

Developing focus on Ambulance and Mental Health Trusts

As the experience of the CGST Board Team developed and as the attention of the service became more broadly focussed, so we received requests for support and guidance from Mental Health, and Ambulance Boards and/or from Strategic Health Authorities concerned about the way that clinical governance was being interpreted and implemented in some of these organisations. It was immediately clear that, just as no two Boards of acute Trusts face identical challenges, so there are a number of profound differences in the way that clinical governance implementation needs to be understood and addressed by the Boards and clinical staff of different types of NHS organisation.

To ensure that our work was informed by these different realities, members of the CGST Board Team spent time alongside front line clinical and administrative staff –

as well as with Executive and non-Executive Directors in these settings. This taught us two fundamental lessons. One was the importance of grounding all of our work in the contextual realities of the organisations and the Boards with which we were dealing – so that we understood and could communicate with them in their own “clinical and organisational vernacular”. The other was to re-emphasise the inter-connectedness of the NHS itself. In other words it brought home powerfully to the Team the extent to which the quality of the clinically governed care provided by an Ambulance Trust was significantly influenced by – and in its own turn influenced – the quality of care available from local primary and acute providers. The same was equally true for Mental Health Trusts – though here the complexity was further compounded by the interdependence with provision made by local social or voluntary care organisations and the need for cross sectoral co-ordination and management of the patient experience and carer support. This taught us powerful lessons about the way in which the local system of health and social care can act as a major constraint upon the overall safety and quality of clinically governed care that an individual NHS organisation can provide and/or can provide a major opportunity to work collaboratively across organisational or sectoral frontiers to promote flexible, patient centred and clinically governed care along a life-long pathway. This became a key element in the feedback that was provided by the Board Team to the new Healthcare Commission – and played some part in ensuring that these themes are powerfully reflected in the developmental elements of the Standards for Better Health.

The origin of the Primary Care Trust (PCT) Strategic Leadership of Clinical Governance Programme

As the number of newly formed PCTs grew and as their key and pivotal responsibilities both as providers and as commissioners of care became clear so the need to engage actively with PCTs became a high priority. Once a team member had spent time with GPs, with doctor’s receptionists, with community nurses, with executives and non executives and with CG leads in PCTs, three things were clear.

The first was the scale of the multi-faceted clinical governance challenges that confronted PCTs. The second was the uniqueness and the complexity of their governance arrangements that resulted from the key role assigned within PCTs to the Professional Executive Committee (PEC) and to the professional Chairperson of that Committee. Together with the PCT Board Chair and the CEO, they form a core leadership triumvirate – the “Three at the Top”. Under the leadership of the Chairperson the PEC (made up of local General Practitioners and other primary care professionals, nominated by their peers) discharges many of the key clinical and other governance functions on behalf of and in concert with the PCT Board. The third issue was that the CGST Board Team lacked both the manpower and financial resource, to respond in a timely and effective fashion to the needs for guidance and support being articulated by a significant proportion of the 300 + PCTs in England and their SHAs alike.

This third problem proved the most straightforward. Through a collaborative partnership with another arm of the then Modernisation Agency, the National and Primary Care Trust Development Programme (NatPaCT), funds were identified that were dedicated to the generation of a PCT specific clinical governance programme for Board and Professional Executive Committee Members.

In order to maximise value for money – and to reach the largest number of PCTs in the shortest time, the CGST agreed to develop and pilot an innovative supported open learning process that would provide learning materials that underpinned a diagnostic questionnaire. The questions were designed to be answered by every individual member of the Board and PEC and explored every aspect of the organisations clinical governance duties and responsibilities. The programme sought to define and respond to the nature and scale of the multi-faceted challenges facing PCTs and to address and seek to clarify some of the complexities arising from the duality of Board/PEC clinical governance responsibilities and roles. Despite initial concerns that the time demand of engaging with such a detailed analytic process would be a major obstacle to participation (not least from hard pressed GPs and other clinical staff) more than 60 PCTs took part in an evaluated pilot programme and more than 1200 members of PCTs Boards and PECs completed the diagnostic programme. The impact of the programme at the level of the individual PCT – and the powerful messages that emerged from a meta-analysis of all of the data which was shared with all participating PCT and the wider primary care community generated powerful learning.

Key Learning about strategic leadership of clinical governance success factors in PCTs:

- The calibre of the “three at the top” and the quality of their collaborative working.
- The pro-active management of the Board/PEC interface, the investment of time in face to face discussions and debates.
- An ongoing two way flow of “intelligent information” between them so that there is clarity and consensus about their respective roles and functions.
- The extent to which the Non Executive Director role is understood and valued by Board and PEC members alike.
- The clarity and transparency of clinical governance structures, roles and responsibilities.
- The capacity and the calibre of a middle management tier that is able to operationalise existing strategies and to free senior executives to concentrate upon strategic development.

This learning was shared with the Healthcare Commission, with the National Audit office and with other national regulatory and quality support agencies. The key learning was also embedded in revised and refined definitive learning materials and the programme was rolled out in 2004 to a further cohort of 30+ PCTs. This generated some interesting evidence of the progress by made by the PCT community on the “ten year journey” of clinical governance implementation originally described by Donaldson, Halligan *et al*. In the intervening year the mean score advanced from the 5.2 recorded by the 2003 cohort to 5.8 (Figure 1).

The programme has provided unique snapshots of the stage/stages of clinical governance implementation in primary care and has been one powerful stimulus to the development of focussed streams of work that have responded to the priority needs identified by more than 30 per cent of all PCTs in England as well as to those of other

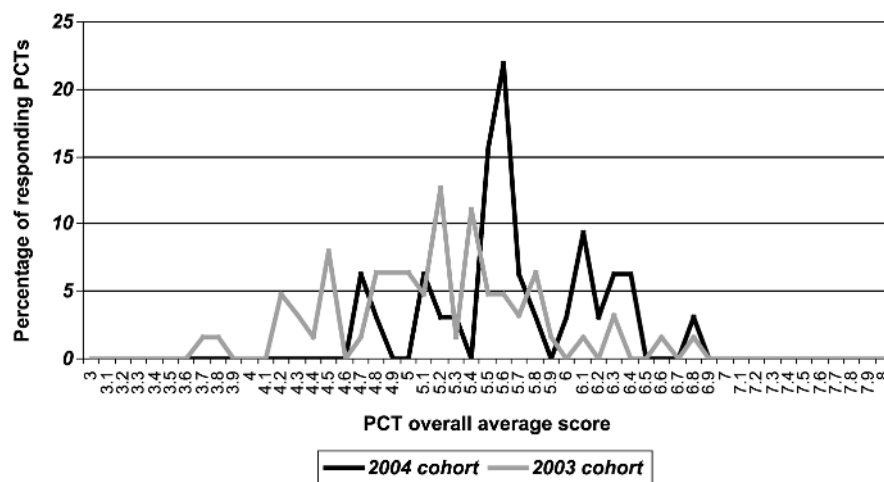


Figure 1.
Distribution of PCT
overall average scores,
2004 cohort vs 2003 cohort

NHS organisations, patients and their carers. This has been a concrete response by CGST to the fact that work with a Board, though essential is not, of itself, sufficient to promote the systematic exercise of the duty of trust to patients.

Additional priority CGST Board Team work streams

As a direct result of the outcomes of the PCT Strategic Leadership Programme the Team has developed the “Commissioning for Quality” programme that has, to date, engaged more than sixty PCTs and their local network of acute providers in the development of commissioning strategies that embed clinical governance in all aspects of the commissioning cycle for locally prioritised clinical conditions and help these PCTs to generate evidence of compliance with the commissioning focussed elements of Standards for Better Health:

Commissioning quality care for our local population is the single largest challenge that the PCT has to face (Clinical Governance Lead, PCT March 2005).

It is not only in relation to the commissioning function that Standards for Better Health has provided a further opportunity to highlight and prioritise the quality of patient centred, clinically governed care. Through close collaborative working with the DH funded Health Care Standards Unit and with the Healthcare Commission, the CGST Board Team has made explicit the connection between clinical governance and the standards and has already been able to support more than 150 NHSTs/PCTs to prepare actively and constructively for the “Statement on Compliance” with the “Core” standards that they will be required to make in April 2006.

Although the initial focus of work had been upon organisations and their own clinical governance, the management of complex and long term conditions demands new forms of inter-organisational governance. Work with the Boards of the 20 + Cancer Networks in England together with new collaborative work with a Coronary Heart Disease Collaborative and with the Diabetes National Service Framework team has proved to be a rich source of learning and provide excellent opportunities to learn

about “clinical governance in action” across organisational boundaries and along the patient pathway.

In order to remain “fit for purpose” the composition of the Board Team itself has had to change and adapt as the scope and nature of the work has developed. The Board Team began its work with just four members but it has grown and has diversified its experience and expertise base so that it is better able to respond to the needs of the service and the system. The majority of the Team has always been drawn from those who have had experience at CEO level in acute Trusts or Health Authorities, but over time this has been complemented both by those with Executive experience within PCTs and with staff with a wider experience at Board level in the voluntary and social care sectors.

Crucially, the Team has strengthened its clinical base to ensure that it can speak with authority to the medical and nursing communities and, just as importantly it now has Associate Directors (as joint appointments with the Patient Experience Team) who bring a wealth of experience and wisdom gleaned from their extensive experience as Patients and as Carers. They in particular have helped to ensure that patient and carer perspectives remain at the heart of all of our work with those who govern NHS organisations. With their support and the active participation of patients and carers themselves we have captured, in a growing range of “Digital Patient Stories”, first hand messages about what the duty of trust means in practice – and the consequences for individuals where this duty is not exercised. Through our work with carers themselves and the voluntary sector organisations that represent them, we have tried to raise the profile of all those who care at home (whether from love, duty or necessity) and whose massive contribution to the safety and quality of care provided to patients is too often invisible, unrecognised and unsupported.

Because the Board Team is a small one, we have learned that we need to work in collaborative partnerships not only with NHS organisations but with other national and local bodies if we are to maximise the positive leverage that we can exert. Through one such initiative with the NHS Alliance (a body that represents a substantial proportion of General Practitioners) we were able to respond to a key message from our PCT work – namely that front line clinicians felt detached from the NHS reform agenda. This led to the development of a strategy for engagement and the influential *Making a Difference* publication that was commended by the Secretary of State for Health.

Finally, the Board Team has learned how important it is to share the things that we learn from the Boards with which we work with the wider national and international health and social care community. Through presentations at international and national conferences and through a stream of publications in the professional literature we have attempted to capture and disseminate our emerging thinking and to develop an international network of linkages to other organisations and bodies, from the private as well as the public sector, who share our interest in promoting effective governance.

Summary and conclusions

If anything, the importance of strategic clinical governance leadership from Boards has grown in the five years since CGST was founded. The increased devolution of authority from the centre to local organisations and the challenge of translating the aspirations set out in the *NHS Improvement Plan* (Department of Health, 2004b) and

Creating a Patient Led NHS (Department of Health, 2005) into reality at the same time as demonstrating compliance with the national *Standards for Better Health* all pose major clinical governance demands upon those who govern health care organisations and networks. It is our belief that NHS Trusts and PCTs have already made significant progress to improve the safety and the quality of the care that they provide and to enact their duty of trust to patients and to local communities. However, clinical governance is a long and demanding journey and the challenges of the next five years are likely to prove no less exacting and no less fascinating than those of the past. As the CEO of the NHS wrote recently:

Since 2000, we have built up capacity, delivered some early reforms...and made the step change in performance necessary to improve services . . . at the same time we have introduced clinical governance, standards and new arrangements for securing patient safety.

But the ambition for the next few years is to deliver a change which is even more profound – to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health – a fundamental change in our relationships with patients and the public. In other words, to move from a service that does thing to and for its patients to one which is patient-led, where the service works with patients to support them with their health needs. (Sir Nigel Crisp, Introduction to *Creating A Patient Led NHS* (Department of Health, 2005)).

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Developing large group working in clinical governance

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Abstract

Purpose – To report on how service changes can be accelerated by working with large groups that represent all parts of a complete healthcare service or care pathway, during specific events, and using well-defined facilitation techniques.

Design/methodology/approach – Case examples are cited from the Clinical Governance Support Team's "protected time" programme and subsequent work, and specific quotes and examples from large group events are used to describe the potential impact of the approach.

Findings – Established group facilitation techniques can be adapted for use in the context of a large group representative of a whole clinical system or pathway, to accelerate service improvement.

Originality/value – The paper reports on the practical findings from Clinical Governance Support Team group facilitators working on large group events from a number of UK NHS Trusts.

Keywords Clinical governance, Service improvements, National Health Service

Paper type General review

The whole system in one room

How do we improve what we do for people who need urgent care? Over two days a group of around 40 people met in a local hotel to address this issue. In one room, all parts of the emergency care system that a patient may come into contact were represented. They included nurses, hospital consultants, general practitioners (GPs) ambulance personnel, patient groups and a local primary care trust. Getting the "whole system into the room" (Weisbord and Janoff, 2000) as a critical mass of people required careful attention to planning, and to design.

The two day event was highly structured. Getting people to work together, to agree and act on decisions to improve the patient's experience involved closely facilitated interventions designed to obtain concrete outcomes, whilst also encouraging creative and innovative ideas among all present.



External facilitators with experience in adapting a range of tried and tested large group working tools and techniques (see Appendix Table AI) supported the event, along with a “design team” comprised of a core group of stakeholders whose individual ideas contributed to the purpose of the event (Pratt *et al.*, 1999). They would also work together to identify its outcomes. The facilitators benefited from their insights into the mood of the participants; their issues, beliefs and any potential conflict that may affect management of the group.

Facilitators started the first day by uncovering the different perspectives of participants around what was happening in emergency care “now”. What was working well? What might people start doing differently? Participants also shared their understanding and representations of each other. For example, GPs were able to explain some of the reasons why they may send a person to Accident and Emergency (A&E) at the hospital, even though (to some) it may appear an inappropriate place for them to be. They were able to talk about the kind of factors that they had to consider in making such decisions.

Participating “stakeholders” then process mapped (NHS Modernisation Agency, 2005b) the current emergency system from the patient’s perspective, using case study examples, developed around the types of problems that a patient could present with in A&E. This exercise enabled them to identify key changes that could be made to the process and identified opportunities where things could be done differently. The surprise for many was the complexity of an individual patient’s journey across primary and secondary care.

Senior management support was an explicit part of the event. It was opened by the Director of Nursing and the chief executive officers of the PCT and Hospital Trust showed solidarity by visiting the event together. They talked with the group and identified messages from the process mapping that they needed to take back to the senior management of their organisations.

Overall, the event helped the participating stakeholders to make connections across the whole health economy and think more systemically and holistically about the experience of the patient when they need accident and emergency care. This was only achieved once the focus of the original event was shifted from “Improving the A&E department” towards “What can we do when people need urgent care?” The latter highlighted the need for partnership working and shared responsibility across traditional organisational boundaries. It focussed the event more clearly on improving the experience of the person in receipt of services.

This is not to say that facilitating this event was easy. For example, two people in the room were united in their belief that they could do nothing to improve the patient experience of emergency care. No improvement to A&E could be made without additional resources. Resources were identified and acknowledged as an issue, before facilitators asked the group to devise changes to the service that would require no resources, only a different way of working. People were allowed to say what concerned them, and after their views had been heard, the whole group was able to move on positively to what could be done and how.

A background in “Protected Time”

The case above demonstrates how a team of facilitators within the NHS Clinical Governance Support Team worked with a group from across a system of care to explore new ways forward for service improvement. The origins of this method of working within CGST programmes is in a team of national facilitators set up to support a national initiative called “Protected-Time”, which was launched as a pilot programme in 19 NHS organisations across England in early 2001 (Hedley *et al.*, 2003). The programme aimed to bring about patient and service benefits through using tried and tested methods to accelerate improvement in services for patients.

A core part of the programme, and one of its successes, was the events held at the 19 sites, over a few days, where key stakeholders came together from across “whole systems”; from secondary and primary care, community care and in some cases housing and social services. These events were designed, planned and facilitated in a style many had not worked with before. Usually they occurred over two or three days, but had the flexibility to operate over, say, consecutive weeks, or as a one day event for a large audience, followed by events for subsets of this group and a final event for everyone. Once the whole system was brought together in the same room, at the same time, people could gain a collective perspective of the patient journey in its widest context, share ideas, agree an action plan and measures for success and commit to its delivery in their local organisation and community. The underpinning philosophy was that people will support what they help to create.

Each of the sites’ accelerating service improvement projects had senior level sponsorship from within the organisation. This was an important factor in addressing some of the difficulties around releasing key staff and ensuring sustainability after their stakeholder events. High level steering groups were also responsible to oversee the process in its entirety, channelling progress to Trust Boards.

The consequence of meeting

The design of the whole systems event encouraged healthcare professionals to engage with stakeholders in their service differently, and learn from each other to produce improvements in the services offered to patients. One consequence was that new relationships were formed across professional boundaries of care (see below) and existing relationships were strengthened:

Coming together for patients

“Before these three day events you would never see anyone from the therapy unit getting further into the community hospital than the shop. Things have changed quite a lot since then. In fact we had a power cut the other Friday. We don’t have a generator back up and we had virtually all the beds full. We had lots of people on electric pressure relief mattresses and so we went over to the therapy unit equipment store and borrowed every single mattress they had plus their hoists. And the whole lot came into the community hospital to bale us out, for what turned out to be only a few hours in the end. Now, that would never have happened in the past” (Project Manager, Protected-Time Celebration Event, November 2002).

For many, working within a large group setting challenged current thinking and the ways in which different NHS professionals related to each other, both in and beyond

their own organisation. The case study below demonstrates that raising one simple question among primary and secondary care colleagues can have implications that go beyond “the room” to the patient’s experience of a whole service:

“They had never had that discussion”

During a large event workshop, a consultant orthopaedic surgeon talked about the number of follow-up patients he had coming through his out-patients clinic. This was a very big list of patients. He mentioned that he followed up his patients who had received hip replacements for life.

A GP in the room asked, “Why do you follow them up for life?”

The surgeon explained that he was looking for a certain complication.

“But, I can look for that. I’m aware of it”, said the GP.

“Could you really?” said the consultant.

The GP said she would see the patient anyway, so of course she could do the follow up too.

And an agreement was made there and then in the room.

The consultant and the GP had never had that discussion before, and yet it had huge implications. The surgeon had been following up all of his patients, initially every few months and eventually every year for life. The outcome of this short discussion was that around 40 patients per year no longer needed a hospital appointment. These were usually elderly patients who may have required ambulance transport and for whom travelling to hospital could be very difficult. Slots in the surgeon’s busy orthopaedic clinic were also freed up. This was just one hospital and one GP in the area, but what the surgeon didn’t realise was that the GPs were aware of this complication and were more than capable of assessing a patient for it.

Building a team to work with large groups

When the Protected Time Programme came to an end in October 2002, there was a continuing demand for events which brought people together to accelerate the process of improving patient care and bring about “real time” clinical governance.

The national facilitators had trained local facilitators for each of the “Protect-Time” sites in facilitation techniques, and, with other experts in the field, delivered a series of workshops on whole systems/large group working. (NHS Clinical Governance Support Team, 2001) This was to ensure that each organisation had a person or group of people with the skills required and the dedicated time to maintain momentum after the event.

These experiences meant that the facilitators had acquired a range of skills and knowledge about large group working which could equally be applied to supporting other CGST programmes. In 2003, members of the Protected-Time team began working as a clinical governance Large Group Work team.

Tools and techniques on whole systems/large group methodologies were available in the NHS Modernisation Agency (of which the CGST was a part) but had not been widely used in a concerted way to accelerate whole systems service improvement, with ongoing support and capability building at a local level. The Large Group Work Team realised how good these tools were as a starting point and wanted to explore other methodologies within this field. Increasingly, they were asked to support events that were occurring through clinical governance work, by helping to design and deliver events and agree on ways to capture the impact and the outcomes. The CGST decided

to build on this learning to support large group working techniques across the CGST and the NHS.

Additional experienced facilitators were recruited onto the team from primary care, learning disabilities, social care and acute care to broaden the team's knowledge base. They brought with them, a range of approaches and experience, including coaching and facilitation techniques. The team engaged with a variety of internationally renowned and proven experts in the field and a small group from the CGST and wider Modernisation Agency were trained in this area. There was now an opportunity to work with and adapt multiple Large Group Working methodologies to bring about change in health and social care organisations across the NHS. Work was commissioned from within the CGST from its other programmes to help NHS Trusts to:

- diagnose organisational issues;
- create the future direction and priorities for services;
- improve service delivery;
- increase participation and collaboration in decision making; and
- explore issues around patient and public involvement and develop techniques to ensure equity of patient and user participation.

Over a period of a year team members started to work more regularly on behalf of other teams within the CGST, sharing their skills and knowledge more extensively and gradually diversifying to establish individual roles within the:

- Performance Development Team – substantively in facilitating organisational development within nil-star rated NHS Trusts in England.
- Patient Experience Team.
- Team Resource Management Team-using facilitation skills to work with large organisational and cross-organisational teams.
- Primary Care Team.
- Board Development Team.

Learning from large group working

Benedict Bunker and Alban (1997) have said "It is not the events that comprise the change process but the change process itself that counts". As the Appendix shows, many of these processes, and these are only a sample, overlap and compliment one another. Weisbord and Janoff (2000) have considered the variety of large group methodologies available and view the concept of a "best model" as an anachronism, preferring to see a "kaleidoscope" of methods, where "we are all working with the same bits of coloured glass, evoking new patterns as we gain experience." They highlight the importance of an exploration of these methodologies as a way of "helping people experience wholeness in a time of unprecedented complexity, bewilderment, and change". The learning of facilitators in large group working methods has led them to take particular components of these methodologies to create hybrid interventions on a

bespoke basis, in response to particular organisational circumstances or needs. For example elements of *Real Time Strategic Change* combined with *Future Search* and “accelerated service redesign”.

Some of the learning from facilitating large group working events in different organisational settings and climates is summarised below:

- Facilitators need to meet with organisations early in the process to clarify the purpose and objectives of the event and set up design teams.
- The core group of stakeholders who make up the design team is often the key to an event’s success. Developing local capacity and capability is essential to ensure sustained change.
- The event design needs to be flexible. It may need to be adapted on the day.
- Stakeholder analysis is a critical part of event planning.
- The right people need to be in the room. For whole system working, ensuring representation of all the “system” (including patients and carers) is in the room is key.
- The style and purpose of the event needs to clearly match with the selection of appropriate methods, tools and techniques.
- The purpose of the event has to be absolutely clear and agreed by all the stakeholders or the group will work towards disparate goals.
- Senior management commitment must be explicit.
- Ensure variety through a mix of presentation and group work. Long speeches at the beginning of an event can “turn people off”.
- Giving people “a voice” (Benedict Bunker and Alban, 1997) and making it “safe to speak” early on means participants can express their views and air any issues or concerns they brought with them.
- Jumping into “pet solutions” is to be avoided (“Oh, we have been here before”, and “If we just do this, it will be fine”). This may result in a narrow perspective of a complex, whole system issue.
- An evaluation of every event is important to get feedback from participants about whether it worked for them.

Conclusions

The whole systems approach to large group working in organisations means that clinical governance is implemented in “real time”, at the event. At the heart of the whole system, like clinical governance, is people and the way that they relate to each other. It is about openness, honesty, and rigorous, structured examination of systems and processes which make up all parts of the patient journey. It is about flattening out hierarchies and removing boundaries between groups, service providers and partners. It is also about building in measures to monitor progress, and ensuring patients and users have an equal voice in the relationship, through careful coaching and facilitation.

The message from the clinical governance facilitators is:

Don't underestimate the number of new and innovative solutions that can be generated in an environment where the knowledge of the system, the shared commitment to improvement, and the right people who know about the system, who care about the system, and who can do something about the system are together in one room.

Lesson learned from large group working

Never underestimate the power of pooled collective understanding to solve seemingly intractable problems in hitherto unthought of ways.

The biggest mistake

Getting sidetracked into over theorising and forgetting that the basic tenant here is: "What would I want from this service for my loved ones, or myself, how do we make that happen, and how do we prove it's happening?"

What has to change to enable clinical governance to be delivered?

An equal partnership of staff and users need the opportunity to be heard if they are to be encouraged to take responsibility for the services they deliver.

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| Method | Summary |
|------------------------------|--|
| Open space | Participants create the agenda, topics and groups for discussion. Voluntary self-selection means that everyone has the choice to join conversations that interest them/move between sessions they have signed up for. Law of two feet applies: if you neither learn nor contribute – move! (Owens, 1997) |
| Appreciative inquiry (AI) | A process that involves people in conversations to recognise and build on what they like and appreciate. It encourages people to reflect and learn from what has worked well and apply this to current problems (NHS Modernisation Agency, 2005a). |
| Real time strategic change | Using interactive large group meetings to enable people across entire organisations to collaborate in fundamental, accelerated change. People’s daily actions are aligned with an overall strategy they helped to create (Jacobs, 1997). |
| World café | A way to quickly explore topics and come to a shared understanding in a medium/large group by rotating through a series of small discussion groups (NHS Modernisation Agency, 2005a). |
| Future search | Large group action planning meeting that brings a “whole system” into the room on a task-focused agenda and towards a common future. The whole is explored before acting on any part. Three aspects are: a meeting design based on core principles; a philosophy and theory of facilitation; and a change strategy that anyone can join (Weisbord and Janoff, 2000). |
| Accelerated service redesign | A way of combining process mapping with a series of facilitated events. It engages a wide range of participants in a series of activities focused on action planning for improvement of a specific service (NHS MA, 2005a,b). |

Table AI.
Examples of large group methodologies

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Team Resource Management and patient safety

A team focused approach to clinical governance

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Abstract

Purpose – To review three key areas of work managed by the Team Resource Management and Patient Safety Team (TRM), itself part of the Clinical Governance Support Team.

Design/methodology/approach – Information has been collected from TRM staff, UK NHS Trust staff, research publications and reports.

Findings – As treatment programmes become more complex and health care is delivered by multidisciplinary teams, the quality of care and of patient safety is ever more dependent on effective team working. External support and expertise can be effective in helping clinical teams achieve their full potential. Safety and team work practices from other domains such as aviation can be successfully translated into the work of clinical teams. Specific coaching input can also improve the effectiveness of teams and, where teams are recognised as having difficulty working together, external support in particular approaches and techniques can resolve team working problems.

Originality/value – This review summarises the benefits of a healthcare support function which is specifically dedicated to the understanding, supporting and shaping of clinical teams.

Keywords Clinical governance, Patients, Human resource management, Team working, National Health Service

Paper type General review

From the outside it looked like any other clinical unit in the NHS. The corporate signs were there, directing the lost and uninitiated to a welcoming reception. The staff smiled and, despite the busy atmosphere, had time to say “hello”. But at its heart there was something fundamentally wrong there, and it was as if everyone knew it, but no-one was telling. A few conversations were enough to reveal that the staff were of the opinion that they were doing better than the national guidance – so much better that they had abandoned the necessity to work to national guidance and generic clinical standards. Collectively, and over the years, they had managed, ever so elegantly, to detach themselves from scrutiny, and those around them had turned a blind eye. There was no doubt that the staff *really did* believe that they were working to the best interests of their patients. To them, clinical governance was like the unwelcome wasp at the picnic: an imposition that distracted them from what they considered their real job to be, and if they kept going at it long enough, it would be discouraged and ultimately, batted away, never to return (TRM Team Member).



Introduction

What have teams and team working got to do with Clinical Governance and improved patient care? In short a great deal, as the following quote from staff at Torbay Hospital (part of South Devon Healthcare NHS Trust) illustrates:

... [team working] changes in the department have improved morale immensely. We continue to work hard, but we are more organised and benefit from better peer support, both practically and emotionally. We have a more positive working attitude and concentrate on changing matters within our control. We are far more open with each other, sharing information and giving constructive feedback to improve our clinical practice further. Overall, we are less stressed and are able to provide better patient care (NHS Modernisation Agency, available at: www.cgsupport.nhs.uk/Resources/Case_studies/Team_Coaching/TRM_Staff_Morale.asp).

Staff from the Trust participated in a Team Coaching Programme provided across the Torbay healthcare community by the Team Resource Management and Patient Safety Team (TRM) of the Clinical Governance Support Team (CGST). The programme was integrated with ongoing research on Team Based Working by Aston University in this healthcare community and both will be described in more detail below.

This article will describe:

- (1) The importance of effective team working for improved patient care and safety.
- (2) The NHS context:
 - The key areas of work of the Team Resource Management and Patient Safety Team.
 - Building on research and good practice in human factors in other industries;
 - team coaching.
 - Working with “troubled teams”.
- (3) Outcomes and achievements.

The importance of effective team working for patient care and safety

As modern health care becomes increasingly complex it is essential that the members of multi-disciplinary teams work together effectively as described by Arthur *et al.* (2003).

Team working and leadership were highlighted as being at the core of Clinical Governance (Sally and Donaldson, 1998) and emphasised in the government’s vision for improved quality of care (Department of Health, 2000; 2001).

It is known that poor team working can endanger patient safety (NCEPOD, 2002; West *et al.*, 2002); this translates into the stark reality that poor teams put patients’ lives at risk (Mayor, 2002). Conversely effective team working leads to better clinical outcomes (Borrill *et al.*, 2000a, 2000b; Haward *et al.*, 2003; West and Slater, 1996; West and Wallace, 1991).

Results of research carried out on team working and effectiveness in the NHS by Borrill *et al.* (2000b) of Aston University led them to conclude that high quality and innovative patient care is provided by teams whose members:

- emphasise quality;
- state clear and shared work objectives;
- have high levels of participation in team work;
- hold good quality meetings;
- communicate well; and
- contain a diverse range of professional groups.

They also showed that these teams are better motivated and have lower stress levels, so confirming previous reports from Firth-Cozens and Moss (1998).

The NHS context

Although the benefits to both patients and staff have been established, challenges exist to developing good practice in effective team working throughout the NHS, caused in part by:

- barriers between different professional groups;
- multiple lines of management accountability;
- perceived status differentials; and
- absence of organisational structures for supporting teams.

Huge variation exists in the levels of cohesion in cancer services teams (Birchall *et al.*, 2003; Department of Health, 1999). Indeed over 80 per cent of NHS staff surveyed indicated that, although in a team, fewer than half thought that their team operated effectively. Closer examination and sampling has suggested that the true figure may in fact be less than 20 per cent, rather than fewer than half. (NHS Commission for Health Improvement, 2003). An earlier study showed variation in the perception of how well specific teams worked. Doctors considered team work and communication to be of higher quality than did nurses in the same teams (Sexton *et al.*, 2000).

The team resource management programme and patient safety team (TRM)

In 2002, the Team Resource Management and Patient Safety Team (TRM) was formed within the Clinical Governance Support Team (CGST), partly in response to this research evidence. Its purpose is to ensure that national efforts to articulate and support the clinical governance agenda properly recognise the significance of team working and its impact on the quality and safety of patient care. It also provides practical, direct support and expertise to front line NHS organisations that have a specific and identified need to improve team working.

Team working is a complex area and the key aspects that must be addressed by team members and organisations are:

- commitment by organisations to developing an ethos of good team working;
- effective leadership;
- thorough understanding by all staff of the principles of team working;
- training in tools and techniques;
- sharing objectives and responsibility in working practice; and
- co-operation between disciplines and hierarchies.

Teams do not become effective just by acknowledging the need for this, or even wanting to; teams need support to effect change. Staff in those teams which are already effective have to be motivated in order to keep abreast of, and adapt to, new ways of working. Those teams who are not able to work well together need expert help in learning the tools and skills which can convert a “group” into a team, whose members fulfil the criteria outlined by Borrill *et al.* (2000b).

To provide this range of support, the team's efforts are directed into three key areas:

- (1) Participation in, and the promotion of, research addressing:
 - how team effectiveness contributes to patient safety, (with particular emphasis on understanding the significance of human factors in other safety critical industries, such as aviation); and
 - the factors influencing the effectiveness of healthcare teams (as described above).
- (2) Promoting the concept of team coaches – through the provision of Team Coaching Programmes and ongoing training and development for coaches.
- (3) Bespoke interventions with poorly functioning teams, or teams within poorly functioning organisations or services.

These are described in more detail below.

Building on research and good practice in human factors in other industries

Background

The TRM team looked at research and good practice in organisations where the highest standards of safety were essential. After all why reinvent the wheel? Among commercial industries, including the oil industry, the aviation industry has had to address the enormous role played by human factors in ensuring safety. Comparisons between health care and aviation had already been drawn (Sexton *et al.*, 2000) and had been established as a good model.

As the technical provision for aircraft safety improved, the aviation industry recognised that the majority of accidents and “near misses” were attributable to human factors aspects as opposed to weather, technical faults etc. Collaborating with researchers from the University of Texas, the industry introduced the following concepts into training, to reduce the risks associated with human factors issues:

- team building;
- techniques of group decision making;
- briefing and debriefing strategies;
- situational awareness; and
- stress management.

Their training programme, Crew Resource Management (CRM), trains cabin and cockpit crews together, combining training in technical and human factors. It is mandatory and all crew members must achieve required standards in both aspects for annual re-licensing. Underlying CRM is the acceptance that human error is ubiquitous and inevitable; the aim is to manage the risk through error countermeasures incorporating three lines of defence:

- (1) procedures for the avoidance of error;
- (2) analysis of these procedures; and
- (3) management procedures for use when errors occur.

Avoidance of error includes a pro-active approach through confidential, non-jeopardy reporting of safety concerns. In the event of an accident or incident endangering safety the events are reviewed as standard procedure by a process called “Error Chain Analysis” (ECA). ECA is based on the understanding that serious errors seldom have a single cause, but result from the culmination of a number of factors, and investigates all stages leading to the incident. Essential to success is a non-punitive culture (Helmreich *et al.*, 1999; Helmreich, 2000). The industry has accepted that error is inevitable but has introduced CRM and ECA as a robust system for managing it.

TRM’s approach

The TRM team commissioned research in three Trusts to investigate whether aviation’s human factors approach to safety can be transferred successfully to health care. Error chain analysis (ECA) in the health care setting involves a process of mapping the events leading up to an incident by examining each step in the chain and ensuring that each is covered, even as far back as before the patient enters the service.

Training

Global Air Training (GAT) and Terema, are organisations providing accredited training for the airline industry and are now offering a range of training programmes and interventions applicable to teams in the NHS (www.globalairtraining.com/health.htm and www.terema.co.uk/).

For this research training was designed and delivered by GAT and analysed and evaluated independently. A team approach to incident investigation was found to lead to a more thorough analysis of root causes and was endorsed by the Trusts, all of whom have incorporated an Error Prevention Programme into their training and day-to-day practice (NHS Modernisation Agency, 2003).

The ECA used by GAT has eleven links each of which may individually cause errors, but which if they become cumulative, will almost certainly do so and examination of serious incidents in healthcare illustrates this very clearly.

Examples of the links are:

- *Ambiguity*: two different sets of clinical guidelines in use.
- *Fixation or pre-occupation*: staff under pressure – fixation on deadlines/targets.
- *No one “flying the aircraft”*: no clear leader/lead clinician, staff groups with different managers, patient not included in the “team”.
- *No one “looking out of the window”*: focus upon one aspect of care/set of symptoms, safety culture shown to be lacking.
- *Incomplete communications*: failure to check written guidance is understood, poor record keeping.
- *Violating limitations and minimum standards*: patients treated outside working hours despite lack of trained staff.

Terema has also completed a number of different assignments introducing human factors concepts into Trusts. For example they offer a one day course in meeting the challenges presented to teams who come together to provide night cover i.e “Hospital at Night”.

Terema also specialise in working with Trusts where teams experience difficult professional relationships or communication problems. Programmes have evaluated well and appear to have high face validity with participants. In some cases the Terema work has been supported by the introduction of team coaching.

The Chief Executive of a NHS Trust requested the help of CGST as a result of a fatality thought to be caused by failure of local systems. The TRM team and GAT worked with the Trust on their human factors approach to safety and risk management. ECA again proved useful and led to the creation of a single practical action plan to prevent similar incidents (NHS Modernisation Agency, 2004).

The University Hospitals of Coventry and Warwickshire, recently awarded first prize in the “Hospital Care” category in the “Quality and Safety in Health Care Awards”, acknowledge their partnership with Terema (national_award.htm).

Evolution of programmes

Initially training within the NHS was commissioned through the CGST, but after evaluation had demonstrated its relevance to, and success in, the health care setting, organisations and individuals now approach GAT and Terema directly.

Lessons learned from using error chain analysis in a clinical setting include:

- That the process of itself leads to a better quality of incident investigation.
- It enables a greater contribution from those involved and the information gained is broader based and more accurate.
- The style encourages a move away from “blame” and allows for a deeper, more frank analysis of the facts surrounding the incident.
- It encourages co-operation and a team approach to analysis and will lead to breaking down of barriers between departments, teams and individuals.
- It helps the investigation team to take account of all contributing factors and systems and raises awareness of the human factors.
- Training and practice in using the process highlights potential causes leading to prevention.
- The process can reduce errors; litigation, wasted capacity and patient stay.

Team coaching

Background

In the commercial sector, good HR practices are recognised as increasing efficiency and a similar body of evidence is now building up in the NHS (Borrill *et al.*, 2000a; 2000b). The second strand of the TRM team’s work consists of developing the concept of team coaching to support team based working – an example of such good practice.

TRM’s approach

Team coaching has been successful in supporting workplace teams undertaking service redesign and improvement work in key NHS sites such as Leicester Royal Infirmary in the 1990s and, building on that experience, the TRM team designed a programme for training coaches in the NHS.

In order to increase the rate at which training could be provided, and to meet demand, much of the delivery was contracted out to two consultants who were selected on the basis of a shared philosophy (John MackMerish and the Universal Improvement

Company). By Autumn 2002 a programme was piloted, evaluated and then rolled out in 2003.

Training

Courses to train people in the tools and techniques of team coaching are delivered to groups of 12-16 participants and are composed of a series of modules over nine months – one of three days followed by six of two days. After the first session, participants work on a project or a practical problem developing their experience in utilising the techniques learned while gaining capability and confidence. A key feature of the sessions is the exchange of experience, discussion and the evaluation of progress on workplace projects by all members of the group. An ethos of mutual support is built up between participants. Support is given between sessions online, by telephone or, if necessary, face to face.

Attendance enables participants to work within services or across organisations often in addition to, or as part of, their substantive role and some have become full-time coaches as organisations have recognised the value of their contribution. Coaches are invited back for refreshers, events and training in specific techniques and have set up a mutual support network.

After team coach training, one participant reported:

I knew about the tools, but I didn't know the practicalities of them, I didn't know how to use them ... to change anything you've got to get down there and do it. The team coaching programme was a valuable and essential environment to learn and use these tools.

Between 2002 and 2004 the TRM team delivered nine programmes of training with between eight and eighteen participants. Such has been their impact that a number of organisations have subsequently commissioned additional programmes at their own cost. By October 2004, 299 organisations had put one or more participants through the programme.

Recruitment to the programme

Initially participants were recruited nationally, but although this appeared to be fair to all regions, it proved difficult for trained coaches to engage in mutual support across a wide geographical area. The TRM team now believes that organisations within a defined health economy (as in West Midlands South Health Authority), or those involved with "national initiatives" (such as the development of Treatment Centres or E-booking) and where there is commitment to change and service improvement, will benefit most from team coaches. The learning from their programmes can be transferred to other health economies or other organisations in the NHS undertaking similar initiatives.

Success in the Torbay healthcare community (South Devon Healthcare NHS Trust and Torbay PCT), is also an illustration of this. In addition, they were part of ongoing research with Aston University following that undertaken previously in relation to Team Based Working (TBW). Across Torbay, change management and service improvement are part of the culture, all staff within the organisations are aware of a team working ethos and a critical mass of staff have experienced training in team based working, supported by team coaches trained through the programme. Development of team working skills is certainly more successful when team coaches

are embedded in the structure of the organisation working alongside teams on a day-to-day basis.

Factors contributing to the success of team coaching in South Devon Healthcare NHS Trust:

- Total commitment of the organisation to the role of TBW in ensuring high quality, safe patient care.
- TBW launched across the Trust.
- Team facilitators (coaches) nominated by their own department.
- Team coach training provided through the Team Coaching Programme.
- Facilitators (coaches) recruited from staff of different grades.
- Facilitators (coaches) meeting monthly to maintain momentum.

The design of the training programmes has evolved over time in the light of experience and the TRM team now uses a model of eight days basic training on tools and techniques followed by an optional advanced programme on, e.g. adult learning, change management, conflict resolution.

Outcomes and case studies

The success of the coaching programme is reported by NHS staff from different organisations who describe the benefits of using an experienced team coach:

With support and advice from the team coach I was able to initiate some changes within the department that have not only helped the staff with their workload and improved the patients pathway through the department, but have met government targets and met with the approval of all our consultants. We have improved our communication in so many ways. Our meetings run more effectively, all the agenda items are time bound, which the nominated chairperson is responsible for monitoring. We now find that we can discuss more issues and our meetings are productive. They are democratic and safe, enabling us to speak honestly without hierarchical barriers.

(Case studies are available at: www.cgsupport.nhs.uk/Resources/Case_studies/#TRM).

Working with troubled teams

Background

Another fascinating and challenging facet of the work of the TRM Team is working directly with “troubled teams” – teams experiencing difficulties working together (Arthur *et al.*, 2003).

As described earlier and shown by the Aston group (Borrill *et al.*, 2000b), effective team working depends on good communication, shared objectives and shared accountability for meeting them. It has also been shown that this is often far from the actuality and problems can arise within teams for a number of reasons which include:

- no team meetings;
- lack of leadership;
- no clear vision for the service;
- undemocratic decision making;
- inequality of working conditions and practices;

- personality clashes; and
- staff who are unable or unwilling to participate as a team player.

Troubled teams, who may be within any type of NHS Trust, may be referred in a number of ways, e.g. through the Healthcare Commission; the Chief Medical Officer's office, Department of Health; the National Clinical Assessment Authority, a Strategic Health Authority or an individual Chief Executive. Requests do, at times, out-strip the capacity to respond.

TRM's approach

Before engagement, there has to be explicit support from the Chief Executive and a commitment to action after the intervention. Troubled teams can do immense harm to an organisation and therefore to the patients in their care.

The type of support provided varies according to circumstances and context. Usually, after discussion of the problems being encountered there is either direct intervention by the TRM team, or by health professionals who have been trained as coaches and in specific techniques for conflict resolution.

The processes consist of:

- *Diagnosis*: to find the root cause of the difficulties – carried out by a process of observations and interviews with all members of the team and people involved with that team.
- *Intervention*: the methods and approaches that the external coach will use to support the team to become more effective.
- *Embedding*: the development of sustainable systems (including local coaching) to support effective team working.
- *Disengagement*: planned reduction of support while ensuring that embedding of the ongoing systems base has taken place.

One lesson learned is that intervention is needed as early as possible. Many situations have proved to be complex and sometimes of long-standing and occasionally the situation is so serious that external specialist help has been needed, especially where there are ruptured relationships or conflict.

Outcomes and case studies

For reasons of confidentiality these are often not published, but one is on the CGST web site:

An extreme case involved a team, most of whom were nurses, who were having such problems that they were not even talking. This impacted on their working relationships and on the quality of care for patients. With help and support from the TRM programme, a team coach worked with the staff who agreed to review their practices to ensure effectiveness, to prioritise actions and to hold weekly team meetings. (Case study "Helping teams develop" available at: www.cgsupport.nhs.uk/Resources/Case_studies/Team_Coaching/TRM_Helping_Teams_Develop.asp)

Outcomes and achievements

The three strands of work of the Team Resource Management and Patient Safety Team at CGST have been well illustrated here.

The body of evidence about human factors in the aviation and health care industries shows that many issues are common to both and there is no doubt that the work on error management which has benefited aviation and other industries during the 1980s and 1990s is applicable and appropriate for health care. TRM have successfully supported and promoted this approach within the NHS.

In addition, the concept of team coaching and the team coach programmes developed and rolled out by TRM are playing a vital role in the development of effective team working in the NHS. As an element of good HR practice, this has been clearly linked by Professor Michael West and his team at Aston, to lower patient mortality.

The work with “troubled teams” is essential to provide objective assistance where team difficulties have, for whatever reason, become so significant as to directly affect the well being of patients and staff.

The contribution of the above areas of practice and research must be sustained if all health care professionals are to be enabled to work effectively in different types of teams, within different environments, throughout the NHS.

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RAID methodology: the NHS Clinical Governance Team's approach to service improvement

RAID
methodology

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Abstract

Purpose – To describe the methodology used to introduce Clinical Governance into the NHS and to review progress.

Design/methodology/approach – The RAID (Review, Agreement, Implementation, Demonstration) process and its use in introducing the Clinical Governance Development Programme into the NHS are described.

Findings – The NHS Clinical Governance Programme employs RAID, a modification of an accepted “bottom-up” approach to achieving successful organisational change, as the means of effecting service improvement. The “Review” stage involves analysis and understanding of the service; “Agreement” ensures that all staff, the organisation and stakeholders are committed to recommended changes; the “Implementation” phase tests effects that the changes have made to the service and “Demonstration” allows evaluation and monitoring. Lessons learned from the process can lead to further improvements. Initially staff from the Clinical Governance Support Team introduced the Programme but thereafter the process can be run internally. Specialised programmes, e.g. The Stroke Programme, have developed out of the general programme and the RAID process has been disseminated to other public sector services. Over half of NHS organisations have participated.

Originality/value – RAID is described in the context of the NHS and its implementation is summarised.

Keywords Clinical governance, Change management, National Health Service, Change management

Paper type General review

Developing a modern perinatal service for women with mental health problems in Tyneside

Newcastle, North Tyneside and Northumberland Mental Health NHS Trust invited the NHS Clinical Governance Support Team to facilitate a development programme as part of the implementation of their new clinical governance strategy. The Perinatal Community team joined the programme with a view to further developing their service in the light of drivers such as “Women’s mental health into the mainstream”. In addition to the perinatal team, the group that attended the programme also included a colleague from a neighbouring PCT, a service user and the local CG facilitator.

The review undertaken by the team showed that in many respect the service provided North Tyneside and Newcastle was very good. However, the stakeholder listening exercise identified a need to improve on the response time from receipt of the referral to the client’s initial assessment.

The author would like to thank all of the delegates who have taken part in the Clinical Governance Development Programme for their efforts and achievements in improving the services they provided to patients, their families and carers.



A process mapping event identified 16 steps from the point of referral to initial assessment, of these seven added no value to the client. One example was the practice of discussing all referrals at the weekly team meeting before allocating them to staff for action. In addition to the detailed process mapping exercise a team member undertook demand and capacity training, enabling a fundamental redesign of the team's response to referral process. The introduction of a full booking system improved response times by allowing appointments to be allocated to new referrals on receipt. The new process also means that clients can now choose the venue and time of their appointment and the gender of the practitioner they meet.

The team's response times have gone from anything between 1-49 days on the old system to no longer than ten days on the new. Indeed the majority of clients have their initial assessment between five-seven days of the team receiving the referral. Not surprisingly client satisfaction with the service has improved.

Introduction

Introduction of clinical governance as a means to drive up the quality of health care required action at all levels within NHS organisations. Implementation of the concept reflected that need, with an approach that combined national, strategic and local operational action. The national drive to promote understanding of the concept and Department of Health policy was led by the Chief Medical Officer. The Clinical Governance Development Programme (CGDP) became a key element of the drive to engage and empower front-line staff, and to embed clinical governance in local systems and processes.

This paper describes the locally led approach to introducing clinical governance promoted by the NHS Clinical Governance Support Team (CGST) through the multi-disciplinary CGDP and the rationale for the RAID methodology (Review, Agree, Implement and Demonstrate) on which the development programme was based.

The CGDP was initially offered to frontline clinical teams in January 2000. It was the first of what has become a portfolio of innovative programmes all of which were designed to develop clinical governance capability within the NHS. Since its launch over 460 teams from some 286 organisations providing health care services in England have attended the CGDP. The bodies represented range from newly formed primary care trusts, to larger well established acute service trusts as well as social services, the prison service, and general medical and dental practices. The Development Programme was designed to enable multi-disciplinary teams, including service users ("delegate teams"), to explore the relationship between clinical governance and service quality improvement, and to support them throughout a patient centred programme of facilitated change. Change is fundamental to service improvement and a priority for those seeking to improve the experiences of patients and staff. The CGDP provided the knowledge healthcare teams needed to initiate a programme of change and, uniquely, the on site help often required to secure local agreement and ensure successful implementation of the projects.

From the outset the aim was to support the development of a small cohort of staff within an organisation. The expectation was that these groups and those directly involved in the local development work would act as a catalyst for further development within their organisation. The success of the Development Programme has ensured

that over half of all NHS organisations have benefited from the skilled support available from the national team; subsequently the methodology has also been successfully deployed in Wales and more recently in Northern Ireland.

“Bottom-up” led service improvement

The CGDP and the RAID methodology on which it was based promoted a “bottom-up” approach that emphasised the contribution of those delivering healthcare services. This departure from the established “top-down” model, in which change initiatives originate at the top of a hierarchal system to then be driven downwards, reflect the belief that engagement of people; those providing, managing and using particular healthcare services has to precede the development of solutions to problems within those services. Such involvement is essential if the solutions decided upon are to be successfully implemented, owned and hence sustained by the people most directly affected by them. This thinking reflects the work of Beer *et al.* (1990) who studied the characteristics of successful organisational change efforts in large complex organisations. They discovered that contrary to traditional thinking, successful transformation often started at the periphery of organisations where frontline staff were striving to deal with concrete business problems. They found that successful change initiatives were the ones which concentrated on the work the organisation did, rather than on abstract concepts such as “participation” or “culture”, or top-down organisation-wide efforts to redefine corporate philosophy or mission statements.

Beer *et al.* (1990) also observed that the “task” focused change being driven by frontline staff often occurred unbeknown to senior management. However they acknowledge that although the direct involvement of senior managers was not necessarily essential, having the sustained support and patronage of those at the top of the organisational hierarchy did increase the likelihood of successful change. Such patronage is also essential if the learning derived during the change process is to be disseminated for the benefit of the wider organisation. Consequently, as well as working with frontline healthcare teams to provide them with the knowledge and skills to lead change in their service areas, the Development Programme team also directly engages the chief executives of organisations sponsoring delegates teams. This approach ensures a clear understanding of the aims and methods of the CGDP at the outset, as well as what is expected of the host organisation. It also establishes a channel of communication that is maintained throughout the programme in order to leverage maximum support for the delegates leading service improvement projects. As one former delegate commented:

Trust support has been tremendous and that is because they have witnessed clinical governance in action and money has followed us (Practice Development Coordinator).

In their study of work focused change efforts, Beer *et al.* (1990) identified a sequence of six overlapping but distinctive steps that they described as the “critical pathway” of successful change management, and which provided the basis for the RAID methodology developed by the NHS Clinical Governance Support Team. Table I shows the relationship between the phase of the RAID model and Beer *et al.*’s original work.

Why RAID?

The RAID methodology is one of many change management models, several of which have been advocated by different parts of the NHS Modernisation Agency. To appreciate why one approach might be more appropriate than another in a given situation it is helpful to consider Ralph Stacey’s work on complex adaptive systems (1996). The Stacey Diagram (Figure 1) describes the complexity of a situation in terms of the degree of agreement that exists amongst those involved with the issue in question, and the certainty of cause and effect in respect of the possible decisions that might be made in that situation. Considering a given situation against these variables can help change leaders and clinical teams select the most appropriate change management model for that situation. Figure 2 proposes a relationship between the complexity of the change process and the main change methodologies employed by the NHS Modernisation Agency.

A high degree of certainty and agreement is often based on a good level of awareness amongst stakeholders of the main change options and the impact these have had in other similar settings, or services. The approach here is based on knowing what has worked in the past or elsewhere and repeating it in order to improve efficiency and effectiveness. Very specific courses of action are planned in order to achieve clearly defined outcomes, progress is closely monitored against anticipated behaviour. It is at

Beer *et al.*’s critical pathway for effective change

| | |
|-------------|--|
| Review | Mobilising commitment to change through joint diagnosis of business problems Develop a shared vision of how to organise and manage for competitiveness |
| Agree | Foster consensus for the new vision, competence to enact it, and cohesion to move it along |
| Implement | Spread revitalisation to all departments without pushing it from the top Institutionalise revitalisation through formal policies, systems and structure |
| Demonstrate | Monitor and adjust strategies in response to problems in the revitalisation process |

Table I.
The antecedents of the RAID methodology

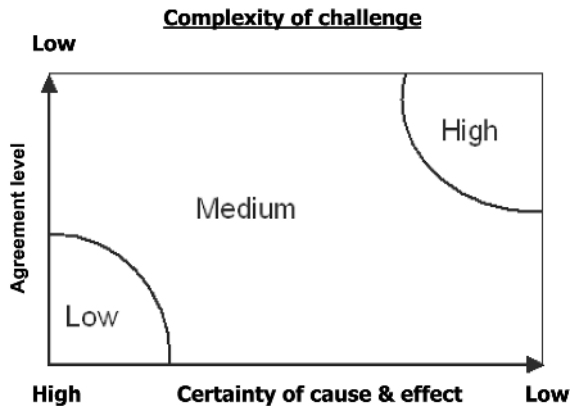


Figure 1.
Stacey Diagram

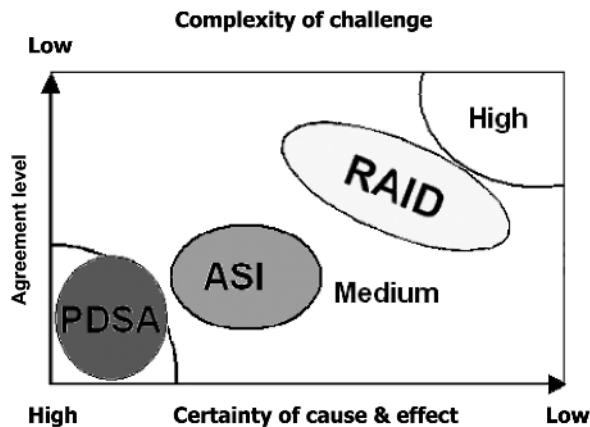


Figure 2.
Relationship between the complexity of the change process and possible change methodologies

this level of complexity that Plan, Do, Study, Act (PDSA) cycles work well (Langley *et al.*, 1996).

Towards the middle ground where there is less agreement and certainty about cause and effect relationships, politics becomes more important. In this environment accelerated service improvement techniques (ASI) like large group interventions, are useful to build coalitions and agree the compromises necessary to determine an organisation's priorities and direction.

Finally, where the complexity of the challenge borders on the high, the place Stacey referred to as "the edge of chaos", a different approach is needed again. Here those involved with the issues have to work together to develop a common understanding of the situation and the possible decisions that might be made before agreeing on any affiliations and actions. It is a place where creativity, innovation and breaking with the past to create new modes of operating can flourish. It is in this sort of environment that the RAID methodology, with its emphasis on a careful review of a service and the engagement of all involved with it, works best.

Programme structure

The Clinical Governance Development Programme comprises five interactive learning days usually spread over a nine-month period, and structured around the RAID model (see Figure 3). Multi-disciplinary teams, often representing a number of different health and social care organisations, join the CGDP to focus on a specific services area in which improvement is sought. During the first two learning days participants focus primarily on conducting a review of their service, subsequent days then address issues associated with gaining agreement for their proposed changes, the implementation and management of change projects and finally, issues associated with demonstrating the outcomes and improvements in service that they have achieved. However it would be wrong to think of the model as a series of discrete stages; rather each phase of RAID merges into the next as the process moves forward.

The time given to delegates between learning days is a unique and key feature of the CGDP. Unlike many theoretical change management programmes that simply

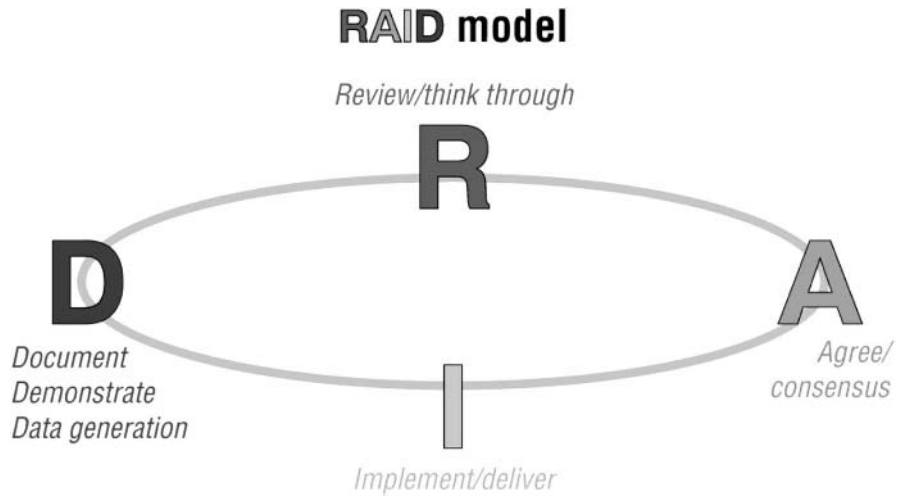


Figure 3.
RAID model

provide participants with the knowledge they require, the CGDP is experiential in nature. The exposure to and exploration of new knowledge coincides with delegates' application of that knowledge and learning within their work environments; a process that is supported throughout and beyond the nine months of the programme by programme managers from the Development Programme team. This on site support for delegate teams is another unique feature of the CGDP and one especially valued by participants who find the advice and coaching on offer acts as an important boost to team morale during the inevitable periods of uncertainty or difficulty:

I also felt that the team in Leicester did much to support us, for example, coming down to our place and discussing with us, or taking the role as a facilitator, for example, in our half day exercises with the whole ward staff. This was very, very helpful and we wouldn't have come to these results without that support (Parker *et al.*, 2003).

Beyond the five formal learning days of the CGDP delegate teams continue to be supported by the National Team via ongoing contact with their programme manager. As well as being a source of encouragement and advice in relation to their change projects, the programme manager also acts as a point of referral for the others services offered by the NCGST.

At some point usually between nine months and one year after completion of the programme, delegate teams are invited to a review day. The review day acts both as a showcase for the teams' achievements as well as an opportunity for other teams to learn from the experiences of their colleagues, whether part of the same speciality or from a different field but with similar challenges.

Review

The first task delegate teams take on is a "review" of the service they provide or use. The review serves several purposes: developing a better understanding of the local service, the national context in which it exists and the challenges it faces. The main elements of the review are a comprehensive listening and information gathering

exercise in which the views of clinical and support staff, services users, their carers and families, as well as managers are sought. Experience has demonstrated that teams must consider with care the various techniques available (see below (lesson card 2/2 “Hear what patients say”)):

Hear what patients say

Staff in a community dental service had a sense that their arrangements for seeking views from patients were not effective. A significant proportion of their patients have learning disabilities. Interviews with patients seemed a better way. It would allow them to “talk” to patients who were not good at filling in forms. A structure for the interviews was designed and arrangements made for dental nurses from other localities to interview patients. The new approach has been a big success and is popular with staff and patients. (Clinical Governance Strategies Collection 2/2 available at: www.cgsupport.nhs.uk/Resources/Lesson_Cards/Collection_2.asp#2)

The information gathered through the listening exercise is then combined with a detailed literature review and analysis of audit and other relevant performance data to provide a full picture of the current state of the teams’ service area. It will enable the team to see more clearly the challenges to be addressed and provide the evidence base to support proposed changes to improve the service.

The listening exercise also serves to set the scene for how the team will operate. It engages those who will be directly affected by any change from the outset of the process and invites them to contribute to the change process – see below (lesson cards 1/3 “Involve everyone”) As a result of this involvement people are more likely to want to participate in the implementation of the change solutions which ultimately emerge from the review. This emphasis on developing a sense of ownership of the change process is “key” to the “bottom-up” approach which the development programme promotes and sets the RAID methodology apart from other change models. In addition, by involving other stakeholders with an interest in, if not a direct involvement with the service, the listening exercise cultivates the interest and support of a wider circle of people inside and outside the service, or even the organisation and lays the ground work for the move to gain agreement:

Involve everyone

When a hospital’s A&E team was looking at ways to improve their “door to needle time” they made sure that their work was truly multi-disciplinary. It was the receptionists that made the breakthrough. They suggested that they could direct patients presenting at reception with chest pain straight to the chest pain area within A&E. This change enabled the Department to improve from 30% of patients receiving thrombolytic drugs within 30 minutes to 88% – the best in the Region. (Clinical Governance Strategies Collection 1/3 available at: www.cgsupport.nhs.uk/Resources/Lesson_Cards/Collection_1.asp#Involve_everyone)

The work of the review is captured by the team in a review document, this summarises the team findings and set out their recommendations and indicates how improvement will be charted.

Agree

The “agreement” phase begins when those involved in the review have begun to move towards a consensus on what needs to be done to improve the quality of the service.

The production of the review document, including specific recommendations for service improvement projects, encourages the team to seek agreement at several levels.

At an organisational level the senior managers and other stakeholders who contributed to the review need to be persuaded that the proposed change projects fit the organisation's strategic direction, implementation plans or and other priorities. The managers will need to approve any work to redesigns services that may impact – positively or negatively – on other departments and services. These consequences may not be immediately apparent to the delegate team (see below – lesson card 2/1 “Get issues in the open”):

Get issues in the open

Theatre Services were chosen as a focus when a Trust was introducing clinical governance although there were few apparent problems. When the work started, opportunities to make the service better soon became apparent. More sensitive scheduling in theatres could ensure that radiology support was provided more efficiently. Theatre lists now take account of radiography requirements – and make it easier for radiology to respond. (Clinical Governance Strategies Collection 2/1 available at: www.cgsupport.nhs.uk/Resources/Lesson_Cards/Collection_2.asp#1)

Within the team the focus is more operational. Decisions have to be made about which change projects should be prioritised, which will deliver morale boosting “quick wins” and which require more sustained effort and resources. Who will lead and be involved in the various project sub-groups? And how will the delegate team steer the improvement efforts of a growing number of people? These are important questions; looking for ways to spread the load is important (see below – lesson card 1/16 “Encourage volunteers”):

Encourage volunteers

Paediatric services were provided from several places on a hospital site - there was scope for much improvement. Success would depend however on whether the review team could enrol their clinical colleagues to take on some of the project work. During their discussions the team found that they were able to instil a sense of enthusiasm in others which they were later able to translate this into action. The volunteers are growing into a valuable cohort of people able to manage change. (Clinical Governance Strategies Collection 1/16 available at: [www.cgsupport.nhs.uk/Resources/Lesson_Cards/Collection_1.asp#Encourage volunteers](http://www.cgsupport.nhs.uk/Resources/Lesson_Cards/Collection_1.asp#Encourage%20volunteers))

Implement

The “implementation” phase is the point at which changes in the service begin to happen. Usually this requires the creation of a number of project teams to deal with specific recommendations emerging from the review. Often a member of the original delegate team leads these individual sub groups but importantly they include a wider circle of staff and service users from the service area. Many teams learnt the value of setting up a short trial to test new systems and procedures – before they are recommended for wide scale adoption (see below – lesson card 2/9 “Show how it works”):

Show how it works

A primary care group planning its move to Trust status decided that the creation of a process for handling significant events seemed to be a sensible place to start. A new system soon started to emerge and training to help people use it was a priority. The group enlisted “Actors

in Industry” to perform a “real-life” significant event about an unsafe discharge of an older person. This “live” example proved a useful way of helping participants learn about the new process and its application, and in developing a common understanding of the nature and purpose of significant event auditing. (Clinical Governance Strategies Collection 2/9 available at: www.cgsupport.nhs.uk/Resources/Lesson_Cards/Collection_2.asp#9)

Delegate team are encouraged to use simple project management techniques to identify the main stages of the project and to arrange them in a logical sequence. Many teams use Gantt charts (see Baguley, 1999) to help clarify the sequencing of activity, to identify timings and dependencies within the projects (Nicholls *et al.*, 2001). However successful project management relies upon effective communication. It is important that the team has a communication strategy that identifies and responds to the information needs of those associated in any way with the service, and identifies how and through whom these will be met (see below – lesson card 3/10 “Use their language”). A range of media can be employed to reach the desired audiences, and to provide information and signpost sources of advice and support to people who might feel uncomfortable in the transition to a new way of working. Of course this has to be backed up with real help and advice; if people don’t feel their concerns are being addressed, they may lose faith in the programme and worse, become resistant to it:

Use their language

As part of its work with “Looked After Children”, a review team invited a focus group of twelve young people (aged 12 to 18 years) to help them design a new leaflet for young people about health assessments. Based on the group’s advice, the leaflet is very colourful and “jargon free”. It has small amounts of text in “speech bubbles” set out as “questions and answers”. Young people are asked for their views on the leaflet to help the team evaluate its effectiveness. (Clinical Governance Strategies Collection 3/10 available at: www.cgsupport.nhs.uk/Resources/Lesson_Cards/Collection_3.asp#10)

Demonstrate

The “demonstration” phase of activity within RAID emphasises the need for reflection on the change process and evaluation of the impact of the implemented changes. An important phase of the CGDP encourages teams to discuss and identify the lessons learnt. See below (from a case study in Hastings). This learning is then applied to the service to support further improvements in the experience of those using and providing it, and can be disseminated within the organisations involved to aid in the wider work to improve the effectiveness and efficiency of healthcare services:

Lessons noted by a review team: Theatre Services at Hastings and Rother NHS Trust:

- Make sure that the team has adequate time set aside for the work – it may not be possible to squeeze it in between other commitments.
- Make sure from the outset that you have adequate secretarial and administrative support – don’t wait until you are desperate for help!
- Be realistic about the scope of any review – keep the agenda manageable. The scale of this review was probably too broad.
- Recognise that the pace of the work will slow when other activities have to take priority.
- When you are asking people to work with you make sure that you work with them – help them to help you. Your priority may not be theirs – they will be facing their own pressures.

- If the work shows that you have got to build bridges between different parts of the organisation – build them yourself. Don't expect others to do it for you.
 - Think carefully before using a questionnaire to collect the views of patients – is it the best way?
 - Take care when approaching patients – choose the “right” time and the “right” messenger. Nurses may be best equipped to tackle this task.
- And finally – be aware that your efforts might be affected by any local merger agenda – be flexible and ready for change! (Clinical Governance Case study available at: www.cgsupport.nhs.uk/Resources/Case_studies/Theatre_Services/Hastings_and_Rother_Case_Study.asp)

This phase should involve measurement of the improvements achieved and the communication of them. The latter is important not simply to celebrate the team's success or to justify the organisations investment in the team. It is important to let others know how the service has improved and how they may interact with it more effectively. But it is equally important to monitor the new service to ensure that the intended improvements are maintained (see below from lesson card 3/12 “Keep you finger on the pulse”). Sharing the experience and learning associated with the use of RAID may also encourage other teams to consider the approach as they contemplate how they will develop and improve the services they offer:

Keep your finger on the pulse

Following a serious complaint, a service review at a Children's Hospital led to the creation of an Analysis and Learning Team.. It was determined to intervene early as trends started to emerge and use the lessons to improve the quality of care. In its first year it spotted a trend in the number of children receiving cuts and abrasions during the removal of plaster casts. As a result, the Surgical Directorate implemented a new guideline for their safe removal. (Clinical Governance Strategies Collection 3/12 available at: www.cgsupport.nhs.uk/Resources/Lesson_Cards/Collection_3.asp#12)

Programme evolution

Although the fundamental structure and underpinning philosophy of the Clinical Governance Development Programme has changed little since its introduction in 2000, the way the programme is focused and delivered has evolved to meet the changing needs of healthcare professionals and the organisations they work within, something which reflects, at least in part, the demands associated with current national policy and Department of Health directives. Early programmes were run close to the team's base in Leicester and catered for delegates from a variety of organisations and a range of clinical services. Although these general programmes remained a feature of the team's work until very recently, the demand for them diminished as specialised programmes became available. Some of these specialised programmes have been designed around particular services such as stroke, maternity care, and healthcare acquired infection.

Health community programmes have enabled healthcare professionals and others to take a more holistic look at the services they provide within a particular locality. These locally delivered programmes, like others developed to build capacity rapidly within single organisations, paved the way for a number of franchised development programmes. These were based upon the Clinical Governance Development

Programme, but were adapted and delivered in conjunction with local facilitators to meet the needs of local organisations. This approach led to the RAID methodology being adopted by the Welsh Assembly Government's Clinical Governance Support and Development Unit and more recently by the Northern Ireland Clinical and Social Care Governance Support Team.

Conclusion

In terms of the NHS workforce as a whole, the number of healthcare professional and service users who have attended the Clinical Governance Development Programme and have used the RAID methodology may seem small. Nevertheless, impact of the programme can be argued to be significant. The majority of individuals who have attended the CGDP have reported benefits in terms of their own personal and professional development, local team working and, importantly, in respect of the services in which they work. The experiences of patients and staff have been improved by the teams who have used the RAID approach to bring about change.

The programme can be deemed a success in several ways, specifically by:

- Providing a supportive process to help NHS organisations change their culture and apply the principles of clinical governance – safe effective care provided by caring staff.
- Engaging over half of NHS organisations and reaching a "tipping point" of momentum across the NHS.
- Demonstrating the effectiveness of the process used (RAID – networking etc.).
- Equipping multi-disciplinary cohorts of staff with the knowledge and skills to act as catalysts and resources for change within their organisations.
- Involving many individual and groups of patients and their carers in service development initiatives.
- Producing real and practical improvements to local services.

This paper includes just a few examples of the work of delegates, many others can be found on the Resources pages of the CGST web site (www.cgsupport.nhs.uk)

Addendum

As a result of the recent governmental review of arm's length bodies (Department of Health, 2004), the Clinical Governance Development Programme will not continue. The demand that remains for support and guidance in relation to improving healthcare services will now be met by those who have benefited from attending the CGDP over the past five years, as well as by the many Modernisation Agency staff who have returned to work in Strategic Health Authorities and NHS Trusts. In this way the RAID methodology will continue to be applied, as it needs to be, by those providing frontline services to the challenges they face in their particular service.

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Modernising stroke services using clinical governance

Modernising
stroke services

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Abstract

Purpose – To report progress made by the National Clinical Governance Support Team's (CGST) Programme for Stroke between 2001 and 2004 and its effects on service provision.

Design/methodology/approach – The effectiveness of the Stroke Programme on services was assessed by comparing changes in services in Trusts which had undergone the process with those in a control group.

Findings – Using the Review, Agree, Implement, Demonstrate (RAID) model, the Stroke Programme led to benefits which include greater participation by patients and carers in treatment programmes and in development of services. Quantitative assessment of the extent of change in stroke services showed a significantly greater change in stroke unit provision, staffing levels and new funding in those sites which had attended the Stroke Programme.

Originality/value – The review provides an overview of recent developments in stroke services in the UK and describes the benefits of intervention by the Clinical Governance Programme.

Keywords Clinical governance, Patients, Carers

Paper type General review

We were in the kitchen, I knew that I had to hold the sink, and then I can't remember anything. And I must have fell down, my husband will tell you that it was the worst he'd ever heard because the terrible noise that came out of my mouth, wasn't words. Somehow I must have [been taken] to the bed and I must have gone to sleep, and then I look up and there's two men. I can remember thinking "oh they're green, so they must be ambulance men" and I thought "why aren't they smiling, what have I done wrong?", because they're not smiling. I can remember [listening in] the ambulance and thinking "we're going to this [big] hospital when there's a small hospital nearby, so I must be bad". Then I came through to the emergency room, then through into another ward and I thought, "all my children are here, so I must be really ill". But I didn't know I was ill, it was as though I was asleep. But it wasn't until I got to the ward afterwards, that they told me I'd had a stroke. I didn't know what a stroke was – never knew what a stroke was. Then I had the most awful headache and after that I just couldn't talk, I couldn't talk for a year (Stroke Patient, 2005).

Introduction

Stroke is a devastating disease that is both common and serious, with profound social and economic effects on individuals and on society as a whole. Stroke is the major cause of serious disability and is the cause of around 10-12 per cent of deaths in the UK (Office of Population Censuses and Surveys, 2002). Over 5 per cent of the entire health service budget is attributed to stroke (Mant *et al.*, 2004).

Organised stroke care makes a substantial difference to clinical outcomes after stroke: compared to conventional care, organised care on a specialist stroke unit



reduces the risk of death by 17 per cent, reduces the risk of death or dependency by 31 per cent and reduces the risk of death or the need for long-term institutional care by 25 per cent (Stroke Unit Trialists' Collaboration, 2004).

Since 1998, the quality of stroke care in the UK has been measured through the Royal College of Physicians' National Sentinel Audit of Stroke (Royal College of Physicians (Intercollegiate Stroke Working Party), 2001/2002, 2004; Royal College of Physicians, 2005). Every two years, data are extracted from hospital admissions records and management information, and analysed to produce results in the two key domains of *organisation* of care (such as the existence of a stroke unit at the site) and *process* of care (such as the proportion of patients spending time on a stroke unit). The audit compares results with standards derived from research evidence, as set out in the National Clinical Guidelines for Stroke (Royal College of Physicians, 2004). A scoring system enables trusts to compare their organisation with national data, with a score of 100 being the optimal score.

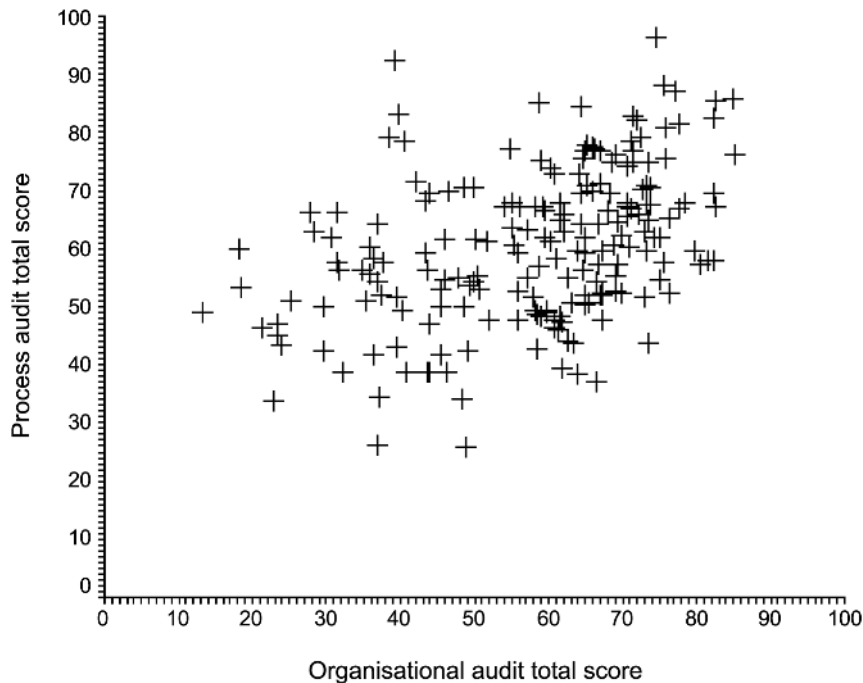
Findings from the National Sentinel Audit of Stroke in 2002 (Royal College of Physicians (Intercollegiate Stroke Working Party), 2001/2002) showed marked variation across the UK in terms of the organisation and process of care (see Figure 1). Furthermore, progress in development of stroke services across the UK was unacceptably slow: in 1999, only 25 per cent of stroke patients spent the majority of their in-patient episode on a stroke unit and by 2002 this had risen to just 27 per cent.

Stroke and clinical governance

The NHS Clinical Governance Development Programme for Stroke (NHS Clinical Governance Support Team, 2003) was launched in 2001 through joint working between the NHS Clinical Governance Support Team (CGST), the Royal College of Physicians and The Stroke Association. The principal goals of the programme were to foster development of patient-centred stroke services and to reduce the heterogeneity of standards of stroke care across the UK.

The principles of clinical governance are especially relevant to the development of services for people with stroke. People who experience stroke are often already vulnerable and frail, have complex health care needs, and require effective team working from multiple health professionals who use evidence-based care. Additionally, the framework of clinical governance fosters the incorporation of clinical guidelines and audit mechanisms, both of which already exist at a national level in stroke through the Royal College of Physicians.

The speciality-specific Stroke Programme, in common with the CGST's general Clinical Governance Development Programme, comprised five "learning days", spread over a nine month period, with participating teams agreeing key actions during the interval periods. It employed a systematic evidence-based approach to transform groups of people, from multiple agencies across stroke care communities, into effective working teams. Teams performed a stroke service review using the RAID (Review, Agree, Implement, Demonstrate) model, which promoted user-involvement, challenged existing practices, and stimulated projects created by front-line staff (Rogers, 2006). In selecting appropriate projects for review, delegates were prompted to consider process



Note: Crosses represent the organisational and process total scores for 240 NHS sites that took part in the audit. The fourth, and most recent, round of the National Sentinel Audit of Stroke in 2004 (Royal College of Physicians (Intercollegiate Stroke Working party), 2004) coincided with the stroke milestones within the National Service Framework for Older People (Department of Health, 2001). Whilst the audit demonstrated some improvement in organisation of care, there remained a clear need for further substantial service developments, particularly in the areas of pre- and early-hospital care, expansion of stroke unit bed numbers, establishment of neurovascular clinics and in long term care

Figure 1.
The Royal College of
Physicians' National
Sentinel Audit of Stroke
2002

complexity factors versus implementation factors, and to include one or two discreet, simple processes that would show results within two months – “quick wins”.

During the review phase, delegates sought information regarding their existing services from users and carers, plus key clinical stakeholders, in addition to information from national and local audit and through process mapping. As there has never been any dedicated central source of funding for stroke, delegates also learned the principles of attracting resources to stroke from other areas with funding, such as through the new general practitioner contract (Department of Health, 2003) and intermediate care services.

Patient and public involvement in Stroke

The involvement and true participation of users, carers and families is a core method to improve the healthcare quality agenda at a local level and is emphasised in the National Clinical Guidelines for Stroke (Royal College of Physicians, 2004). The

particular challenges for involving users in stroke relate to the pre-existent vulnerability of this user group and the high incidence of communication disability after stroke: stroke will leave as many as 60 per cent of all sufferers with some degree of impairment of language ability (Warlow *et al.*, 2003). Teams on the Programme were given a range of tools and techniques to gain information from, and aid discussion with, patients and carers about healthcare services (Squire and Hill, 2006).

Experiences from the Programme

Between March 2001 and June 2004, 200 delegates from 42 Trusts completed four waves of the CGST Stroke Programme. In addition, a follow-up day was organised two months after delegates completed the Programme, to bring together stroke teams that had completed the learning days, so that they could share their progress on service improvements.

The most commonly reported benefits of delegates attending the Programme were improved team working, raised service profile and the involvement of users and carers. Examples of “quick wins”, accomplished by teams to rapidly raise local awareness of stroke services and to heighten team morale, are shown below:

- Newsletter.
- Media coverage.
- Web site.
- Stroke register.
- Carer involvement in therapy.
- Multidisciplinary goal-setting.
- Roving stroke team to assess outlying patients.
- Gastrostomy clinic (monthly follow-up, added to existing clinic).
- Neurovascular clinic (“pump primed” through industry grant).

Effective lobbying of healthcare commissioners, such as Primary Care Trusts or Strategic Health Authorities, by the teams resulted in significant service changes either during the period that delegates attended the Programme, or by the time of the follow-up visit. A total of 62 new stroke beds were opened on dedicated units

Table I.
Stroke unit beds newly
opened during
Programme

| Site | Beds |
|---|------|
| Worcestershire Acute Hospitals NHS Trust | 8 |
| Wrightington, Wigan & Leigh NHS Trust | 12 |
| Milton Keynes General Hospital NHS Trust | 6 |
| Calderdale . . . Huddersfield NHS Trust | 12 |
| Norfolk & Norwich University Hospital NHS Trust | 10 |
| Royal Free Hampstead NHS Trust | 8 |
| Poole Hospitals NHS Trust | 6 |

(see Table I), eight new neurovascular clinics were created, and three stroke specialist nurses, two stroke nurse consultants and two consultant physicians were appointed. Details of the experiences of one team at Worcestershire Acute Hospitals NHS Trust are shown below:

(1) *How it was:*

- Stroke patients scattered throughout Acute Trust.
- No dedicated stroke unit.
- No dedicated neurological rehabilitation team.
- No dedicated stroke consultant.

(2) *How they did it:*

- Three nurses and an occupational therapist attended Stroke Programme.
- Team determined to raise the profile of stroke within the Trust.
- Listened to patients and staff using techniques from the Programme.
- Implemented an in-house stroke training programme.
- Lobbied for dedicated stroke beds in a new Private Finance Initiative (PFI) hospital.
- Lobbied Senior Management Board for stroke physician post.
- Created business case for Neurovascular Clinic.

(3) *How it has improved:*

- New stroke liaison nurse post fashioned from existing resources.
- Designated eight-bed Acute Stroke Unit in new PFI hospital.
- Newly-appointed Stroke Consultant.
- Rapid-access Neurovascular Clinic.
- Increased nursing establishment level on Stroke Rehabilitation Unit.

Evidence of improved user involvement was widely reported by the teams, with patients and carers being both more involved with their own goal-planning during rehabilitation after stroke, and also contributing to discussions about service development. Common themes reported included:

- dispelling of staff anxieties that their work would be criticised;
- realisation by staff that user demands would frequently differ from what staff predicted and that the demands could often be met in a simple and quick manner; and
- involving patients with significant language impairment was possible – delegates reported that dysphasia did not restrict contributions, as long as there was an appropriate pace of explanation and adequate time for expression was given.

Examples of patient involvement at two sites are shown below. The first site was Royal Cornwall Hospitals NHS Trust:

- (1) *How it was:*
 - The team had concerns that previous attempts to involve users had been unsuccessful.
 - Patients said that the hospital setting and being outnumbered by professionals had made them reluctant to contribute.
- (2) *How they did it:*
 - Alternate-monthly meetings held across 3 primary care trusts in community settings.
 - Service users invited by local branch of the charity The Stroke Association (TSA).
 - Patients invited included those with communication disability (dysphasia).
 - TSA representative facilitated discussions about existing services and proposed developments.
- (3) *How it has improved:*
 - Enhanced ratio of users to professionals.
 - Members much freer to contribute to decisions about service change.
 - Professionals learnt techniques to involve those with dysphasia.
 - Created new dysphasia support group with self-referral exercise class.
 - Created a telephone help line for stroke, in partnership with the British Red Cross.

The second site was Walsall Hospitals NHS Trust and Walsall Community Health NHS Trust:

- (1) *How it was:*
 - Only retrospective information from users and carers was available.
 - No timely system existed for prospective involvement of patients in planning of services.
 - Hospital was facing critical media comments after a “Dr Foster” report.
 - Staff felt unfairly represented in report with adverse effect on staff morale and retention.
- (2) *How they did it:*
 - Staff proposed a group of motivated healthcare assistants (HCAs) could develop their communication skills with stroke patients.
 - Training programme devised to help HCAs develop listening skills, including for patients with dysphasia.
 - Competency acquired contributed towards NVQ level 3 award.
 - HCAs interviewed patients during normal duties.
- (3) *How it has improved:*
 - Themes extracted from interviews were addressed.
 - HCAs help deliver treatment programmes designed by therapists.

- Menu and meal times changed to suit patients.
- Team has improved dynamics and confidence.
- HCAs have enhanced professional development.
- Model of engaging users has stimulated interest across the Trust.

Evaluating the effect of the Programme

The Clinical Effectiveness and Evaluation Unit (CEEU) of the Royal College of Physicians (London) conducted a survey in 2003 to assess the extent and principal areas of change in stroke service provision across the UK since the National Sentinel Audit of Stroke 2001/2002. Proformas were sent to the lead clinician for stroke in the 240 sites that participated in the 2001/2002 Audit.

The survey provided the opportunity to evaluate the effect of the Stroke Programme. The CEEU was asked by the CGST to perform a retrospective analysis of the changes in stroke services in those trusts that had completed the first three CGST Stroke Programmes, and to provide a comparison with the changes in trusts that had not been on the Programme.

Response rates to the survey questionnaire were high. Of the 37 sites that had both attended the CGST Stroke Programme and taken part in the 2001/2002 National Sentinel Audit of Stroke, 30 responded to the survey of change carried out by the CEEU; a response rate of 81 per cent. Of the 203 sites that had not attended the CGST Programme, 189 responded to the survey; a response rate of 93 per cent.

Results from the survey are shown in Figures 2-4. There was greater reported change in stroke service development by those sites that had attended the Stroke Programme, compared with those sites that had not attended the Programme. This was not only apparent in changes in stroke unit provision (for example, the opening of a new stroke unit or an increase in stroke bed numbers) but also in related staffing (for instance, stroke consultant and nurse appointments). Sixty-eight per cent (20/29) of the sites that had attended the Programme had obtained new funding for stroke service development, compared with 37 per cent (67/181) of the sites that had not attended the CGST's Stroke Programme.

Conclusions

The NHS Clinical Governance Development Programme for Stroke helped NHS organisations to raise the local profile of stroke, implement evidence-based care, involve patients and public and increase the capacity of their stroke services. Despite the significant communication problems encountered by many patients after stroke, experiences from the Programme demonstrate that they are surmountable and that effective communication with real listening to users can be accomplished.

Although the survey by the Clinical Effectiveness and Evaluation Unit was a retrospective analysis of two non-randomised cohorts, the trends in the findings support the qualitative data from the Programme. The results suggest that effective team working by health professionals, using the principles of clinical governance, can improve the care for people with stroke. Importantly, the results suggest that such improvements are not confined to stroke unit provision but extend to include related

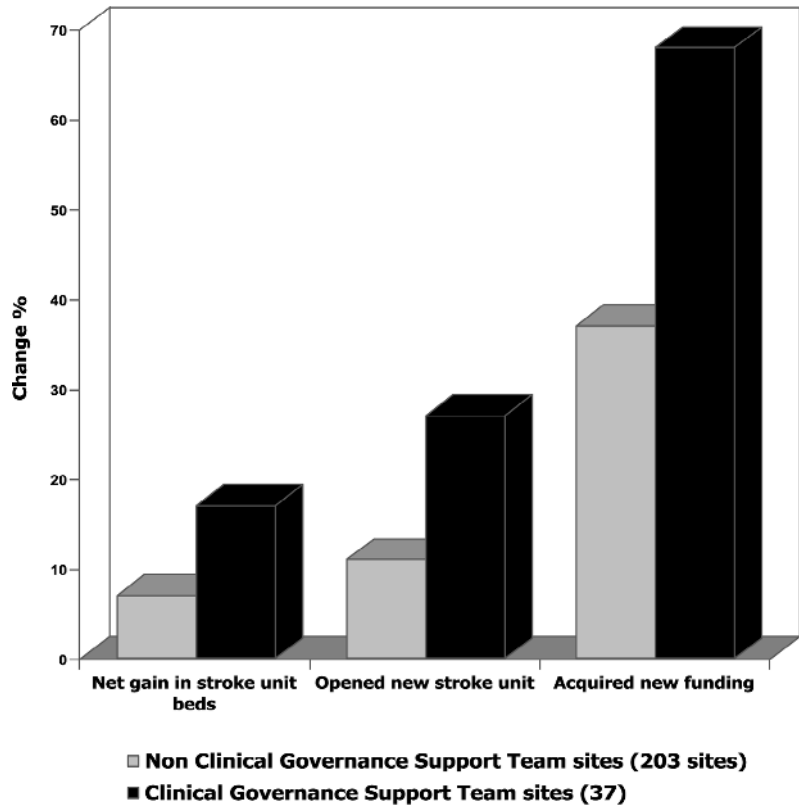


Figure 2.
Changes to stroke services
since 2002 National
Sentinel Audit of Stroke

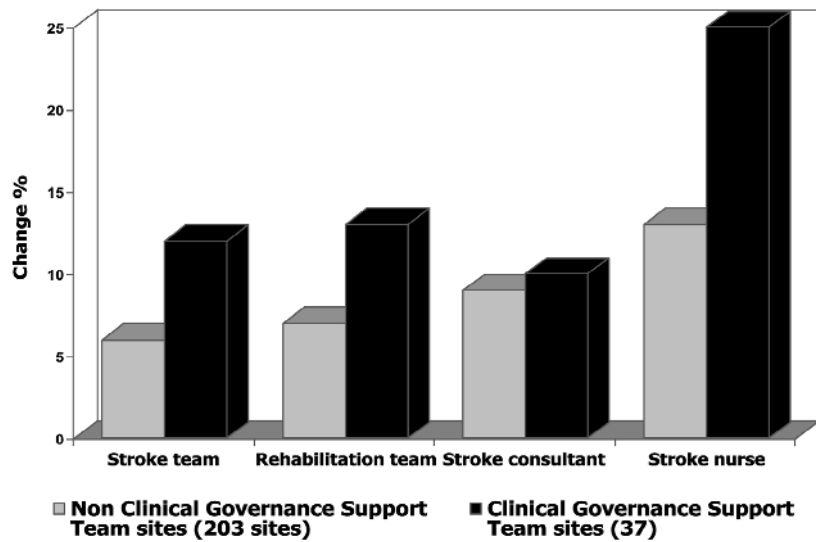


Figure 3.
Staffing levels

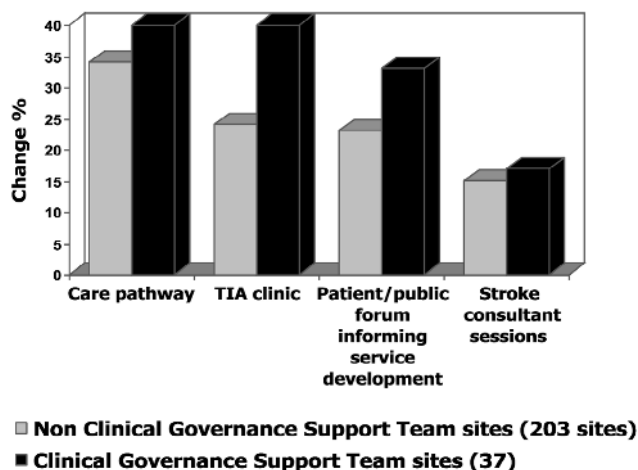


Figure 4.
Stroke service
development

staffing levels and acquisition of new funding. It may be that commissioners of healthcare services are more influenced by bids from teams, which include users and carers, than by those from individual clinicians.

The findings from the National Sentinel Audit of Stroke 2004 demonstrate the need for further improvements in stroke care across the UK. The challenge will be to harness the knowledge gained from the National Clinical Governance Programme for Stroke and embed that in the culture of all stroke services.

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Further reading

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