

# CLINICAL GOVERNANCE

December 2000

## Bulletin

### Clinical effectiveness

#### Editorial

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For many years now, research and development have had a high profile in the health field. As a result, clinical effectiveness has become a key topic for everyone involved in health-care, including patient organisations. Clinical guidelines have been promoted as a means to ensure that research evidence is put into practice and this has been supported by the NHS Executive<sup>1</sup>. The Nuffield Institute for Health has published criteria for the successful development and implementation of clinical guidelines<sup>2</sup> and information on effective treatment has been made available to the NHS through the publication of the *Effective Health Care* bulletins and a number of other sources. The quality agenda of the 'New' NHS has reinforced the importance of ensuring that patients receive treatment that is clinically effective. This also means that scarce resources can be targeted appropriately. The policy agenda is thus supporting principles of evidence-based practice. By setting up the National Institute for Clinical Excellence (NICE) and producing National Service Frameworks, the government will ensure that national standards for the effective delivery of health-care are made explicit<sup>3</sup>.

However, the dissemination of research findings is not a guarantee that they will be put into practice; the implementation process is

complex and, as a study by Oxman has demonstrated<sup>4</sup>, there are 'no magic bullets'. Local health-care organisations are responsible for the implementation of national standards, and therefore need to find ways of 'making it happen' and convince clinical staff of the importance of aligning individual practice to what is deemed best practice<sup>5</sup>. To this end they will need to encourage staff to ask questions such as:

- Are we doing things right?
- What is the evidence relating to our practice?
- How can we ensure necessary changes are put into clinical practice?
- How can we influence colleagues to participate in this process?
- How do we know the changes made are being sustained?

This issue of *Clinical Governance Bulletin* focuses on clinical effectiveness. It gives examples of implementation, such as the prescribing of ACE inhibitors in primary care, the usefulness and benefit of information sources such as the Cochrane Library and the contribution librarians can make to this agenda. It also deals with the effectiveness of individual services and other practical issues.

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For the next issue, the theme will be effective strategy. By that we mean the approach that organisations and teams are taking to ensure effective implementation of the clinical governance agenda. This may include the approach being taken to implement the National Service Frameworks, the support given by organisations to facilitate this process, team and partnership working, and communication. We are therefore looking for contributions that share practical individual or team experience,

highlighting the key learning points. The goal is that all those involved in the implementation of clinical governance benefit and learn from the experience of others. We look forward to hearing from you.

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- 1 NHS Executive. *Promoting Clinical Effectiveness: A Framework For Action In and Through the NHS*. Leeds: NHS Executive, 1996
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## Clinical effectiveness in the real world: lessons learned from a project to improve the management of patients with heart failure

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- Despite strong evidence for the effectiveness of ACE inhibitors in heart disease, the implementation of change towards their more widespread prescription required considerable effort, and the evidence turned out to be less comprehensive and convincing than those involved in the project had initially thought.
- Many GPs had previously *not* been prescribing the clinically effective drugs as much as the evidence suggested that they should. However, the assumption that this was based on their being uninformed about the effectiveness of ACE inhibitors proved to be incorrect. It became apparent that what people know and what they actually do may be quite different.
- Primary care records proved to be a rich source of data, and were helpful in directing the work, but getting at useful information was time-consuming, expensive and difficult. Furthermore, the quality of data was often poor.
- The implementation project raised quantitative research questions about the nature of the evidence

and its transferability, and qualitative questions about clinicians' prescribing behaviour. Answers to these questions could not be found in the literature (1996–98).

Although heart failure is a serious, life-threatening condition, there is strong evidence that angiotensin-converting enzyme (ACE) inhibitors reduce its morbidity and mortality<sup>1</sup>. We report on an implementation project that used audit, surveys of GPs and guidelines to improve patient management in this respect.

### The plan

This project, led by Kensington, Chelsea & Westminster Health Authority, was one of 17 projects funded through a regional research implementation programme<sup>2</sup>. Projects had to meet criteria that included being based upon robust research evidence. This project focused on one locality in the health authority (covered by 21 GPs). The aim was to use audit data, the provision of a new open-access service for echocardi-

ography and locally developed guidelines to increase the proportion of patients with heart failure being prescribed ACE inhibitors. Guidelines were drawn up as the vehicle for changing practice in the diagnosis and management of heart failure in general practice, and for use of the open-access echocardiography service. A re-audit of practice and echocardiography data was conducted a year after the introduction of the guidelines, and GPs' views were surveyed to establish the impact of the work.

### The project

Patients with possible heart failure were identified by searching computerised disease registers for a diagnosis of heart failure or relevant current prescriptions. Patients' records and interviews with GPs were also used to obtain a picture of primary care patients with *diagnosed* heart failure in the locality. This information was used with the European Society for Cardiology's guidelines<sup>3</sup> as a stimulus for discussion and development of local guidelines. All local GPs,

echocardiography technicians, cardiologists and pharmacy technicians were invited to these discussions. The project officer drafted, distributed and revised local guidelines, based on the discussions and subsequent feedback. The revised local guidelines were then disseminated, and their use evaluated through re-audit of practice data, echocardiography service records and a survey of GPs' opinion.

## What was learned

Existing records (in this case, in primary care) proved to be a rich source of data (although often of poor quality). The data were helpful in directing the work, but getting at the information in practices was a slow and demanding process (and therefore expensive). Nonetheless, the project demonstrated that data extraction could be satisfactorily undertaken by someone other than a trained clinician, and the project team concluded that taking a facilitative, helpful approach to the work was the key to getting it done<sup>4</sup>.

The range of systems in use across the locality complicated matters, and the project team found it necessary to adopt a different approach to data collection at every practice. As a consequence, the estimated time required to conduct the audit was considerably underestimated.

The survey of GPs' views and audit at the start of the project highlighted the inconsistency between the way they believed heart failure should be managed<sup>5</sup> and the way they actually managed it: most GPs were familiar with the evidence in favour of prescribing ACE inhibitors, yet fewer than half were prescribing these drugs routinely to diagnosed patients; most GPs were aware of the recommendation to confirm the diagnosis of heart failure by echocardiogram, yet less than a third of diagnosed patients had been subject to this investigation.

The re-audit pointed to increases in the proportions of diagnosed patients being investigated by echocardiogram and other tests. However, it was not possible to attribute this to

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the impact of the project. Interestingly, the proportion of patients considered for ACE inhibitors did not change, despite the increase in investigations.

Finally, and importantly, as a result of digging deeply into the evidence and working with clinicians to implement the recommendations, it became apparent to members of the project team that there was a mismatch between the research evidence and the context in which they wished to apply it. For example, the majority of trials had been conducted in secondary care and had explicitly excluded the type of patients typical of those diagnosed with heart failure in primary care. (The trials usually studied men under the age of 65; in the project locality the diagnosed patients were more often women and the vast majority, of either sex, were over 65.)

The lesson was that attempting to implement a clinically effective change in practice is itself a learning process. The project team take the view that encouraging clinicians and researchers to consider the presence or absence of relevant evidence in this way stimulates the demand for

more appropriate research and prepares the ground for the implementation of its results.

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# Assessing the quality of communication using patient feedback

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- The assessment and development of communication skills are an essential component of clinical governance.
- The Doctors' Interpersonal Skills Questionnaire (DISQ) is a robust instrument for assessing the communication skills of doctors and other health professionals from the patient's perspective.
- The DISQ has been used successfully in a number of settings, such as primary care groups and trusts, NHS trusts and GP vocational training.

Patients want their health looked after in the best way possible. Sometimes the effort demanded of a patient to receive health-care is almost heroic: organising child care, taking tests and visiting referral specialists, travelling to different places, dealing with workplace and domestic needs, coping with feelings and fears, and maintaining other routines such as school functions, family visits and shopping. This effort can be made more rewarding and more efficient if both the practitioner and the patient have good interpersonal skills. However, as the service provider, there is a special responsibility placed upon the practitioner for high levels of interpersonal skill. Such skill is a key element in clinical governance.

Patients have been able to describe what good interpersonal skills mean to them through a questionnaire. They have identified up to 10 aspects of skills and attitudes that they find important in getting health looked after and getting value for effort<sup>1,2</sup>. Here is their list:

- greeted warmly
- being listened to
- clear explanations
- reassurance
- confidence in ability
- being able to express concerns and fears
- being respected
- having enough time in the visit
- consideration of their personal

context in any advice or treatment offered

- concern for the patient as a person, not just a disease

What is not surprising is that doctors and nurses would like to have patients tell them, in a systematic and helpful way, how they, as patients, rate their interpersonal skills, for both know how these help achieve a good history, better treatment choices and take-up and, in the end, mutual satisfaction with the effort and outcomes.

The above list has been summarised in a patient feedback instrument called the Doctors' Interpersonal Skills Questionnaire (DISQ). In the first issue of the *Clinical Governance Bulletin*, Dr Kieran Sweeney mentioned the DISQ as a robust instrument for assessing the interpersonal skills of doctors and nurses<sup>3</sup>. What follows are examples of the varying contexts in which the DISQ is being implemented as a tool for clinical governance. These contexts include primary care groups, NHS trusts (including primary care trusts) and vocational training.

### Primary care groups and trusts

Several primary care groups and trusts throughout the UK have asked their general practices to use the DISQ. To date, over 500 GPs and nurses, as well as some professionals allied to medicine (e.g. physiotherapists) have received feedback from their patients on their interpersonal competence. The feedback is directed at three levels: the individual practitioner, the general practice, and the primary care group as a whole. In this way, individual practitioners are able to incorporate the results into their own continuing professional development plans, while practices and primary care groups can begin to develop strategies and training initiatives to address areas in need of improvement.

The feedback from GPs and nurses has been mostly positive. While initially a daunting exercise for many of them, the results have confirmed their strengths and identified some areas in need of improvement. One of the challenges is to find ways of appropriately discussing an individual practitioner's results in a sensitive and developmental context.

### NHS trusts

Hospital consultants, junior doctors and nurses have begun this activity. In the South West of England, two NHS acute trusts are piloting the DISQ with 41 hospital clinicians (21 consultants, 10 junior doctors and 10 nurses) across a number of specialties, such as oncology, urology, gastroenterology, anaesthetics, orthopaedics, paediatrics and ophthalmology. Similar to the primary care experience, many of the hospital staff have found the exercise a useful one in gauging and providing future directions in the development of their interpersonal skills. Some consultants have already initiated changes in their practice as a result of the feedback. For example, one has increased the amount of time he spends with female patients after finding a 30% difference in scores on this item between male and female patients.

### Vocational training

Several GPs, consultants and nurses have commented that feedback on interpersonal skills should begin in the initial training years of health professionals. In Exeter, the vocational training scheme for general practitioners has implemented the DISQ with 13 pairs of GP trainers and GP registrars. The trainer and registrar discuss their results together. When asked about whether the results assisted them in learning anything new about their ability to relate to patients, all GP registrars and 71% of GP trainers agreed that it did. Furthermore, 86% of the

registrars and 71% of the trainers tried to modify their interpersonal skills as a result. Other comments about the experience of patient feedback from GP registrars and trainers were:

- 'I now better understand whether patients were satisfied with my consultation style or not. Most of them are happy but I need to work on letting patients express their fears/concerns more.'
- 'The results were encouraging for me personally.'
- 'There was an interesting difference in results between "my own patients" and patients "I do not usually see", as well as a difference

between male and female patients.'

## Conclusions

At the heart of good clinical care and governance is the communication between the patient and the service provider. There is a tool that can assess communication skills and provide directions for improvement. Details of the DISQ can be obtained from Client-Focused Evaluations Programme by emailing [cfep@dialstart.net](mailto:cfep@dialstart.net) or by telephoning 01392 256 289. Though initially perceived as a daunting exercise, several hundred GPs, nurses and other health practitioners have

found the feedback very useful. As the concept of user involvement becomes more culturally acceptable, more doctors and other health professionals may adopt the DISQ as an integral part of their professional development.

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# Implementing clinical governance – getting the skills into practice

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- A clinical governance task group that involves one representative from each practice can ensure participation in audits.
- The training of practice data assistants in audit and data validation skills can contribute to the effectiveness of an audit.
- As the data quality project develops, the primary care group will receive increasingly robust data about disease management, which will be important for implementing the National Service Frameworks (NSF).
- The development of data validation skills and their harnessing to NSF requirements can make an important contribution to clinical effectiveness.

Much has been written about developing clinical governance in large organisations but little about the necessity of investing at general practice level. Pringle<sup>1</sup> develops the theme of a team-based approach to quality, and the development of people and services.

In East Devon, the primary care group (PCG) has chosen to provide

funding specifically for the time and training of a data assistant in every practice in order to ensure the provision of clinically effective services. Per practice, £500 was offered, to pay for two hours of staff time per week, and all 13 practices in the PCG area agreed to participate. In the first year (2000), practices identified an enthusiastic receptionist or medical secretary to act as their data assistant. All the practices released their nominated data assistants to attend a day-long introduction to audit (arranged by the PCG audit group) and undertook to perform one PCG-wide audit per quarter and to share the results across the PCG. A clinical governance task group that has a clinician from each practice chooses the topics for these PCG-wide audits.

Practices also agree to allocate the rest of the funded time to developing practice audit. North and East Devon have had a thriving primary care audit group for many years and many practices have taken part in multi-practice audits. Individual practices have also shared audit work with the audit group, but often this work has had to be performed by

individual clinicians without support staff and without systematic direction.

The PCG-wide audits we have designed have each included disease register validation techniques within them. We have tried to make them simple to do but likely to focus practices' attention on important issues.

## Medication in schizophrenia

The first audit was intentionally very simple. It asked practices to audit whether people with schizophrenia between the ages of 18 and 65 had had their medication reviewed within the last 15 months. The timeframe of 15 months was chosen to allow for patients who were late in attending their annual reviews. The standard set was 100% of patients and information available on who carried out the review. The data assistants validated their registers by performing medication searches for antipsychotic prescribing in this age group.

The results showed that 97% of patients with schizophrenia on

long-term antipsychotic medicine had had their medication reviewed within the previous 15 months by a GP, psychiatrist or community psychiatric nurse. The audit revealed that some practices had a considerably higher number of patients with schizophrenia, raising issues of prescribing budgets, staffing levels in small practices and education. It also showed that our area had slightly fewer cases than the national average, but this may be accounted for by the audit including only people between 18 and 64 years (Devon having a high proportion of older people).

### Cholesterol care in patients who have had coronary artery surgery

The second audit looked at the care of patients who had had coronary artery surgery. A standard was set that 70% of such patients below the age of 80 should either be taking a statin or should have had their cholesterol measured and a record made of the decision whether or not to treat it.

Many of our practices have fully Read-coded summaries, but some

discovered as a result of this audit that their registers of patients with coronary heart disease (CHD) were missing patients who had had bypass grafts. Often audits of cholesterol reduction had been carried out on their CHD registers but had missed this group of patients. In an author's practice we discovered that 10 patients had had coronary artery operations which were not coded under the standard Read code for coronary artery venous graft (44 patients had the code). These 10 patients had their coding altered, so that they would be included in this and future audits.

All practices in the PCG area took part. The total population aged 80 years and under was 104,067 and 678 patients had been coded as having had coronary artery bypass surgery (a prevalence of 0.65%). Of these, 67% were on a statin, 16% had had a documented decision that they either did not need or declined statin treatment, or that it was contraindicated, and 17% were neither on a statin nor had a decision documented. The results of this audit are being made available within the clinical governance structures of

the PCG and the team will recommend that the data assistants contact these patients and ask them to attend the CHD secondary prevention clinics that the PCG is helping practices set up.

### Conclusions

The provision of funding to all practices in a PCG area has enabled a universal participation in audits of clinically effective treatments. The PCG has now decided to allocate funding to a data quality improvement project that will systematically develop data validation skills and harness them to NSF requirements. In return, the PCG will receive robust data on disease management in primary care. Because of the demonstrated importance of accurate clinical records, the PCG has also funded a catch-up programme of note summarising in non-training practices and continuing summarising in all practices using PCG-agreed Read codes.

### Reference

- 1 Pringle M. Clinical governance in primary care: participating in clinical governance. *British Medical Journal* 2000;321:737-40

## Top tips for implementing changes in practice based on research evidence

### David Evans

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The following tips are inspired by experience of 17 research implementation projects across 15 health authorities.

- Select a topic where the evidence is conclusive and difficult to deny. It is essential to have confidence in the evidence underpinning the changes you wish to make. Enlist the support of key people (e.g. clinician, academic, senior manager) who support the objective, have local credibility and are willing to defend the cause.
- Focus on changes that will have a visible effect and be widely celebrated, ideally by patients, clinicians and managers. (Awareness of local priorities and opportunities will be the key to this: it's easier pushing at an open door.)
- Identify the best *readily available* indicators of impact or outcome and measure these before, during and after the lifespan of the work. It may be necessary to be pragmatic about what can be measured, but it is vital to have a credible yardstick in order to demonstrate the difference made.
- Look for and exploit natural links with other priorities and initiatives. Make the connections with training and audit. All whose jobs are affected by a change in practice should be identified and involved as stakeholders in the change process at an early stage. Listen to their views and be responsive so that common ownership is fostered.
- Above all else, tackle something realistic and deliverable. The biggest danger is over-ambition. Even apparently simple changes have complex knock-on effects that may be impossible to predict. Remember that sustainable change is most likely to be achieved when its implementation is *incremental*.

# A strategy for supporting the implementation of evidence-based practice

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- Strategies are needed to support the implementation of evidence-based practice.
- It is possible to identify systematic reviews from reputable sources that meet the twin criteria of having a minimum level of scientific quality and a clear, relevant message.
- Assessment of these reviews by a local committee can identify any need for change in clinical practice and potential areas for clinical audit.

It is known that, on its own, the dissemination of research evidence is insufficient to alter clinical practice<sup>1</sup>. No single intervention seems to be optimal in stimulating such change and a combination of approaches is generally recommended. Effective strategies therefore tend to be resource intensive and there continues to be a need for new, simple approaches that might produce benefit for relatively modest input.

## The Research, Development and Effectiveness Committee (RDEC)

In September 1999 a new committee was established in the Taunton & Somerset NHS Trust, taking on the roles of the former Research and Development (R&D) and Clinical Audit Committees, but in addition seeking to bridge the gap between the two activities. Membership includes:

- a consultant from each of the clinical directorates
- nursing and PAM representatives
- non-clinical staff from R&D, clinical audit, finance and the trust board
- the local health authority's director of clinical governance.

More recently, a lay representative has joined the committee. The RDEC meets every six to eight weeks and two executive subgroups meet monthly to consider proposed research and audit projects, respectively. It reports quarterly to the Clinical Governance Committee.

One of the RDEC's key roles is the assessment of research evidence and its local implications. Such an assessment may be triggered by a particular issue, for example a proposal for new local development, but more commonly the committee examines the research evidence as it emerges and considers what action, if any, is required locally.

Relevant research evidence is identified by the Research & Development Support Unit (RDSU) in the form of new systematic reviews arising in reputable sources. In practice, this means sources that use established quality criteria that are generally more stringent than the peer review employed by most journals. These include:

- reports from the National Institute for Clinical Excellence (NICE)
- the Cochrane Database of Systematic Reviews (within the Cochrane Library)
- *Effective Health Care* bulletins
- Health Technology Assessment (HTA) reports
- the journals *Evidence-Based Medicine* and *Evidence-Based Nursing*
- *Bandolier*

New reviews identified in these sources are assessed for relevance; in particular, reviews are not taken any further if there is no 'bottom line' recommendation (other than that more research be conducted). The abstracts of appropriate reviews are

distributed to other trusts and primary care groups in the county of Somerset and those that are appropriate for further consideration by the RDEC are also identified. Each such review is sent to two members of the RDEC, one from the most relevant clinical directorate and one who has no direct interest in the subject matter of the review. At the next meeting of the committee, the review is briefly summarised by the two designated individuals and consideration is given to what further action (if any) is required. Opinions from appropriate subspecialists are often sought before final consideration. Special consideration is given to guidance from NICE, in that hard data are sought as evidence of local compliance.

## The first year

In its first year of operation the RDEC met seven times and considered 79 reviews (an average of 11 per meeting), eight of which were still on-going at the time of writing. In 37 (52%) of the remaining 71 cases, local practice was said to be in accord with the findings; in 22 (31%) a change in practice was not considered to be warranted, for reasons such as inconclusive findings or poor generalisability; and in 12 (17%) the reviews have been taken further. Many of these 12 have been more widely disseminated throughout the trust and to primary care groups; some have been made the subject of a departmental education/audit meeting or a more substantial audit (e.g. the Cochrane review on intrauterine devices for menorrhagia<sup>2</sup>); and some have had a direct impact (e.g. a review<sup>3</sup> reported in *Bandolier*<sup>4</sup> on the prevention of catheter-related bacteriuria led to the formulation of a policy on catheter use within the trust).

## Conclusions

The work of the RDEC is not being evaluated as a formal research project (e.g. in a controlled trial) and it is impossible to attribute directly to it any changes in practice. In addition, the approach generally deals with evidence as it arises rather than being problem driven. Nevertheless, the structure described provides a useful mechanism for

actively disseminating new evidence and enabling health professionals to assess current practice against such evidence. Where reviews have been taken further in some form, clinical audits will be undertaken to assess the impact.

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# Cochrane in practice

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- The Cochrane Library is now available to NHS practitioners, but many still do not realise that it is available, or that help in using it is close by.
- Most people find that it takes practice to become proficient at using the Cochrane Library; do not be put off if it seems difficult at first.
- Applying systematic reviews in practice always requires consideration of how the information applies to one's own setting.

Most people have now heard of the Cochrane Library, which contains gold standard evidence about the benefits and harms of treatments and other interventions of interest to health professionals.

### What exactly does the Cochrane Library contain?

When it was first launched in 1993, the Library (then the Cochrane Database of Systematic Reviews) was criticised for being too patchy, containing just over 100 systematic reviews. By contrast, the Library is now much more comprehensive, containing (as a library does) several different resources:

- over 850 Cochrane systematic reviews about the benefits and harms of health-care interventions, most containing

- comments on relevance to practice;
- over 1700 detailed abstracts of systematic reviews, assessed by the NHS Centre for Reviews and Dissemination (the Database of Reviews of Effectiveness, 'DARE');
- over 250,000 abstracts of individual randomised controlled trials – most of those ever completed (the Cochrane Controlled Trials Register);
- over 1000 abstracts of articles about research methods, particularly those pertaining to systematic reviews;
- contact details for health professionals involved with Cochrane all over the world.

### Examples of the thousands of topics covered

The topics covered include:

- wound care
- social and medical treatments for depression and schizophrenia
- analgesia for osteoarthritis
- smoking prevention programmes
- fluid regimens
- treatments for adult and childhood asthma
- best practice for audit

### How up to date is Cochrane information?

Cochrane disks are issued each quarter on CD-Rom, while the web

version is updated continuously. Most reviews are updated about once a year, although some are older. All are stamped with a date at the top, so you can see when they were last updated with results from new studies.

### How can you access the Cochrane Library?

- Online by subscription, although NHS staff in the London region are entitled to free access. Telephone your local library or postgraduate dean centre to find out how to access it.
- In any NHS or health-related library, including local post-graduate dean centres.
- On many (although not all) hospital computers.

### How easy is the Cochrane Library to use?

Although easy to use with a little practice, most people need help the first time they sit down to use the Cochrane Library. Librarians in all NHS and educational centres are trained to show people both how to use the Cochrane Library quickly and the different resources it contains.

One great feature that many inexperienced users miss is the 'Summary of Analyses'. These give a visual summary of all the data contained within each review. You can

find the Summary of Analyses listed within the small 'Outline' box above the text of each Cochrane systematic review.

To make best use of Cochrane data, it is helpful to know how to interpret things like relative risk figures and tables, and odds ratios. The glossary in the Library explains some of these things and there are interactive websites where you can calculate your own (try <http://www.shef.ac.uk/~scharr/ir/netting/> or <http://plaza.v-wave.com/medlink/EBMcalc/treatment.htm>, which is an excellent site).

It is possible to print out a whole review for your own use, or to share with colleagues and patients. However, if you do not want the whole thing (often 20 pages or more), you need to copy the whole review into a word processor file, and then cut and paste the sections you want.

### How do I apply Cochrane review data to my own practice?

Applying Cochrane reviews to practice requires readers to think about how the information relates to their own setting. A quick checklist to consider is 'PIO':

- Participants – were the people in

## Editorial Committee

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the review the same as the people I am working with?

- Intervention – are the interventions in the review the same as those that I am trying to make a decision about?
- Outcomes – are the outcomes in the review those that I am interested in?

Some practical common uses of the Cochrane Library are:

- checking to see whether there is any reliable evidence about the benefits or harms of treatments;
- sharing information about treatments with colleagues and patients;
- commissioning, planning and conducting research;
- finding people interested in reviewing research within a particular field.

## Working together to improve patient care: the clinical skills trainer and the clinical support librarian

Jocelyn Hewitt<sup>1</sup>, Julie Anne Watson<sup>2</sup> and Anne Weist<sup>3</sup>

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- Finding the evidence to improve patient care can be very difficult.
- Staff may not know where or how to search effectively.
- An experienced health librarian can help busy clinicians get to the evidence more quickly.
- Appropriate evidence can change practice.

Putting evidence into practice requires support, facilitation and access to relevant evidence. Two new posts

have been created to help move the effectiveness agenda forward and increase the support already available for individuals and teams within clinical services.

### New posts

The clinical skills trainer and the clinical support librarian have formed an excellent working relationship and have been able to promote evidence-based practice.

Both posts are new and have short-term funding. The trainer is funded by the Outer London Education Consortium and South Bank University and the librarian is funded by the Thames Postgraduate Deanery.

### The clinical support librarian (CSL)

Key areas of her work have been with the clinical improvement groups, the

G Grade Community Nurse Development Programme, evidence-based mental health journal clubs, senior nurses, doctors and therapists<sup>1</sup>. She has been able to promote and extend the work of the existing library team by facilitating clinicians' use of front-line electronic library information in 20 clinical areas (as of November 2000).

### The clinical skills trainer (CST)

The CST provides interprofessional clinical skills training. Areas covered include intravenous cannulation and female catheterisation, suturing, venepuncture and non-invasive monitoring. She works in partnership with lead medical and nursing staff, and coordinates consultant and specialist registrar taught skills sessions for medical staff. She also facilitates workshops for nurses on practical skills such as CVP measurement and chest drain management.

### Finding the evidence

Finding quality evidence to support patient care is difficult<sup>2</sup>. There are a large number of possible sources, which can have very different search interfaces, and so staff may not know where to search or how to do so effectively<sup>3</sup>. Even in-house at Forest Healthcare, there are three different major search interfaces, not including those for electronic textbooks or the intranet. On the Internet itself there are a host of different search facilities. Again, all are easy to get 'some' results out of and herein lies the danger. The CSL uses her searching expertise to help busy clinicians find the best evidence available<sup>4</sup>. The CST and her fellow

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trainers have used the CSL to clarify questions raised over clinical procedures. The following example is illustrative of the joint work of the CST and CSL.

### Wound cleansing

During teaching sessions for medical and nursing staff in the clinical skills laboratory, there was much debate about which cleansing solution should be used before closure of wounds with interrupted sutures. The CSL was contacted and asked to determine the efficacy of commonly used solutions such as antiseptics and normal saline. The evidence revealed that both tap water and normal saline are clinically effective and cost-effective cleansing agents<sup>5,6</sup>. This simple, clinically proven and carefully appraised evidence will be disseminated to nursing staff attending study days in the future. The wound cleansing work illustrates

how CST and CSL collaboration can result in cost savings and improved clinical outcomes.

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- 2 McKibbin KA, Walker-Dilks CJ. The quality and impact of MEDLINE searches performed by end users. *Health Libraries Review* 1995;12:191-200
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## Clinical effectiveness of the colorectal service at St Mary's NHS Trust

### Paula Taylor

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- Expanding the role of the nurse to complement the colorectal team is clinically effective as well as cost-effective.
- Using a nurse practitioner in this way can increase activity and decrease waiting times.
- This approach has enabled us to respond promptly to the Department of Health's two-week wait initiative for urgent referrals for patients suspected of having colorectal cancer.

Bowel problems are extremely common in the Western world – from haemorrhoids to irritable bowel syndrome, diverticulosis, inflammatory bowel disease and bowel cancer. Many of these diseases give rise to symptoms of a similar nature, which can cause considerable

alarm and anxiety. In addition to this, many people find admitting they have a bowel problem very embarrassing and it may take some time before they will seek advice.

### Nurse-led colorectal clinic

At a London teaching hospital, the surgical team specialising in coloproctology felt that a nurse practitioner (NP) would be able to work with them to enhance patient care and to develop new services in response to the increasing referral rate and local patient needs. This approach was approved and the appointment to the NP role was made in January 1996. After validated, external teaching and assessment, as well as internal teaching from the surgeons and

gastroenterologists, and with the agreement of guidelines for practice, the work began.

The nurse-led one-stop diagnostic colorectal clinic was set up for patients aged over 50 years with symptoms suggestive of a cancer and so who needed prompt full bowel investigation. The NP takes a history and makes the examinations, including flexible sigmoidoscopy. The patient will then have a double-contrast barium enema on the same day. The results are discussed with the clinical team and sent to the GP within 48 hours.

If a cancer is detected, the GP is informed and the NP and the clinical team see the patient within two days in the consultant-led clinic for a decision on a plan of care. Within this clinic the diagnosis will be explained to the patient. The NP will refer for an oncology opinion, if appropriate, and/or arrange admission details for surgery. The essence of the role is that throughout the journey of care the patient is well informed and supported by the colorectal nurses.

The average wait for an appointment in the one-stop clinic is currently three weeks. This clinic is constantly audited. With the first 600 cases there have been no missed colorectal cancers and no complications. Patients have reported high satisfaction with this service, with less anxiety and less time waiting for results. Also they appreciate having only one hospital visit instead of three.

### Nurse-led rectal bleeding clinic

The nurse-led rectal bleeding clinic was developed for patients aged under 50 years who have rectal bleeding only. A research project looking at the nurse's skills in correctly diagnosing and managing these patients was undertaken by comparing her with a doctor of registrar grade<sup>1</sup>.

Eighty-one patients (36 men and 45 women, mean age 30.8 years) were randomly assigned to see the NP or the clinician, each of whom recorded their findings. An independent clinician then compared video recordings with these findings. The study concluded that a NP can safely perform videosigmoidoscopy as well and as accurately as a medical clinician.

## Contributions

*Clinical Governance Bulletin* is a bi-monthly 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
- Strategic effectiveness
- 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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While the NP took more time than the clinician to perform videosigmoidoscopy, patients reported less discomfort when being investigated by the NP. Patient satisfaction scores for the NP were extremely high, with a mean of 9.2 (on a scale of 0–10), and all patients said they would return for a similar consultation if necessary.

A treatment algorithm with a nurse-prescribing protocol has since been written and will allow the NP to run the clinic completely independently, within the community setting<sup>2,3</sup>.

The development of this clinic has allowed the medical team to spend more time with patients who have more complex and serious symptoms. It is now intended to set up a similar rectal bleeding clinic offering evening appointments, to create flexibility for this group of patients.

A second NP was appointed in May 2000. This will facilitate a further reduction in waiting times for patients with suspected colorectal cancer. Also, by working and communicating effectively with the primary care groups we can try to ensure that urgent-referral guidelines are followed.

### Other initiatives

Our colorectal cancer audit recently highlighted the problem of the relatively long wait for colonoscopy investigation once a cancer has been detected on initial clinic investigation. In response to this, the NP suggested a weekly urgent slot within the endoscopy unit, enabling patients to have this investigation within a matter of days rather than weeks and hence reducing delays for surgery or oncology treatment.

The NP's role also involves supporting the inflammatory bowel disease clinic and the anorectal physiology clinic. Patients are assessed and seen with the team and are offered information, support and a contact number if there are any problems between clinic visits.

Nurse practitioners provide a direct link for all colorectal patients and for GPs who need to refer a patient urgently to the team. Patients report that they like the consistency of care and knowing whom to contact for support and advice. Both NPs are regularly involved in teaching nursing and medical staff within the hospital and in the community, which enables them to spread good

practice. Further service development is under way, including the appointment of a colorectal services administrator from January 2001.

## Conclusions

We have been able to demonstrate that a NP-led service is both clinically effective and cost-effective. It has resulted in increased patient

satisfaction and decreased waiting times for patients to be seen. This successful initiative has been underpinned by excellent team support and effective working relationships.

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- 3 Alderman C. One stop to the best patient care – colorectal service. *Nursing Standard*, 16–22 September 1998;12(52):28–30

# WhoWhatWhere?

## Clinical governance on the web

### Journals

British Journal of Clinical Governance  
<http://www.mcb.co.uk/bjcg.htm>

Clinical Governance Bulletin  
<http://www.clinical-governance.com>

Clinician in Management  
<http://www.radcliffe-oxford.com>

Clinical Risk  
<http://www.rsm.ac.uk/pub/cr.htm>

Effective Health Care  
<http://www.rsm.ac.uk/pub/ehc.htm>

Healthcare Risk Report  
<http://www.irseclipse.co.uk/publications/hcrr.html>

Health Services Management Research  
<http://www.rsm.ac.uk/pub/hsmr.htm>

Journal of Clinical Excellence  
<http://www.radcliffe-oxford.com>

Journal of Clinical Governance  
<http://www.le.ac.uk/cgrdu/jclingov.html>

Journal of Integrated Care  
<http://www.rsm.ac.uk/pub/jic.htm>

## The Editors' Choice

National Institute for Clinical Excellence (NICE)  
<http://www.nice.org.uk>

Journal of Health Services Research and Policy  
<http://www.rsm.ac.uk/pub/jhsrp.htm>

### Books

Advancing Clinical Governance  
*Myriam Lugon and Jonathan Secker-Walker*  
<http://www.rsm.ac.uk/pub/bklugon2.htm>

Clinical Governance in Healthcare Practice  
*Thoreya Swage*  
<http://www.bh.com>

Clinical Governance in Primary Care  
*Edited by Tim van Zwanenberg and Jamie Harrison*  
<http://www.radcliffe-oxford.com/bookdetail.asp?ISBN=1+85775+396+8>

Clinical Governance – Making it Happen  
*Edited by Myriam Lugon and Jonathan Secker-Walker*  
<http://www.rsm.ac.uk/pub/bklugon.htm>

Clinical Governance under Construction  
*Steve Dewar*  
<http://www.kingsfund.org.uk>

Clinical Risk Management  
*Charles Vincent*  
<http://www.bmjbookshop.com>

Making Clinical Governance Work for You  
*Ruth Chambers and Gill Wakley*  
<http://www.radcliffe-oxford.com>

Making Sense of Clinical Governance  
*Roy Lilley*  
<http://www.radcliffe-oxford.com/bookdetail.asp?ISBN=1+85775+425+5>

## 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.orriss@rsm.ac.uk](mailto:kirsty.orriss@rsm.ac.uk). In the next issue, we will be listing the websites of discussion lists.