

CLINICAL GOVERNANCE

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Bulletin

Effective strategy

Editorial

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Clinical governance has put quality at the top of the health agenda. Organisations now need to ensure that clinical quality is monitored and is regularly reported upon, and also that action is taken, if appropriate. While chief executives and their boards have been given statutory responsibility, this agenda cannot be progressed if it is not owned by clinical staff at the grass roots. The challenge for any organisation delivering health care, whichever sector it is in, is therefore to translate a top-down initiative into a bottom-up approach and create an environment in which learning from what individuals and teams do is fostered and where the focus is truly on the patients and their experience. This requires a change in culture at all levels. Leadership, a clear direction and strategic vision are essential ingredients of success, as is facilitating, supporting and empowering staff to deliver this agenda and to

develop meaningful partnerships with the patients they treat.

But organisations need to be able to 'demonstrate' that they are complying with clinical governance requirements and that the quality of care given is of the highest standard and results in good outcomes. To this end, a number of questions need to be posed:

- Have we got a clear strategy for implementation and has this been communicated to all staff?
- Does our infrastructure facilitate regular monitoring?
- Do we have robust processes in place to deliver on audit, risk and so on?
- What information do we need to monitor clinical quality?
- Is clinical quality regularly considered at performance review?
- Do clinical teams receive the support they need?
- How do we reconcile the irreconcilable? That is, how do we ensure that time is allowed for clinical teams to reflect and learn?
- Do we have a mechanism to ensure that lessons learnt are widely disseminated?
- Is this improving clinical care?

This issue deals with effective strategy, that is the approach organisations and teams are taking to ensure effective implementation of the clinical governance agenda. It covers the programme run by the NHS Clinical Governance Support Team and changes made by clinical teams who have taken part; effective

Topics for future issues

- Clinical information
- Knowledge management
- Communication

Please share your practical examples with us, and email them to the Editors:
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teamwork across professional and hospital boundaries; the approaches taken by different trusts; and top tips for successful implementation.

While the papers describe different approaches, common threads are found in all contributions, such as:

- the approach has to be multi-disciplinary and involve all staff;
- the approach has to enable clinical teams to take the clinical governance agenda forward;
- it is important to take a patient-focused approach;

- it is important to have a clear framework and well defined accountability;
- there is a need to provide 'technical support' for clinical teams.

We invite you to submit a contribution for the next issue. The theme will be clinical information. By that we mean information that is used to monitor clinical quality – this will include clinical indicators, complaints, clinical audit and other outcome measures – at either

organisational or team level, and how this information is used to review performance. The emphasis needs to be on how clinical information is used to generate changes in clinical practice or organisational processes and how the learning is disseminated to all. We are looking for contributions that share practical experience and highlight the key learning points. The goal is to share the experience of others so that it may benefit the wider NHS. We look forward to receiving your contribution.

NHS Clinical Governance Support Team – facilitating cultural change

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- **Successful, meaningful clinical governance and effective strategies for its implementation involve a shift in the culture of the NHS.**
- **Patients, and the quality of clinical care, are at the heart of this cultural shift.**
- **Organisations, their leaders and their teams are requesting facilitation and support as they identify and implement improvements for patients and for staff.**
- **The programme developed by the NHS Clinical Governance Support Team helps clinical teams take the quality agenda forward.**

Changing 'the way things are done around here'

The relationship between quality improvement and organisational culture has been understood in business and industry for many years. The need to change 'the way we do things around here' in order continuously to improve quality was recognised when the government set out its vision for quality health care in 1997:

achieving meaningful and sustainable quality improvements in the NHS requires a fundamental shift in culture, to focus effort where it is needed and to enable and empower those who work in the NHS to improve quality locally.¹

As we work to improve quality in NHS organisations, the need arises to move towards a more enlightened culture where:

- patients are central – 'nothing about me, without me';
- staff are valued – an asset in which to invest, not a cost to save;
- there is active learning – talking as well as 'hearing and listening';
- questions are asked in the spirit of open learning and shared progress.

Patients first and last

At the centre of clinical governance must be a real partnership between patients and professionals. It is patients who can best tell it 'as it really is' and professionals need to develop the mechanisms and the skills to listen to patients with 'authentic curiosity'.

The Picker Institute² specialises in measuring patients' experiences of health care; in the 12 years since it was established, its research has included more than 450,000 interviews.

'the task is not so much to see what no one yet has seen, but to think what nobody yet has thought, about that which everybody sees.'

Arthur Schopenhauer (1788–1860)

Patients have identified eight 'dimensions of care' that reflect their most important concerns. The list is perhaps quite different from one that professionals might have compiled on a patient's behalf:

- respecting a patient's values, preferences and expressed needs
- access to care
- emotional support
- information, communication and education
- coordination of care
- physical comfort
- involvement of family and friends
- continuity and transition

Only when we can see 'through the patient's eyes' can we be confident that we are building into organisations and systems deliverables that are really meaningful for the patients at their centre.

Recognising the most valuable asset of all

The NHS is a multitude of highly skilled, highly motivated, hard-working and creative individuals. In the past, the inevitable unpredictability that such a rich mix of talent creates sometimes encouraged organisations to design complex rules and systems, to build in check upon check – to insulate in order to protect.

As we work towards making clinical governance a reality, we clearly recognise that ‘the key resource for the NHS is its staff’³. Clinical governance is an opportunity to harness and value the talents and experience of our staff – to recognise the need to mobilise knowledge from the front line.

Clinical governance invites a culture which enables health care professionals to work in well led teams that are empowered to review their own service, empowered to ask ‘Where do we want to go?’ and ‘How are we going to get there?’

It is within the context of the need to support cultural change, in the knowledge of the unlearning and new learning that need to happen, that the NHS Clinical Governance Support Team (CGST), established in September 1999 to support practical, ‘on-the-ground’ implementation of clinical governance, has developed the Clinical Governance Development Programme (CGDP).

The Clinical Governance Development Programme

The CGDP is the cornerstone of the CGST’s commitment to facilitating the cultural change that is necessary to underpin successful clinical governance. It is a nine-month, task-orientated programme of learning that is available to multidisciplinary delegate teams from across the NHS.

The CGST invites NHS chief executives and boards to send us staff who will be missed as opposed to staff who can be spared. The CGDP provides the opportunity for organisations to develop their leaders, and for those leaders to enhance and develop their personal and professional skills, by putting theory into practice in the workplace.

Delegates lead multidisciplinary project teams in their sponsoring organisation as they design and deliver multiple quality-improvement projects. Project managers from the CGST support delegates with on-site visits to help plan direction, action and strategy. Delegates have telephone and electronic access to advice and information from project managers, and the rest of the CGST, throughout and beyond the nine-month CGDP.

Delegate teams take on a challenging task, and knowledge of the organisation, respect for colleagues, trust of seniors and commitment to

lead others through the inevitable turmoil of change are preconditions for success.

Top-down support

Delegates need practical and visible support from senior staff within their own organisation to help transform the culture.

The CGST has developed a complementary programme to help trust boards to identify and fulfil their role in embedding the organisational capability that will deliver continuous quality improvement⁴. This top-down support helps reinforce the simultaneous, multilevel interventions necessary to bring about cultural change and improved quality in the whole organisation⁵.

The Clinical Governance Development Programme – how it changes culture

The delegates use the RAID model (see Figure 1) to identify, plan, implement and measure improvement projects.

The process of review

Delegate teams choose the area to be reviewed by aligning their positions and roles in the organisation with their expertise, their skills and their influence so that each team forms a powerful core from which a number of project teams will later emerge to lead multiple quality initiatives.

The review process is based on five key elements:

- *Multidisciplinary workshops.* These are a vital component of the review process. They allow staff and patients the opportunity to explore, in a non-threatening, mutually supportive environment, what quality and success might

look like for their service. The workshops create links across traditional boundaries, uniting primary and secondary carers, voluntary sector organisations, social services, ambulance trusts and so on in defining excellence.

- *One-to-one interviews* are then conducted with representatives of all identified stakeholders. This helps to develop relationships that will later become key to success. It enables a shared, agreed vision of the current service to be explored, and fills in the ‘little known detail’ so important to a complete understanding of a service – its strengths and its weaknesses.
- *Establishing current performance.* It is important to understand what is currently being measured and use what is currently being achieved as a baseline. Such information may include details like access times, variation in practice, use of guidelines, numbers of patients seen, training opportunities, skill mixes, patient satisfaction surveys, costs, complaints and clinical outcomes.
- *A review of internal documents and external literature* ensures that the programme of work is in line with the strategic and business plans of the organisation and is founded on best evidence. It creates the links that mean that improvement projects and developments inform a future strategic direction.
- *The listening exercise* of the review process signals the arrival of a culture where patients and staff are central, where learning is important and developmental, and where professionals begin to see and believe that they can make a difference to the way we do things in the NHS.

Delegates on the CGDP follow the listening exercise of the review process with a structured approach

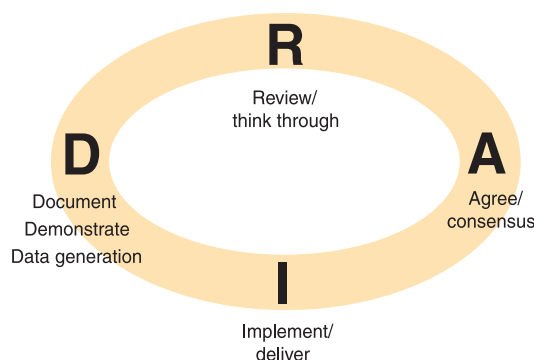


Figure 1. The RAID model.

to developing and managing projects for improvements. Further articles in the *Clinical Governance Bulletin* will provide details and examples of work in progress by the CGST and by delegates to the programme.

References

- 1 Secretary of State for Health. *The New NHS. Modern, Dependable*. London: HMSO, 1997
- 2 The Picker Institute: www.picker.org
- 3 Harrison A, Dixon J. *The NHS. Facing the Future*. London: King's Fund, 2000
- 4 Garratt B. *The Fish Rots from the Head. The Crisis in our Boardroom: Developing the Crucial Skills of the Competent Director*. London: HarperCollins, 1997
- 5 Shortell SM, et al. Assessing the impact of total quality management and organizational culture on multiple outcomes of care for coronary artery bypass graft surgery patients. *Medical Care* 2000;38:207-17

The Clinical Governance Support Team is part of the new NHS Modernisation Agency. It is currently piloting a new website: www.cgsupport.org

Contributions

Clinical Governance Bulletin is a publication for clinicians and managers working in trusts, health authorities and PCGs and aims to communicate practical examples, pool shared experience and highlight and disseminate best practice on a broad range of issues in health management. Themed issues will address:

- Patient experience
- Clinical effectiveness
- Resource effectiveness
- Communication
- Risk management
- Effective teamwork and learning
- Effective strategy
- Clinical information

Contributions that are practical and relevant to everyday practice are welcomed. They should be 500–800 words in length, with a maximum of five references in Vancouver (numerical) style. Please send your contribution, by post (with floppy disk) or email, to one of the Editors:

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NHS Clinical Governance Support Team – cultural shift and some examples of improving services

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- There are many traditional mindsets in the NHS and patterns of working have included adherence to a number of implicit, unwritten 'rules'. A listening exercise, a review of current service provision, allows exploration and challenge of the way things are done.
- The use of 'wicked questions' challenges the way things are done. This brings issues into the open and highlights options and solutions that may not have been immediately obvious.
- An inclusive listening exercise enables teams to implement changes with minimum effort and resources.
- The review process, involving a multidisciplinary team, sets the scene for subsequent action.
- Participation of the whole team is essential if changes made are to be owned and sustained.

The review process challenges assumptions, conventions and mindsets

The review process, described in the previous paper, establishes the means by which culture can be changed. It is an opportunity to uncover, then discuss and challenge the accepted sets of values/unwritten rules and beliefs within the organisation.

A group of 40 senior health care professionals on the Clinical Governance Development Programme (CGDP) was recently asked to list the 'unwritten rules' by which we who work in the NHS currently abide. Their list clearly articulates the unspoken rules we so infrequently examine. It is reproduced in part in Box 1.

'Wicked' questions help challenge assumptions

The review is an ideal opportunity for people to ask 'wicked' questions¹

of the organisation. 'Wicked' questions expose preconceptions. They provide a chance to reveal assumptions and expose ingrained thought patterns and rituals of behaviour.

Simple questions, such as the following, work well:

- Why do we use this form?
- Who actually uses this information ... and how?
- What changes have we made as a result?
- Who has noticed the difference?

'Wicked' questions can be used:

- to change the role of leadership from having the answers to having the questions;
- to open up possibilities which are not immediately obvious;
- to bring in new information to a problem or issue by exposing differences;
- to contrast goals and actual

Box 1. Unspoken rules in the NHS

Meetings constitute activity.
Anonymity confers mutual protection.
It's okay to whinge, but not to complain officially.
Clinicians don't need managers.
Only someone of my profession understands my problem.
Unless there is a protocol for it, it's not happening.
Filling in the form makes it happen.
The more senior you are the more you know!
Doctors know better than nurses.
You have to work as long as the person who works longest.
You have to do things cheaply.
You can't have a cup of tea without making one for everyone.
Doctors don't understand managers and vice versa.
Don't admit to mistakes.
Even though we talk about quality we only assess on the quantity.
Doctors know all the answers (I have to wait for the doctor).
The patients don't/won't like it and won't understand it.
People don't change – change is hard.
Everyone understands the jargon.
It is wrong to be wrong ...
... and it is wrong to admit to being wrong.
I'm the only one who cares.
Consultants' time is more important than anyone else's.
Doctors' time is more valuable than nurses'.
The number of hours worked is equal to the value of the outcome.
Everyone's too busy to take on extra.
The patient is always right.
The doctor is always right.
You mustn't challenge the system.
Nothing ever changes.
Everything is changing all the time.
The past was much better.

circumstances, to promote ongoing inquiry;

- to make the undiscussable discussable.

When empowered and motivated teams work together to uncover the intricacies of existing systems and methods it is often surprisingly simple to recognise and uproot the non-value-adding steps in the health care process. Of course, the process of the review and the listening

exercise create an environment in which people are receptive to such challenges – one in which people can face them head on because the action phase (the agreement and implementation stages) is just around the corner.

The next part of this paper shows how the review process itself can signal seriousness of intent and a commitment to producing improvements for patients and staff. Below are some examples that show how important the large-scale input of staff and patients is to developing services in a meaningful way. They are taken from work in progress by delegate teams on the CGDP.

Improving relationships in obstetrics

When clients' views were explored, among many positive comments a few negative ones were themed around staff attitudes in respect of young pregnant women:

'One of the midwives on the delivery suite was abrupt.'

'I was frightened but they said I shouldn't shout.'

'I wasn't sure what was going on.'

Such feedback was welcomed, recognised as important for organisational learning and to inform the process of continuous improvement. The remarks were used as a basis for a series of workshops for staff at which they explored the problems young pregnant women experience from a variety of perspectives.

The workshops provided staff with an opportunity to gain insights into seeing things through the patient's eyes and with valuable time to reflect on current practice and approach. Time and resources committed to such training and staff development directly in response to an 'on the ground' observation reflect the value that the organisation places on the perspectives of both staff and patients.

Nearly all staff have now attended workshops to look at customer care, prejudices, and different perspectives and attitudes. Staff feel better equipped to cope with what they would previously have found difficult situations and a re-audit of complaints in respect of staff attitudes has shown significant improvement. Moreover, ideas arising from the

workshops have been used to inform further improvement projects in the organisation.

A multidisciplinary approach creates a patient-centred service around drug misuse

The review exercise revealed that a number of teams were working independently of each other. A new multidisciplinary working group has now been established. The group has developed shared policies and changed practice to make their services more client focused.

Professionals involved in drug misuse and young people's services – general practitioners, midwives, obstetricians and social workers – have contributed to an agreed referral policy.

Previous confidentiality issues around interprofessional referral have been resolved and patients now have rapid access to all services.

There has been improved education and learning as information and knowledge have been shared.

Listening to patients improves services for patients and for staff – pain relief

Review data from patients and from staff illustrated that pain relief during dressing changes was less than satisfactory.

Usually oral or intramuscular analgesia was prescribed by someone other than the person changing the dressing. The interval between analgesia delivery and dressing change was variable and pain relief consequently was not always maximally effective.

A project has been established to provide intranasal analgesia at the time of dressing change – pain relief is therefore appropriately timed and instantly effective; patients are less anxious; and nursing time is saved.

How the review process itself can initiate improvement and lay the foundation for further development

Numerous ideas for improved practice flood in as the listening exercise is accomplished. Many of these ideas are simple, practical and easy to implement. They arise from staff and patients who are 'at the sharp end' and who are regularly frustrated by systems and processes that do not work smoothly.

Frequently they are people who, until the review, have found no effective means of voicing problems or of discussing solutions.

Delegate teams on the CGDP always find that as the project teams are assembled to begin work on the implementation phase of the RAID model, some small improvements can be implemented with minimum effort and resources.

These improvements, arising directly from staff and patient feedback, reflecting the solutions designed by those 'on the ground', reassure and reaffirm that the culture of the organisation is changing – things can be done differently, people will be heard, lessons will be learned and further improvements are on their way.

Some simple and early improvements initiated by delegates to the CGDP

Obstetrics and gynaecology

Simple ideas improve care:

- insufficient pillows for patients – 50 ordered immediately;
- ice machines ordered for wards;
- washing machine ordered for long-term patients;
- volunteer rotas now included with staffing rotas to improve liaison and communication;
- volunteers to develop a role description, to clarify how they

can best be involved and contribute;

- information about sexually transmitted diseases for teenagers to be carried on the website (an idea suggested by a nursing auxiliary);
- nurses to lead multidisciplinary audits (even some contentious ones, like getting hold of doctors for outpatient and ward work!).

New guidelines

One team was able to write and swiftly agree guidelines to enable appropriate discharge of coloscopy patients – case-note review had demonstrated that patients were being brought back repeatedly and often unnecessarily.

Accident and emergency

A thick glass screen between the receptionist and public meant that it had been difficult to preserve privacy. The team arranged for a microphone. Patients and staff reported that 'it made a real difference'.

Paediatric outpatient department

Cleaners were able to make really useful suggestions and the team arranged for:

- a fan in a hot and stuffy waiting area;
- a wall-mounted television in one waiting area where accompanying parents often have to spend some time.

The cleaners thanked the review team for including them, and said that no one had ever asked their opinion before.

Mental health

One team provided a kettle on wards for clients to make their own drinks. In response to patients' requests they now offer a continental breakfast so that clients can get up at their leisure and help themselves and each other to breakfast. Previously they had all been woken at the same time to be served a breakfast they had had to choose the day before.

One team provided locks on doors for receptionists, improving security and the working environment.

Conclusions

A number of delegate teams have been asked to make the staff and patient workshops a regular occurrence in the workplace. The hearing and listening process and the 'authentic curiosity' with which services have been reviewed have convinced all those involved that culture can be changed. We *can* learn new and improved ways of 'doing things around here'.

Reference

- 1 Zimmerman B, Lindberg C, Plsek P. *Edgware: Insights from Complexity Science for Health Care Leaders*. Irving, TX: VHA Inc., 1998

Moving clinical governance forward: capturing the experiences of primary care group leads

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- Clinical governance is welcomed as a positive and long-overdue process.
- In primary care, GPs dominate as clinical governance leads and use their pivotal position to move the process forwards.
- Eighteen months after the framework was introduced, clinical governance remains a challenge to implement in primary care.
- A shortage of funding, a lack of

guidance and a concern over the speed of implementation, the volume of work and the impact of mergers have hampered progress.

To date, the practicalities of developing clinical governance (CG) on the ground remain under-reported. With the aim of illuminating the experience of implementing the process, our study¹ planned:

- to identify how CG evolved within primary care groups (PCGs) in the South West region;
- to ascertain the positive and negative influences on the evolving process.

Method

The research used focus groups, individual interviews and negotiated

feedback reports to collect data from 16 PCG CG leads from Bristol and South Devon between March and October 2000. We report the findings from four focus groups and four interviews with PCG CG leads (Table 1). They had been the PCG CG lead for 2–18 months (mean 12.1 months).

Data have been analysed using grounded theory².

Results and discussion

Our data suggest that primary care CG is viewed as a positive and welcome process. Findings indicate that GPs (who dominate as CG leads – see Table 1) are engaged and inspired by the concept, and that they use their pivotal position in the general practice hierarchy to engage other practitioners.

Clinical governance is viewed as a process that will grow and develop over several years, facilitated by reflection, access to information and adequate resources. Leads want to be seen as a resource and advocate for the individual practice. The main messages that emerge from our data are:

- take things slowly
- get everyone on board
- settle for long-term cultural change

While GPs support the notion of linking all health professionals to a quality framework, CG in primary care remains under-resourced and a challenge to implement. The specific challenges and concerns for CG leads are:

- the speed of implementation
- the move from PCGs to primary care trusts
- the volume of work
- the lack of guidelines on non-clinical aspects of the framework
- the paucity of ear-marked and adequate funding

One GP commented:

I think Mike Pringle^[3] brought it out in his article in the *BMJ* about actually making it a proper job. I felt when I read it – he talks about having a fully invested structure to support the new governance – when I read it I was thinking, we have got a bloody good structure, but it would get blown over in a gale ... we are not enough, we are not robust.

We would suggest that considerable progress has been made in

Table 1. Participant profile ($n = 16$)

Characteristic	No. of participants
Gender	
Male	8
Female	8
Employment	
Full time	11
Part time	5
Age range	
30–39	3
40–49	9
50–59	4
Occupation	
GP	10
Nurse	2
Midwife	1
Manager	3
Paid weekly sessions for CG	
Less than one	1
One or two	11
More than two	3
Missing data	1

transforming the rhetoric of CG into reality. However, concerns about the time, effort and personal sacrifices involved, coupled with the possibility that some of the CG leads may relinquish their posts in the near future, could threaten the progress that has already been made.

Conclusions and recommendations

A number of areas where actions might be considered have emerged.

At the PCG level

- It seems critical for the continuing development of the process that GPs *remain engaged and inspired* by CG and that they continue to use their hierarchical position to engage other colleagues across the PCG.
- A clearer understanding of the responsibilities inherent in the role of CG lead would facilitate the selection/appointment process and would help to provide focus for the lead and other members of the PCG.
- PCG CG leads may benefit from *explicit guidelines on the 'carrots and sticks'* that they may use, and of the associated consequences of non-compliance.
- PCG CG leads should receive *adequate financial resources* so that

they can devote time to the development of the process, while being reassured that their partners and patients are not disadvantaged.

- We suggest that a *multiprofessional CG team approach* with managerial support would point to the most sustainable and productive model for PCGs as they become primary care trusts.
- Nurses, midwives, health visitors and managers should be encouraged to play a role in developing CG. Our data suggest that the use of *joint leads* (GP and non-GP) enhances the process, decreases the workload and sense of responsibility for individuals, and helps keep the process grounded and acceptable to colleagues.

At the practice level

- CG leads should continue to use a *supportive and facilitative approach* to implementation.
- Ownership of the process can be facilitated by *encouraging time for reflection and providing adequate financial resources* for protected time, training and dissemination of information at a practice level.
- Practices need to begin to see some *tangible outcomes* as a result of the efforts invested in CG.
- *Immediate colleagues of the PCG CG lead should not feel disadvantaged* by hosting the lead for the PCG.

Acknowledgements

The work has been funded by the NHS Executive South West as a joint venture between Public Health and R&D. We are extremely grateful to the PCG CG leads who have been generous in sharing their experiences with us.

Disclaimer

The views expressed in this paper are those of the authors and not necessarily those of the NHS Executive South West.

Note and references

- 1 This study forms part of a three-year project exploring the implementation and development of CG in primary care in the South West Region, in which all the key players in the process will be invited to share their views and experiences. Further details of the overall project may be obtained from the first author.
- 2 Glaser BG, Strauss AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine, 1967
- 3 Pringle M. Clinical governance in primary care: participating in clinical governance. *BMJ* 2000;321:737–40

Clinical governance – putting it into practice in a trust

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- A multidisciplinary approach needs to be encouraged from the outset to ensure every profession contributes to the implementation of clinical governance – multidisciplinary clinical improvement groups have achieved this in the trust.
- A defined model that can be adapted to individual service needs is important to ensure consistency of implementation across the organisation.
- Clinical teams need to receive clear messages about what is expected of them but must be given scope to progress the agenda at a pace they can sustain.
- Advice and support, in the form of people with technical and interpersonal skills, must be available to help the team through the implementation process.
- Attention needs to be given to the type of information clinical teams require to monitor their practices and the patient experience.

To make clinical governance a reality, the concept of multidisciplinary clinical improvement groups was developed in 1997, as there was a strong belief that clinical governance would not happen without ownership by the staff at the grass roots. But there is always a world of difference between having a good idea and seeing it happen in practice; their establishment therefore did not happen overnight. However, after two years, these groups have become a reality at Forest Healthcare NHS Trust and their work programme has contributed to the successful implementation of clinical governance. Forest Healthcare Trust is a complex organisation, spanning many sites, and provides acute, mental health and primary and community services. Thus the model for implementation had to be flexible for it to respond to the cultural and organisational differences in each of its services.

Clinical improvement groups and their responsibility

Clinical improvement groups¹ (CIGs) were set up in each directorate and in some cases at specialty level using consistent terms of reference, core membership and a template agenda to cover the key aspects of clinical governance. Their role is not necessarily to do all the work associated with clinical governance, but to coordinate and monitor these activities. They are charged to review information on clinical performance such as incidents, claims, complaints and audit results within the directorate and to draw up a work programme that address issues relevant to their particular service. They are responsible for developing a clinical governance plan that will deliver an improvement in the quality of care where shortfalls have been identified, and for monitoring and reporting on progress. The groups are chaired by the respective clinical governance leads.

Framework for implementation

A loose framework has been developed to ensure that all CIGs progress this agenda in a consistent manner and eventually achieve the same end points; this has been described more fully in other publications^{2,3}. The specific areas of this framework are underpinned by detailed guidelines listing the steps to be taken to ensure that the relevant system is in place. The areas considered are:

- managing exceptions – this covers claims, complaints and incidents;
- effective practice – this covers guidelines, audit and the process for addressing output in terms of NHS frameworks;
- patient and user involvement – covering individual care and feedback;

- workforce planning and development – covering skill-mix issues, appraisal and training, and development plans;
- trust and professional performance procedures – dealing with clinical performance and compliance with policies.

Each CIG has used these guidelines to suit its own needs. It is, however, essential that they have a clear idea about their objectives while being realistic about the number of projects they can undertake and the speed at which they can progress. For example, the mental health CIG meets monthly and has a membership of over 20 people, including user representatives, whereas the head and neck CIG meets less frequently and has fewer members. All, however, are asked to ensure that the lessons learnt from their work are disseminated to the whole team.

They have worked at a pace they can sustain and their agenda has been prioritised to meet their specific needs. Some of the CIGs have been in existence for nearly two years whereas others are still relatively new. Some have set up twice-yearly development days to disseminate the lessons learnt from their work not only to the whole team but also to members of other CIGs, such as mental health. Each group has had different challenges to face but they have all gone through a developmental process during which they were encouraged to reflect and learn.

Reporting arrangement

Clear messages are sent about what is expected from CIGs, the committees they report to and the support they can expect from the central support team – the Clinical Risk and Audit Service. A reporting template is used by all CIGs and the Clinical Effectiveness Committee regularly receives their reports; if a specific piece of work has been done, the

material produced can be appended to a report for onward dissemination. These reports contribute to the trust's clinical governance annual report.

The clinical information (incidents, claims, complaints, etc.) considered by each CIG forms part of the performance review.

Support for CIGs

Advice and support, in the form of people with technical and change-management skills, are crucial to the initiation and development of CIGs. As such, the trust has ensured that the six members of the Clinical Risk and Audit Service are equipped with relevant skills such as data analysis, communication, report writing, presentation, negotiating and influencing skills. The staff are thus able to work in a number of areas – clinical risk, clinical audit, research, guideline development – either with specific CIGs or across the trust, providing to clinical teams expertise and training in each of these systems.

The way in which the Clinical Risk and Audit Service works with CIGs is crucial to effective implementation.

Conclusions

Reflecting on the progress over the last two years, CIGs have become an integral part of clinical quality improvement, broadening their scope and providing the organisation with an effective framework for clinical governance. The work will continue to embed these activities into day-to-day practice, respond to new challenges and support clinical teams in delivering high standards of care to the patients they serve.

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Implementation of clinical governance in a teaching trust

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- A clear 'mission statement' or policy document of the organisation's understanding of clinical governance should be comprehensive, accessible and regularly used.
- Terms of reference and lines of accountability should be clearly defined.
- Facilitative technical support should be provided to enable clinical groups to reach their own working solutions.
- Do not underestimate the power of entrenched attitudes.
- Strong, supportive leadership is essential.

Clinical governance is not an innovative activity – its components have existed for some time in most NHS institutions. What is novel is the way in which this initiative provides a vehicle for coordinating information and activity, to provide a driving force for performance improvement. While much guidance is available to describe the concept of clinical governance, there has been

little published about how to make it work. We will describe the approach that was taken in a teaching trust to implement an infrastructure for clinical governance, which immediately started to deliver on the quality agenda.

The successful implementation of clinical governance relies on teamwork, not just between members of a discrete clinical team but also across boundaries, both organisational and cultural. Attitudes to cross-boundary working may be deeply entrenched. In order to overcome this and to create an environment in which meaningful information about the performance of clinical teams is routinely available and drives the quality agenda, the following aspects were systematically addressed:

- organisational strategy
- organisational structure
- technical support
- culture

Organisations that were successfully supporting a quality-

improvement programme were found to have these four components in common^{1,2}. If any of these elements is missing, the organisation will be unable to accomplish a robust programme that is sustainable and independent of political vicissitudes.

The teaching trust described functions both as a centre of excellence for clinical research and technological innovation and also as a general hospital providing a range of services to a diverse socio-economic local community, and as such fulfils two different roles.

Organisational strategy

A strategy should consist of a clear statement defining what, how, who, where and when. The policy document created for the implementation of clinical governance in the trust contained the following:

- a description of what we were trying to achieve and why – the ‘mission statement’;
- clear, high-level objectives, each supported by an itemised action plan;
- actions assigned to named individuals, with time frames identified, regularly monitored and adhered to;
- a core structure for clinical governance, with roles, responsibilities and lines of accountability clearly defined and depicted in both text and diagrams.

Other initiatives, such as clinical audit, have historically met with only limited success, owing not only to a lack of one of the four essential components itemised above but also to a lack of common understanding about what was to be achieved and how. Therefore not only were the trust’s understanding and definition of clinical governance given in the strategy document but, to underpin this, one of the action points stated that all who were to be involved in its management and implementation should be trained in its principles in a uniform fashion.

This document was designed to be referred to and used. It is readable, relevant and practical and has been widely disseminated, both on paper and electronically on the trust intranet. There is little point in writing a policy if it is read by only a small group of people who are divorced from the everyday function-

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ing of the organisation. The purpose of clinical governance is to make the pursuit of clinical excellence underpin the activity of every member of staff in every situation.

This document is therefore critical in providing the basic understanding for a vigorous and healthy programme which is accessible to all and which generates sufficient enthusiasm to make its purpose self-fulfilling.

Organisational structure

To implement such a strategy, a strong infrastructure is required. This structure must enable fast and immediate access to those who allocate services and resources and should facilitate timely two-way communication between service users and providers. This infrastructure must therefore be representative and flexible enough to respond to changing needs and requirements. At the trust we opted for a directorate structure to encourage local ownership and accountability and to provide this necessary flexibility.

Each directorate was required to convene a multidisciplinary directorate quality board (DQB), to meet monthly and act as a forum both to disseminate and respond to information and guidelines and also to monitor service provision, although not at an individually named level. The DQBs also bring together all the different strands of quality that have

been functioning, sometimes in isolation, throughout the organisation and cover core fixed agenda items such as risk management and clinical audit.

These DQBs then provide reports to an umbrella group, the Clinical Quality Steering Committee (CQSC), which is chaired by the medical director and whose members include the chief executive, which therefore allows fast access to the trust board when necessary. It also allows for the germination of ideas and approaches across directorates. The CQSC also includes representation from outside the organisation, which is necessary to help dissipate the insular mentality that can be inherent in any institution. The CQSC is not designed to be prescriptive about functioning but to ensure that activity is taking place appropriately and within a broad remit. One of the requirements of the CQSC is to examine, annually, its own terms of reference and frequency of meeting, to allow for change as this initiative matures.

As the DQBs become sufficiently experienced the CQSC may be able to meet less frequently. Initially, the trust board was unclear about the level of detail that should be included in the monthly reports and discussions at the CQSC were helpful in clarifying a content that was acceptable to both board and directorates.

Technical support

Despite this strong infrastructure, clinical governance will still fail if there is no support to facilitate and provide advice. At the trust there was an existing clinical audit department, which contained some of the resources necessary in terms of both trained personnel and equipment such as hardware, software and journals. This department evolved into one of clinical governance with the provision of extensive training in order to develop further the existing skills of the staff and for them to acquire new ones. This training was provided externally and an ongoing programme both for the department and for individual clinical teams was further revised. In order that early successes could fuel the further development of the programme, the clinical teams trained initially were self-selecting.

The trust programme comprises training in quality-improvement tools and techniques and the longer-term plan is for those who have acquired these new skills and expertise to train others in the trust in an organisational 'cascade'. The aim therefore is not for the central department to be instrumental in 'doing' clinical governance to others but for it to provide assistance for others to become competent themselves. In this way it is hoped that the principles of this quality-improvement initiative will begin to pervade the actions of everyone working within the organisation.

Culture

This final component necessary for the successful introduction and implementation of clinical governance is the most difficult to effect.

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Within a teaching trust the focus historically has been on the technical superiority of the services provided. To turn that around to focus from a user perspective is both difficult and slow to achieve. To hold up too critical a mirror to the professionals may paralyse the professional certainty without which they cannot function to the best of their ability, and a highly trained and skilled workforce may feel disenfranchised by what they perceive as irrelevant demands.

To change cultural attitudes, therefore, a complex matrix of tactics must be employed. These include training and team building, both overt and covert, the use of champions, widespread dissemination of information, and other, more subtle, personal approaches tailored to individual personalities, all of which must be repeated constantly. However, the most important individual element in signalling the direction for an organisational culture change is strong leadership. Leadership that is visibly supportive

of those who are trying to embed clinical governance in the everyday practice of all staff is essential if there is to be a shift from the traditionally hierarchical and secretive culture of the NHS to one where all staff feel valued and empowered.

Conclusion

All organisations are unique and it would be foolish to expect that what works for one is suitable for all. However, we hope that this short summary of some of the practical lessons we have learned may help others.

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Top tips for effective strategy

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Rowland B Hopkinson: a clinical governance strategy for an acute trust

- A patient focus is essential. Patient representatives and commissioners must figure at every stage. Change must focus on the patient experience.
- The strategy must address the involvement of all staff at every level. All staff need to understand their individual responsibilities for patient care. The first stage of any strategy will be to develop the performance management/monitoring structures but the organisational development must follow. Clinical governance

requires a major change in culture within acute trusts and systematic organisational development is essential. Personal and leadership development for all staff is vital.

- The target must be to create multidisciplinary teams with defined clinical outputs, which are inclusive of primary care, the community and trust support services. Traditional bureaucratic, professional and geographical boundaries must be challenged through the strategy when this benefits patient care.
- The strategy must integrate all the components of clinical governance, risk management, clinical standards and the patient

experience with business planning. This will provide the trust with a cohesive structure for prioritising risks and demands within the organisation before implementing needed change.

Marcia Saunders: make sure the fundamentals are sound

- The organisation needs to give its staff clear direction; the implementation plan must be accessible to all staff and clearly understood. Awareness training is therefore helpful in ensuring that all health care staff (from the porter to the consultant) understand their role and responsibilities in delivering good-quality care to the patients they serve.
- The flip side of 'clear direction' is a reciprocal relationship, not a 'top-down' one. This means that

clinical governance strategies and boards must be robust and flexible enough to respond positively to sound cases made by clinical teams for service changes, and to advocate for additional resources from within and outside the organisation.

- The patient must be central to the activities of the trust. A programme of patient/user involvement is necessary for the successful implementation of clinical governance – their experience must inform change. A strategy for patient/carer involvement is therefore essential.
- Multidisciplinary clinical teams must be empowered to progress the clinical governance agenda. The organisation needs to accept that not all teams will be at the same level of development. Support and facilitation must be

made available and time allowed for reflection and learning.

- Clinical governance has to be part of everyday business and form an integral part of strategy, performance review and business planning. It needs to underpin the implementation of all initiatives in the NHS, such as the National Plan.
- Thus clinical governance is not just about creating systems, measuring impact, monitoring quality, learning and developing – as if that weren't enough: it is an essential part of the decision-making and investment process. And without planned and sustained investment in the basics – staff numbers, staff salaries, beds and the estate, for example – the staff morale, teamwork, rigour and creativity that are at the heart of clinical governance will be undermined.

WhoWhatWhere?

Clinical governance on the web

Discussion lists

<http://www.mailbase.ac.uk/lists/governance-primary-care/>

This list aims to encourage the exchange of ideas about clinical governance, and to act as a source of advice. It is open to anyone involved in quality improvement or clinical governance initiatives in UK primary care, and is run by the National Primary Care Research and Development Centre, University of Manchester. *Last message is dated June 2000.*

<http://www.mailbase.ac.uk/lists/cgss/>

This list is for the Clinical Governance Support Service, organised by the Royal College of Psychiatrists' Research Unit. The main topic of discussion is clinical governance in mental health. *Last message is dated March 2000.*

<http://www.mailbase.ac.uk/lists/clinical-governance-group/>

This is a self-selected group of health professionals wishing to discuss, share and learn about clinical governance

The Editors' Choice

WISDOM PCG Clinical Governance Discussion Group
<http://www.wisdomnet.co.uk/vconf.asp#cg>

WISDOM uses a website in combination with email discussion groups to provide networked professional learning, courses and 'virtual conferences'. This popular forum explores the issues affecting primary care groups, with an emphasis on clinical governance. Last message is dated March 2001.

issues. The group is a subset of CHAIN, developed by the London Regional Office of the NHS Executive. *Last message is dated February 2001.*

<http://www.jiscmail.ac.uk/lists/public-health-in-trusts.html>

This is an open mailing list for discussion about developing the public health function in acute, community and primary care provider organisations with

particular reference to clinical governance. *Last message is dated November 2000.*

Why not email us your suggestions?

If you know of any useful websites that you would like us to mention in *Clinical Governance Bulletin*, please email kirsty.orriis@rsm.ac.uk.