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Editorial: Chronic disease management and the implications for clinical governance

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Chronic diseases are responsible for significant morbidity and mortality worldwide: according to the World Health Organization, they account for 46% of the burden of disease.[1] It has been reported that about 17.5 million people in the UK are suffering from a chronic condition. Around 60% of adults report a chronic health problem. Over three-quarters of these have more than one disease and around a quarter will have three or more such problems.[2] The number of people with chronic disease is set to double by 2030.

People with long-term conditions account for some 80% of consultations with GPs. Management of these conditions is complex. Around 50% of people do not take their medication as prescribed. Providing services for people with chronic diseases is putting increasing pressure on health-care resources but at last the NHS is waking up to the need to develop new ways of delivering long-term care. Increasingly, chronic diseases feature in the development of both health-care policies and new ways of working across sectors and across professional boundaries.

Various elements of clinical governance are essential in supporting effective care for people with chronic conditions:

- evidence-based care and its assessment through audit are crucial in producing best outcomes for patients;
- staff and patients require tailored training and development programmes;
- accurate and timely information systems underpin care provision.

Best outcomes for patients

The effective delivery of chronic care requires a culture that promotes quality and the use of improvement strategies[3] that are responsive to what those with chronic conditions need and want. To this end, much more must be done to ensure that the views of these patients are sought and that their feedback is taken into account. The national 'expert patient' programme[4] goes some way towards empowering patients, but much more needs to be done at local level to ensure that patients are involved in the clinical governance agenda and the development of services.

Patients have a much broader perspective than individual health-care professionals, as they come into contact with different parts of the health-care system and understand what it means to live with a chronic

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condition; they can also inform services of what outcome measures would be of value to them and what would help them make informed decisions.[5] The views of users and carers can be sought in many ways, for example through interviews or focus groups, but some innovative approaches have also been used, such as giving patients disposable cameras to 'record their lives' and to use these records to influence the views of health-care professionals.[6]

The needs of people with long-term conditions are not always understood by health-care professionals and awareness of these must be raised.[7] This can be done by putting in place specific awareness training, tailored to those staff who come into contact with these patients and by ensuring that they have access to sources of information and support, for example from the various local and national patient organizations and the Long-Term Medical Conditions Alliance.[8]

Audit plays an important role in the monitoring of clinical practice and service delivery. When pathways and protocols are developed, an audit tool needs to be created to allow prospective evaluation of the care delivered and the outcomes achieved, including quality-of-life measures. Clinical teams and patients should be involved in determining how best to record outcomes, so that the measures developed address what really matters to patients.

Audit should also be used to monitor and review the number of acute exacerbations suffered by patients with chronic disease, particularly when these affect the ability of patients to carry out the activities they wish and when they require admission to hospital. The audit should focus on the potential for avoidance of the problem in future, covering areas such as adequacy of regular care, medication prescribing and use, frequency of monitoring and sufficient understanding from patient, carer and professional staff of the signs warning of deterioration. Health-care organizations and their teams should also take part in whatever national audits have been developed; such audits can act as an incentive for improvement and allow comparators to be developed with similar institutions.[9]

Measures of patient satisfaction with the care they receive must be included in a regular monitoring programme. The information generated in the process will help identify where changes are needed. As part of a robust audit process, time needs to be made available for teams to come together to review audit results, together with all available clinical information (such as complaints and incidents), to reflect on current practice and to identify the next steps required.[10,11]

Agreement should be reached about the type of information (e.g. complaints, incidents, survey results, performance indicators) that is to be routinely collected, who is to collect it and who needs to receive it. This information should be regularly considered at team meetings alongside appropriate guidelines from the National Institute for Health and Clinical Excellence (NICE), audit data and other relevant facts.

Training

Health organizations will need to use their staff flexibly. A range of staff will need to acquire new skills and/or extend their role to support the management of chronic disease. This has major implications for the training and development agenda locally. The type of staff needed (both professional and support staff) and the skills and competences they require to manage and monitor people with long-term conditions must be dictated by the services patients require. This may indicate that new roles are needed. Targeted training can then be developed and delivered. Some training areas are essential; these include the ability to assess risk and stratify patients accordingly, and the ability to identify deterioration in a patient's condition as early as possible. The training programme should be formally accredited and appropriate career paths should be devised for staff moving into new roles.

The skills and competences of care coordinators and the training they need require particular attention, as these staff will deal with the more complex patients, often those with more than one condition. The competences required include understanding the management of chronic disease, knowledge of specific diseases and the ability to teach patients the skills to manage their own conditions (such as monitoring peak flow, blood pressure and sugar level). Care coordinators should be able to work with groups, multidisciplinary teams and across organizational boundaries, have knowledge of what services are available locally and have good communication skills, but also be self-motivated, enthusiastic and willing to embrace change. A range of staff, such as nurses, occupational therapists and physiotherapists, can fulfil this role provided they have, or can acquire, the necessary skills and competences to provide high standards of care.

Ongoing training and development will also need to be available. As care is delivered in teams, a team-based approach[12] to learning should be considered. Training should also be provided across agencies and disciplines whenever possible. Other necessary programmes include training and development for carers in residential and nursing homes to help to avoid unnecessary hospital admissions.

Staff working in different capacities and in different settings need to be clear about their roles, responsibilities and accountability. Effective supervision will ensure that staff work within the limit of their competences and that training needs can be identified. Health-care organizations will need to agree who has overall responsibility for monitoring staff performance and provide access to relevant ongoing training and development.

Educating patients

Educating patients in how to manage their own disease and how to access relevant information is essential. Patients require advice about managing their medicines, the range of activities and support available from the statutory, private and voluntary sectors locally, whom to contact when they want advice, where to find accessible information and what to do if their condition flares up.

Information and communication

Delivering chronic care is a complex endeavour: it involves many different staff from many different organizations. To avoid patients 'falling through the net', effective means of communication must be in place. Effective working will need to be underpinned by good information technology (IT) in order to facilitate communication between the different sectors and the different professionals involved in the management of patients with chronic

diseases. Because IT systems in the NHS are so fragmented, great attention needs to be given to how they can interface with each other and how health-care and social-care systems can communicate with each other. Organizations will need to consider the types of information they should share, agree who has access to what, ensure the timeliness and accuracy of information, agree principles for sharing information, and address confidentiality and security issues. Ideally, both patients and relevant staff should be able to access care plans electronically. Robust information will need to be captured in appropriate databases to facilitate the follow-up and monitoring of individual patients, and to make it easier for relevant staff to access the information they need to care for those patients effectively.

Communication does not concern only health-care professionals. Communication with patients needs to be proactive. We can no longer assume 'that patients have relinquished control of their destiny to the clinicians'.[13]

Finally, to ensure the care delivered is of a high standard, systems and processes such as the management of complaints, management of risk, audit, staff management and learning needs assessment must be robust and work across organizational boundaries. Primary care should take the lead in ensuring that all necessary systems and processes are in place and are used by teams both as a learning tool and continuously to improve services.

Conclusion

The increasing burden of chronic disease requires a move from the traditional model of care delivery to an approach focused on community and primary care, with patients empowered and supported to manage their condition(s) confidently themselves, supported by accessible, timely information. This requires close partnerships across statutory, private and voluntary agencies; it is necessary to be clear about respective roles and responsibilities, not only of staff but also of their employing organizations. Clinical governance arrangements will need to transcend organizational boundaries. Teams from different sectors will need to come together, with patients, to reflect and learn from what they do and to use continuous-improvement strategies to ensure that patients with long-term conditions receive high standards of evidence-based care.

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Evolution of an elective cardioversion service: learning from patients' experience

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- Organizational development towards a tertiary cardiology service has helped support the evolution of an elective cardioversion service.
- A patient satisfaction survey indicated that good communication was a key feature in ensuring patient understanding in the preparation process for cardioversion.
- A four-week review clinic was added to the care pathway to optimize patient medication.
- Details of cardioversion activity for the year, including results from the four-week review clinic, are presented.

Elective trans-thoracic cardioversion remains an important therapeutic option for selected patients suffering from atrial fibrillation or flutter. The authors have previously described the development of a day-case elective cardioversion (ECV) service, the formulation of an integrated care pathway and a patient information leaflet.[1] This development in service provision was deemed an improvement over the previous *ad hoc* arrangement and was felt by all stakeholders to utilize resources in a more efficient manner, improve communication and enhance patient experience. An acknowledgement was made that evolution was considered necessary to improve this service further. This article reports on the subsequent shaping of the

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service better to suit patient needs; this process took advantage of organizational expansion and incorporated the views of service users following a satisfaction survey.

Service development

The service developed in three distinct areas: administrative change, organizational expansion and a four-week post-cardioversion review clinic.

Administrative change

The task of formalizing the waiting list function was devolved to a clerical team. Now formal referrals are made and are processed in the same administrative manner as other investigational modalities. Regular waiting lists are now generated to ensure the clinical team is kept up to date with all referrals.

Organizational expansion

The addition of a cardiac catheter laboratory and an 11-bed day-case unit, linked to the coronary-care unit, as an interim measure while tertiary facilities were being built, enabled cardiac day-case services to be focused in one area. The cardioversion service benefited from this expansion in capacity, as it was able to relocate from the arrangement which utilized spare sessions within the day-surgery centre to a cardiology-oriented area. This move brought with it a sense of permanence to the service and the ability to plan pre-assessment, cardioversion and follow-up clinics in a more organized manner. The two-stage process, as described in the previous article,[1] was augmented by the review clinic. The cardioversion procedure itself took place in a side ward on the coronary-care unit.

Four-week post-cardioversion review clinic

This follow-up clinic, staffed by a middle-grade cardiologist, was put in place to review individual patients' clinical status, including heart rhythm, to optimize anti-arrhythmia and anticoagulation medications and to devise a plan for future care. In addition, an integrated care plan was devised, which included guidelines on starting, discontinuing and changing anti-arrhythmia, anticoagulation and anti-thrombotic therapy.

Satisfaction survey

All 40 patients who underwent an ECV in 2003, and who were alive at the point of questionnaire distribution, were invited to complete a survey designed to gauge satisfaction with the cardioversion process and whether this could be improved.

The survey questionnaire was posted, with a stamped addressed envelope, to patients following their procedure. Early in 2004, 32 returned questionnaires were analysed independently by a clinical governance coordinator (unattached to the cardiac services division). The conclusions were as follows:

- The return rate was noted to be high and generally the responses were very positive.
- It was noted that less than half the patients felt they had had an input into when they were admitted for ECV.
- Communication was a strong feature. It was felt that very few patients were given an explanation as to why they could not be involved in choosing an admission date. Not all patients received adequate information about their

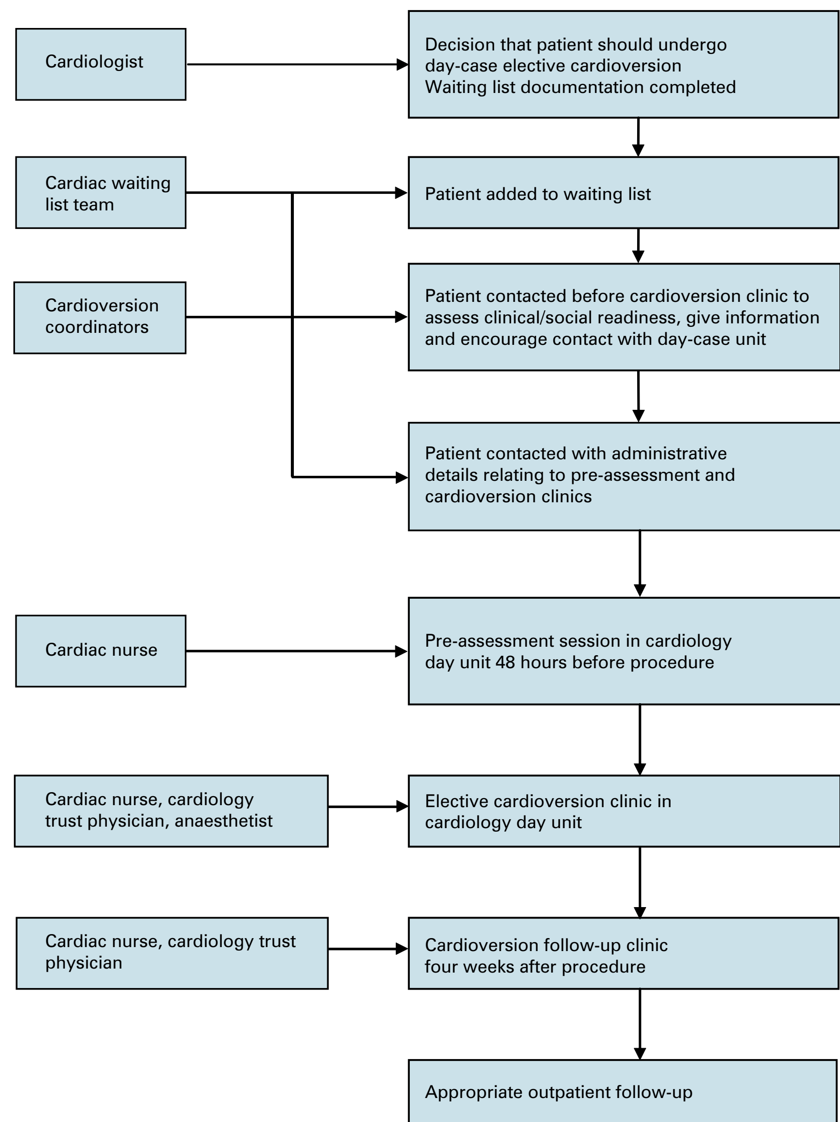

Figure 1. Algorithm for a day-case elective cardioversion service (2004).

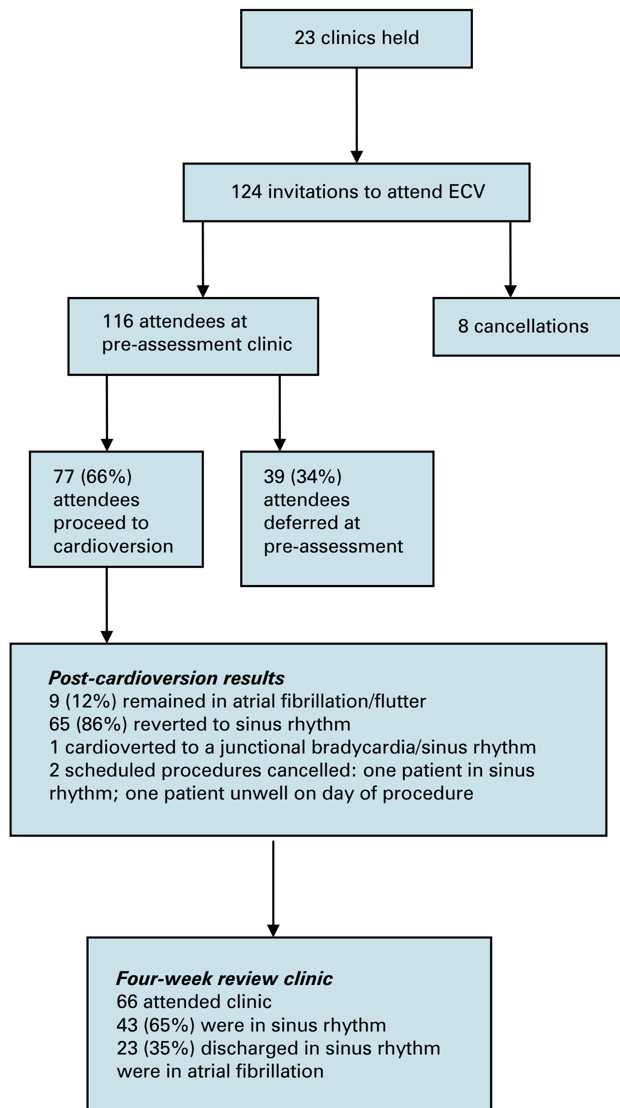

Figure 2. Evaluation of day-case elective cardioversion and four-week review clinic in 2004.

admission and some felt that they would have liked to know more about why the procedure failed. Some felt that the information they received from different people involved in their care was inconsistent.

- It was reassuring to note that many positive aspects of their care and environment were commented upon; however, inevitably, some causes for concern and areas for improvement were highlighted.

It was evident from the responses to the survey that good communication with patients is a requirement. They alerted the team to areas that could be improved upon, particularly in relation to the challenges of ensuring that patients awaiting ECV have an understanding of the relationship between a stable therapeutic international normalized ratio (INR) and their procedure.

ECV is an anxiety-provoking procedure for patients on the waiting list; thus, establishing a system to inform them of the cardioversion process when they first present on the list, to answer queries and to begin the consent process was seen as an important development. Patients referred to the list are contacted, given an explanation of the process and encouraged to contact the day-case unit with their INRs when they have them done, which enables the clinical team to keep in regular contact and empowers patients to take a degree of responsibility for their own treatment.

Evaluation

Drawing the different aspects of service development together, an algorithm is offered (Figure 1), which was built upon the previously described process.[1]

Evaluation of ECV activity for the year is presented in Figure 2; this is for a mix of patients – those who had already started on anti-coagulation therapy as well as those waiting to start. The average time from the date a patient appeared on the waiting list to ECV was 121 days (median 102 days). Organizational stability, and with it the opportunity to plan care, enabled more patients to have the procedure. Patients having to be deferred at pre-assessment (34% of attendees) remain a clinical challenge; however, conversion to sinus rhythm following ECV improved to 86% (from 60% in 2003[1]), which may reflect a more efficient pathway of care.

Conclusion

Despite recent debate regarding the management of atrial fibrillation,[2] ECV remains a therapeutic option for selected patients; however, planning ECV for individual patients can be organizationally taxing, both for the clinical team and for the patients involved. Our day-case ECV service evolved to take advantage of organizational expansion and infrastructure stability, which enabled the clinical team to give a more complete service to patients. Development of tertiary services in our trust, located in a new building with purpose-built day-case facilities, will afford the opportunity to consider augmenting the ECV service further. Most importantly, the satisfaction survey has afforded the clinical team an insight into the experience of patients undergoing ECV and it is gratifying that the vast majority of the responses were positive. Developing a service to enhance patient experience and organizational efficiency is an ongoing process and good communication within an active partnership between clinical team and patient remains the key to providing quality care for people awaiting ECV.

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The Doncaster West approach to learning from significant events

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- Learning from significant events is a useful method of improving practice in all areas of health care.
- Training is required to enable health-care teams to use significant event audit constructively and supportively.
- Learning from significant events should be a team activity: clinical staff can learn much from non-clinical staff and vice versa.
- Teams can learn from the experiences of others: wide circulation of key learning points from significant event reports has enabled other teams to improve their performance and to reduce the risk of error.
- Discussion of significant events across the interface between primary and secondary care can lead to improvements in communication and service delivery, and can strengthen the 'no blame' culture.
- Learning from incidents helps both primary and secondary care to bring about change and to deliver services effectively.

The Clinical Governance Team of Doncaster West Primary Care Trust (PCT) is committed to encouraging and supporting all who work in primary care continually to improve the quality of what they do. Over the past three years, we have in particular encouraged learning from significant events. Significant events may be:

- big – the death of a baby in a surgery waiting room, for instance;
- small – for example another pathology report mislaid;
- good – such as a 'thank you' letter from a patient;
- or less good – for example another 24-hour cancer breach.

Significant event audit – or, as we prefer to call it, learning from significant events – has been defined as:

> a mutually supportive, multi-disciplinary, rigorous, retrospective analysis of key events occurring in a clinical setting, by those involved, with a view to learning lessons and making changes necessary in order to improve future quality of care.[1]

Although the definition does mention that these audits should be 'mutually supportive', it does not specifically mention team working. We believe that learning from significant events is a team activity and, done well, it helps to bond and strengthen teams.

Training

The first sessions for practice teams were held in the summer of 2001, when 24 of the 26 teams in the PCT were trained. Each training session consisted of a plenary session covering the theory of significant event audit, its principles and benefits, the recognition of significant events and the process whereby these could be examined in a structured way for educational purposes and to improve quality. This was followed by group work, during which practice teams worked through given examples and any of their own in a structured way with the help of a facilitator.

The practice teams attending varied greatly in size and composition, but all included at least one GP; most also contained the practice manager and at least one practice nurse. The largest team consisted of 23 people (including GPs, practice manager, practice nurses and receptionists). The sessions were lively and interactive, and the evaluations were very positive.

Method

The majority of general practice teams left their training sessions enthusiastic about looking for and discussing significant events in their practices. Reception and administrative staff were especially keen to put their new skills into practice and we wanted to encourage this. We therefore used the 'Investing in Primary Care' Programme to incentivize practices to record significant events that occur in their practices and to discuss them.

A standard reporting form was devised for use throughout the PCT. Once an event had been discussed, a practice returned a completed but anonymized copy of the form to the Clinical Governance Team.

From informal discussions with practices we have learned that, where whole practice teams or primary-care teams discuss significant events, the contributions made by receptionists and administrative staff are often the most useful. At the same time, the opportunities offered to them to play an equal part in discussing significant events has greatly increased the confidence and feelings of self-worth of such staff. They have felt more empowered – more able to ask the (to them) obvious question or to make the commonsense suggestion. We see this as a significant benefit of the process.

Within practices, some discussions around significant events have led to audits being carried out. For example, one practice audited compliance with guidance from the National Institute for Health and Clinical Excellence (NICE) in relation to the prescribing of orlistat and sibutramine.

Results

Figure 1 shows the numbers of reports received in each quarter of 2003–04. The number received in quarter 4 alone was almost as large as the total for 2002–03. Forms are also now being submitted from an even wider range of practices and departments. Consequently, we have developed a system to enable the audit forms for significant events to be submitted and analysed electronically. The PCT loads the report on to DATIX incident analysis software along with all the incidents received from independent contractors, and identifies themes.

The report forms we receive are full of learning points. Right from the start we had agreed that if practices had taken the trouble to send us their reports, then the least we could do

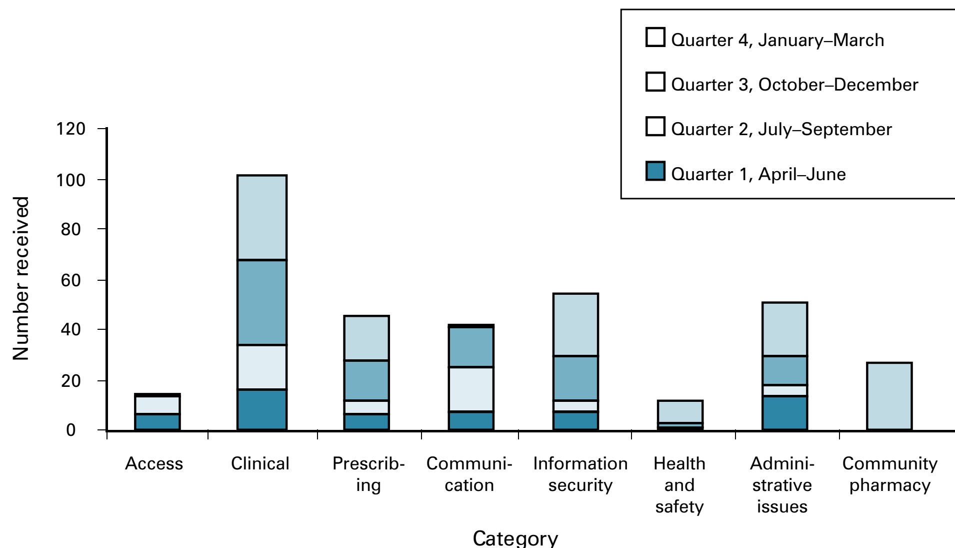

Figure 1. Numbers of significant event reports received, 2003–04.

was to look carefully at them and to extract these learning points. We therefore began to produce a quarterly newsletter that flags up general themes and key points. The two-page *Learning Lessons* bulletin is distributed to all independent contractors, community nurses and PCT staff. Key feedback points from the last quarter included:

- remove trailing wires – following damage to equipment and trip hazards identified in optometric practice – and undertaking risk assessments in this regard;
- flagging up similarly named patients in the notes or computer system, and using the date of birth as a secondary identifier to ensure correct matching of patient to record;
- prevention of vandalism;
- wrongly delivered mail;
- security issues.

The DATIX system is directly linked to the electronic National Reporting and Learning System (NRLS) run by the National Patient Safety Agency (NPSA), so all patient safety incident learning points and themes are also shared on a national basis. Our reported significant event audits will have contributed to the NPSA's recent first issue of its *Patient Safety Bulletin*.

Audit: is it all worthwhile?

Questions have been asked about the value of all the effort being put into the collation and dissemination of information on significant events. Does anyone actually read the feedback? More significantly, does any practice actually change anything as a result of reading about another practice's reporting of significant events? An audit has recently been carried out to address such questions.

A questionnaire was distributed to all the practice managers who were present at one of the bimonthly meetings of the practice managers' forum. The most pleasing finding was the fact that so many practices (42%) had made changes as a result of reading about a significant event discussion in another practice. Examples of changes made are detailed in Box 1.

Rolling out the process

It is not only GPs and their staff who can use discussion of significant events as a means to educate their teams and as a way to improve the quality of what they do. The process can be equally of value to other independent contractors. We felt that some of the learning points we

Box 1. Examples of changes made in practices following discussion of a significant event

- Secretaries ring to make sure cancer 'two-week wait' referrals have been received
- Changed baby clinic to an appointment system due to duplication of a vaccination
- Protocol reviewed on repeat medication
- External workers issued with instructions regarding removing any patient identifiable information from the premises
- All members of staff were again made aware of Caldicott and signed statements to this effect
- Internal locks to all doors
- Double check with a second member of staff before giving any results out to patients with the same name
- Staff multi-skilled to cover others
- Protocols and procedures put in place
- Awareness and communication systems improved
- Changed policy for contacting patients regarding results
- Recording of blood tests
- 'Similar names' alerts put on to information technology system
- Now have a death record book in place and inform all relevant people of patient's death
- Notice 'Not to turn off' now on plugs of vaccine fridges
- Digital lock on office doors after staff were threatened by a patient
- Special red laundry bags for contaminated laundry (previously all laundry was put in the same bag)
- Realized we are all guilty of mistakes and admire others' honesty so that we can all learn by them

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identified from reading the reports from the general practices could also be of interest to them, so we began sending our quarterly reports to community pharmacists, optometrists and dentists. The feedback from community pharmacists was particularly positive: they appreciated being included.

More recently, training sessions have been arranged for community pharmacists, dentists and optometrists, and community pharmacists and optometrists have begun to submit significant events to us.

Community staff and PCT employees have for many years been expected to report formally on any adverse incidents or 'near misses' that occur during working hours, using the Incident Reporting 1 form. These forms were collated for administrative and statistical purposes, and sometimes managers would discuss a specific adverse event and issue instructions to staff with a view to preventing a recurrence, but the staff involved were not necessarily given an opportunity to contribute to these discussions, so there was little facility for shared learning.

We have therefore made training in significant event audit available to community nursing staff and they are now also learning from and sharing information about their significant events.

Interface issues

Many of the significant events reported to us involve the interface between primary care and other agencies, in particular secondary care. The main problems identified involve communication.

One recurring communication problem reported was 'wrongly addressed mail'. There are six GPs in Doncaster West who share a surname with one or more other GPs in the area and their practices were frequently reporting instances where either they received clinical information that should have been sent to another practice, or information they needed was being unnecessarily delayed because it had initially been delivered elsewhere.

We therefore decided to ask the five practices involved to collect for one month every single piece of mail they received that was not intended for their practice. The practices collected 64 pieces of wrongly delivered mail, although, to our surprise, the GP with a similar name to another was not the major source of errors. A second audit was therefore carried out, involving all the practices in the three Doncaster PCTs and, as a result of this, work is being undertaken to rectify the problem.

The three PCTs in Doncaster have also set up a joint working group, the Significant Incident Interface Group, with the local acute trust to look at ways of dealing with interface significant events. Meetings are held every quarter and are attended by clinical governance team members from all the organizations involved, together with representatives from the patient advice and liaison service. The aims of the group are:

- to develop a 'no blame' culture between primary and secondary care;
- to identify and facilitate action to address recurrent interface issues;
- to learn from incidents, supporting both primary and secondary care to bring about change and to deliver services effectively;
- to analyse trends.

The local mental health trust and a neighbouring PCT that uses the same acute trust have also been invited to take part in this initiative.

The future

Significant events will continue to happen. Some will be repetitions of old ones, either because new staff arrive who have not had the benefit of past learning or because existing staff have forgotten. This will require practices to revisit old scenarios: the solutions second or third time around may not be the same as the first time. Others will be new, unforeseen events.

There will remain an enormous potential to learn from individual cases. To use them fully to improve care will continue to need a structured approach in a 'no blame' environment.

Doncaster West PCT sees learning from significant events as an important way of improving patient care and will continue to support primary care in using this tool to its fullest potential.

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Engaging independent contractors in a practice quality improvement programme

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- The Clinical Governance Team at Bedford Primary Care Trust has succeeded in engaging general practices as well as optometry, pharmacy and dental practices in a quality improvement programme.
- Benefits to practices include improved quality of care, reduced risk and peer comparison.
- Benefits to the Trust include closer relationships with contractors, which in turn facilitate assessment, monitoring and improved services.

Bedford Primary Care Trust's clinical governance relationship with general practices has been sustained over some years, initially through a practice quality improvement programme (PQIP) and now also through the Quality and Outcomes Framework (QOF). The model of the PQIP has been extended to other primary-care professions, beginning with the optometrists in October 2004.

Having nominated clinical governance leads, the optometry practices engaged in a record card audit. The audit tool and analysis were provided by the Primary Care Trust (PCT) and the results were presented in an anonymized form to all practices. Possible improvements were discussed at a meeting of the clinical governance leads and a re-audit was carried out after practices had implemented changes. This showed there had been improvement in all areas, but especially in terms of patient care and service consistency. Some practices also experienced improved sales, where they were now following up on questions regarding hobbies and interests, and so providing more tinted lenses, ski and diving goggles and so on to patients.

The Practice Quality Improvement Plan

The PQIP has since been extended to pharmacists and dentists, who, with the optometrists, are now involved in conducting patient surveys, infection control audits, audits of significant events and regular clinical governance meetings.

The criteria for the PQIP are that it should:

- be an agreement between the PCT and the independent contractor;
- lead to measurable quality improvement;
- be equitable across independent contractors, who are all given the same incentive payments for similar PQIPs;
- improve communication between services and across boundaries;
- not contain work included in a contract.

For a successful outcome it is necessary to have the support of PCT senior management as well as financial commitment. It is also vital to have a local professional prepared to act as a clinical governance lead, and to work with the clinical governance facilitators.

Bedford PCT's Clinical Governance Team's statement of purpose is to provide primary-care staff with 'expert leadership and facilitation, to champion continuous improvement in patient services, through education, quality management and modernization'. We take this as a commitment to the independent contractors to develop a relationship based on shared learning and development.

Meetings of the clinical governance leads

Meetings of the clinical governance leads are held quarterly for each profession. Subjects discussed have included audit results, shared learning from significant events, child protection, health improvement initiatives such as smoking cessation and healthy living campaigns, and clinical topics. Every effort is made to ensure the topics are of value and interest. The meetings also provide a forum for professionals to get together to discuss practice and exchange ideas, often informally.

Why should independent contractors get involved?

Engaging the practices in the PQIP has in some cases been difficult, although some were enthusiastic from the outset. Bedford PCT has been fortunate in having financial and managerial commitment, which has been appreciated by the contractors.

To secure their engagement, practices were sent information on the PQIP by post and invited to a meeting of clinical governance leads. This invitation was followed up by telephone where necessary. This initial meeting served to explain the role of the PCT, outline clinical governance and the PQIP, and set the scene for further meetings and audits.

The benefits of engagement, which are spelt out to the contractors, include:

- improved quality of patient care;
- reduced inequality of care;
- inclusion of all practice staff and new roles and responsibilities for them;
- fewer risks, as staff are more aware;
- a demonstrable commitment to quality, which leaves a practice less exposed when incidents occur or complaints are made;
- peer group comparison;
- provision of a forum for issues to be raised with the PCT;
- PCT support, for example the provision of audit tools, data analysis and administrative support;
- incentive payments, which practices use to reward staff or pay for incidental expenses incurred by the PQIP.

Advantages to the PCT of the PQIP

The advantages listed above of course also pertain to the PCT. Additionally the PQIP allows for a relationship to be developed with the contractors, which helps the PCT to carry out its assessment and monitoring responsibilities.

Implementing clinical guidelines – a successful strategy in a large hospitals services division

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- The support of senior leadership (i.e. the medical director) is essential in the implementation of clinical guidelines.
- The implementation team should be small and focused.
- Flexibility is needed to take into consideration the local multidisciplinary expertise.
- The initiative must be viewed as a long-term commitment (in this case over two years).

SIGN 45: antibiotic prophylaxis in surgery

SIGN (the Scottish Intercollegiate Guidelines Network) has been developing, disseminating and reviewing national evidence-based clinical guidelines since 1993. These contain recommendations for effective practice based on current evidence. The aim of the SIGN guidelines is to improve the quality of health care for patients in Scotland by reducing variation in practice and outcome.

The proposal for a SIGN guideline on surgical antibiotic prophylaxis arose out of a multidisciplinary meeting in November 1997 at which strategies were discussed to address escalating problems of inappropriate antibiotic prescribing and its impact on drug resistance in hospitals. Participants identified antibiotic prophylaxis as one of the areas where there was a great variation in practice across Scotland, which might be addressed by evidence-based guidelines. SIGN 45 was published in July 2000.[1]

Note that at the start of implementation of the strategy described in this article, the acute hospitals division was the Lothian University Hospitals Trust, in which surgical operations were performed over four sites.

Box 1. Membership of the SIGN 45 Working Group

- Chair and division chief pharmacist
- Audit lead (a consultant anaesthetist)
- Lead microbiologist
- Audit/guideline implementation coordinator
- Lead pharmacist (the protocol coordinator)

Implementation in the Lothian Hospitals Division

The implementation of this guideline was seen as an important part of the division's clinical effectiveness effort. In particular, it contributes to:

- explicit agreed protocols to identify which patient groups require antibiotic prophylaxis and what antibiotic should be administered to ensure best care is delivered to patients;
- good patient outcomes through a reduction in hospital-acquired infection;
- ensuring that divisional resources are used to best effect, with due consideration being given to the need to minimize antibiotic resistance through good antibiotic stewardship;
- reducing the chance of communication errors between surgeons and anaesthetists, which can lead to a failure to administer required antibiotic prophylaxis;
- development of a system that addresses changes in current evidence;
- ensuring that protocol review and continuous re-audit are in place following implementation.

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A Sign 45 implementation group was established by the medical director, who appointed the chair of the group. The group's composition is shown in Box 1.

The group divided the work into the concurrent updating of the local protocols (see Table 1) and the organizing of a trust-wide audit (see Table 2).

What was achieved?

- All units in the surgical division were audited and recommendations were made.
- Protocols for antibiotic prophylaxis based on SIGN 45 were developed and signed off in the surgical departments.
- There was increased awareness in all surgical specialties in the division of the recommendations of SIGN 45.
- A systematic approach was developed for the production of local guidelines.
- A system was put in place for re-audit and review of local protocols.
- The refined audit pack specifically for antibiotic prophylaxis in surgery is now available on the intranet and is currently being used to re-audit practice within the division.
- In 3 of the 50 (6%) areas reviewed, there was current evidence that antibiotic prophylaxis had been updated since the publication of SIGN 45 (e.g. by Royal College guidelines). This was documented and the protocols were developed accordingly.
- Some orthopaedic and paediatric surgical procedures were not covered specifically by the SIGN guideline. Protocols are now being revised using updated evidence and the gaps we found in the SIGN guidelines were reported back to SIGN for consideration when reviewing the guideline.

Facing up to challenges

The local adaptation and implementation of guidelines face a number of challenges that need to be overcome. These include:

Table 1. Review of protocols relating to antibiotic prophylaxis

Task	Lead person	Action
Collecting existing protocols	Working group, local clinicians, pharmacists and microbiologist	• Collected written local protocols from all relevant services within the trust • Identified areas where protocols were not readily available
Test degree of compliance with SIGN 45	Working group	• Developed an assessment tool • Reviewed 50 available policies for compliance with SIGN 45 guideline using the tool
Feedback to clinicians on gaps in protocols	Chief pharmacist	• Clinical directors (CDs) were sent a completed assessment form with recommendations for changes to the protocols within their directorates
Develop a protocol template	Chief pharmacist	• Protocol template was developed, derived from the recommendations of SIGN 45 • Template was sent out to all surgical CDs, lead clinicians, lead pharmacists and microbiologist • The protocol had to be signed off by all of the above within the specific specialty before it was finalized
Development of local protocols using the template	Lead pharmacist	• Pharmacist was appointed part-time to coordinate and support all units to 'fast track' the production, development and signing off of new local protocols based on the template • Consistency of approach to antibiotic use and dosage was achieved by use of the template • Feedback provided on draft protocol and agreement sought from clinical team on its format, content, audit and implementation • Where practice involved multiple dosing, primary literature sources were independently reviewed and, in certain cases, other hospitals were contacted to ascertain best clinical practice
Link with antibiotic prescribing guidelines	Microbiologists	• Discussed local resistance patterns • Served on each of the specialty teams and signed off protocols
Group supported regularly by medical director and CDs	Chief pharmacist	• Medical director, assistant medical directors and CDs updated and informed of delays in protocol development and acted on this by encouraging their staff to expedite the process

Table 2. Trust-wide audit of antibiotic prophylaxis

Task	Lead person	Action
Initiated trust-wide baseline audit of antibiotic prophylaxis	Consultant anaesthetist with the support of the Audit and Clinical Effectiveness Department	• Trust-wide audit initiated by consultant anaesthetist (audit lead) • Clinical directors (CDs), lead clinician, lead pharmacist and microbiologist identified in each unit. These were notified of the group's work and forthcoming audits • A data-collection form was developed that was used across the divisions to ensure consistency of data
Data collection	Senior house officers (SHOs) and specialist registrars (SpRs) in different units	• Data were collected by SHOs in all units (thus providing audit experience for SHOs) • Data collected on divisional form for all patients having surgery in one week
Data analysis and reports	SHO/SpR, audit lead and guideline coordinator	• All data initially checked by audit lead and coordinator to check accuracy, analyse data and help with reports for each unit • All reports were produced using the same template (for consistency) • Copies of all data and final reports filed
Database of audit progress in all relevant units	Guideline coordinator	• Database contained the lead contacts for each unit, the stage of the audit and protocol development in each unit • Updated regularly by coordinator so could be accessed at any time to identify delays in the process of audit • Action needed was addressed at the regular group meetings
Feedback on audit reports of each unit to the CDs, lead clinicians and lead pharmacists	Working group	• Copies of all audit reports were sent back to the lead contacts previously identified for each unit and the anaesthetics CD. The audit reports were discussed and disseminated at CLIP team meetings (meetings of the Multidisciplinary Clinical Improvement Programme teams in each directorate)
Audit pack refined	Implementation group	• An audit pack was produced and used. It contained instructions for data collection, a data-collection sheet and a report template • Comments on any difficulties in using the pack were taken into account and the pack was refined accordingly, to increase ease of use
Definition of continuing responsibility	Chief pharmacist and chair of SIGN 45 group	• Recommendation made to medical director that CDs be advised to ensure that regular audit of protocols is included in CLIP teamwork

- keeping up the momentum – this process took over two years to complete;
- busy clinicians who viewed protocols as challenging their authority or clinical discretion, or creating a risk for litigation;
- initial lack of enthusiasm for getting involved in clinical audit.

These challenges were met by using a number of different approaches:

- The implementation group was small, had specific tasks, met regularly and followed up progress closely.
- The flexible approach to developing protocols and noting justification for departure provided the opportunity to make the guideline relevant to patient groups, thereby improving ownership.
- The view was encouraged that if the guideline is developed by local consensus, and is evidence based, it is more likely to be followed and therefore to protect against litigation.
- Additional pharmacist resources were specifically deployed to support local directorate pharmacists.
- Discussions of specific details of protocols with lead clinicians were at a time of their choice. This saved time and avoided lengthy discussions at meetings of the implementation group.
- Management was involved for advice on difficulties with implementation.
- The support of the medical director was obtained (e.g. directives were sent out from the medical director reiterating the importance of participation when the group was faced with clinical indifference).
- Audit experience is now an invaluable asset in appraisals and job applications and on CVs.

Reference

1 Scottish Intercollegiate Guidelines Network. *Antibiotic Prophylaxis in Surgery* (SIGN 45). Edinburgh: SIGN, July 2000. Available at www.sign.ac.uk/pdf/sign45.pdf