

Editorial: Organisational culture and quality

Myriam Lugon

Consultant, Clinical Governance and Health-Care Policy, London

While the clinical governance agenda can succeed only if it is owned by all staff in health-care organisations, the organisations themselves have many responsibilities. These include:

- to ensure consistency in implementation;
- to have in place the necessary systems and processes to underpin quality;
- to ensure that staff have the right skills and competencies to do their jobs.

However, an important ingredient of making the quality agenda a success is also a just and fair culture that promotes reflective learning. Measuring organisational culture is complex and this is addressed in the extended editorial commissioned from Rosemary Hittinger and Peter Fielding.

If you have practical examples of the influence of organisational culture or performance management we would like to receive them (as well as contributions on any other aspects of clinical governance).

Cultural indicators – a tool for performance improvement

Rosemary Hittinger¹ and L. Peter Fielding²

¹Group Director of Clinical Governance, HCA International, London, UK, email Rosemary.Hittinger@HCAhealthcare.co.uk; ²Medical Director, Surgical Service Line, and Chairman, Department of Surgery, York Hospital, 1001 South George Street, York, PA 17405, USA, email lpfielding@wellspan.org

Culture is a body of learned behavior, a collection of beliefs, habits, practices and traditions shared by a group of people and successfully learned by new members who enter the society.¹

Although the culture of a hospital may seem intangible, we suggest that by observing certain features of organisational structure and the behaviour of staff, by asking the right questions and by reviewing the appropriate documents, a picture of an organisation emerges that could be called its 'culture'². The success of a health-care institution

should be judged by the clinical outcomes it produces. We believe that one of the most important factors that determines these clinical outcomes is the organisational culture in which people work and interact. It is therefore important – and especially under circumstances of capacity constraints and other organisational limitations – that these 'cultural micro-environments' are understood and effectively led. A robust set of cultural indicators may provide a tool with which to distinguish the promises inherent in well meaning

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vision statements from reality (which may be rather different). The tool comprises a set of measures to assess eight areas – termed ‘domains’ – of professional activity. While there is some crossover between these indicators, each can be separately assessed.

The eight components of this proposed assessment tool have proved useful for identifying the positive and negative features of a local culture and may, therefore, be helpful for internal institutional development and for external inspection.

1. Human resources and staffing

Recruitment

Human resources departments should acknowledge that those recruited ought to be selected for both their professional talent and their cultural maturity. In addition, there should be a formally constructed and regular orientation process for new employees, including medical staff and all senior management.

Staff evaluation

Annual performance appraisals should be in evidence for all staff grades, including nurses, doctors and management (not less than annually), in which the identification of problems and their resolution are documented. There should be open responses from all those reviewed, with meaningful professional development plans, all structured within a ‘blame free’ policy.

Signs of a negative culture include:

- late appraisals;
- little or no contribution to the documentation by affected individual staff members;
- missing information for specific staff groupings;
- a lack of evidence of development, change and improvement.

There must be a clear, ‘zero tolerance’ policy on bullying, retaliation, gender harassment and other forms of disruptive behaviour.

Disciplinary procedures

There should be a clear, graded disciplinary process, with counselling and personnel development at its core.

Staffing statistics

Staff turnover and sickness rates should be documented, with evidence of regular review and up-to-date lists

of staff who have resigned or who have been dismissed, with evidence of their exit interviews. Any lack of these is a sign of a negative culture and an insufficiently active human resources department.

Staff satisfaction surveys

The purposes of staff surveys are two-fold:

- to obtain information (while recognising that polling methods give biased results);
- to demonstrate that management is interested in the opinion and welfare of those who work in the organisation.

Consequently, 15–20 well chosen questions on topics important to staff will help to identify those areas which need attention. Perhaps not all subjects can be studied simultaneously but, as the process evolves, there will be effects on staff’s sense of well-being.

2. Policies and procedures

Total disclosure (transparency) policy

It is a common finding that when a human resources department or hospital administration is criticised, the staff close ranks and defend their positions. This is also a common response to patient complaints about the provision of health-care or adjunct services. A declared and evident commitment to ‘telling the truth’ is necessary. Although it may seem strange to put this item in a list of requirements to identify a ‘positive culture’, we believe that the majority of institutions declare honesty and transparency but function with concealment and protectionism. In addition, there should be evidence that complaints and criticisms have been responded to expediently. Delayed or protective responses are signs of a negative culture.

Performance management

The great majority of those in health-care come to work each day setting out to do their best. For this majority, issues of performance improvement and counselling can be successfully achieved in an educational (formative) context. By contrast, for the minority of those who are unable either to recognise their deficiency or to curb their disruptive behaviours, disciplinary (normative) procedures

are needed; these should be wholly separate from educational remedial processes. Those involved with an institution’s organisational plan need to recognise the distinction between formative and normative processes, and use separate structures and separate personnel for these purposes. Attempting to achieve performance improvement for the majority by using disciplinary methods is demotivating, counterproductive and indicative of a negative culture.

3. Goals and objectives

Signs of institutional cultural health include:

- an organised approach to the identification of annual goals and objectives in the context of the pre-stated vision, with annual assessments against these goals and objectives;
- goals and objectives specifically stated and associated with measurable outcomes and metrics of change;
- plans either to carry forward or to abandon ideas as results are obtained.

The documentation of these functions should be available for the hospital in general and also for its sub-units, along with departmental reports, minutes and attendance registers. Goals and objectives need to be reviewed from year to year and changed as necessary.

In contrast, features which are likely to be associated with a negative culture include the documentation of institutional activity in reports written in broad and non-specific language. Sustained non-attendance on the part of those groups and teams working on goals and objectives (which is most often observed with physicians) requires remediation to prevent the practice of disruptive denial by those who habitually fail to participate.

4. Performance indicators

Aggregate data at the divisional and departmental levels are essential for an organised approach to clinical performance improvement. When no such data exist, it is likely that the divisional or departmental reputation will be either defended by generalisations or protected by claims of confidentiality. If and when

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poor outcome data are identified, either from analysis of aggregate data or based on individual patient outcomes, the lack of an organised approach to data gathering and analysis may precipitate a negative cultural reaction of protectionism and self-serving denial. The institution must demonstrate that performance information has been used to achieve sustained change³.

Physician variance

Although physician-specific variance studies have been carried out for more than two decades⁴⁻⁶, this subject engenders great sensitivity and reactivity by the profession in general and by the physicians involved in particular. The need to distinguish between educational (formative) and corrective (normative) actions (see above) in response to doctor-specific variance is not sufficiently understood. However, the use of 'scorecards' and other forms of regular clinical governance reports for individual results should be encouraged as part of the formative process; most physicians will respond positively when these results are presented in an informative and educational manner. Minutes of regular peer review and audit meetings should be available and attendance of members of the multi-disciplinary teams (particularly of

doctors) to support these activities is further evidence of a positive and forward-looking institutional culture.

A 'no blame' environment

Although difficult to envision, critical incident review, peer review and clinical incident analysis should be constructed to achieve a 'no blame', educational approach. Disciplinary remedy should be a separate process that is called upon when individuals or groups appear to be unable or unwilling to participate in a productive fashion. This will encourage the handling of problem topics within the context of a 'no blame' educational environment, in which systems rather than individuals are identified as giving rise to most of the error⁷.

5. Process change and re-engineering

Although some processes in hospitals are complex, many are relatively simple or can be made so by re-engineering. There should be documented evidence in all parts of the hospital organisation that people are encouraged to make suggestions for process simplification and improvement. There should be clearly defined organisational charts and plans in place to minimise the administrative overhead. A

consistent pattern of increased complexity, which is frequently associated with the creation of new administrative positions, may be a sign of poor morale and a negative, authoritarian cultural environment.

If systems are to be redesigned around the patient there should be no need for new administrative posts to monitor implementation. Good design will address the routine capture of robust clinical information about both process and outcome.

6. Risk management

Critical incident reviews should be conducted in a non-judgemental fashion, with root cause analysis and neutral identification of facts as well as of process and personnel errors. These reviews need to be recorded with considerable administrative skill to prevent 'finger pointing' and blame attribution.

In a review of an institution's culture, confidential questioning of staff involved in recent incidents should reveal a willingness to speak about their experiences and demonstrate that they have felt supported.

Cultural improvement is needed if individuals demonstrate a fear of retribution. Well maintained management databases should be available, to store evidence that critical incident reviews have led to remedial action plans that have been implemented and that progress has been monitored. There should also be evidence that incident reports made by staff members from all areas of the institution have been addressed and resolved in a reasonable timeframe and staff should be aware that these have been addressed. Lack of awareness by staff members that incident reports have resulted in appropriate review and actions are signs of a negative culture.

7. Environmental issues

The general appearance of a facility may help identify an institution with high morale and a positive culture. Cleanliness, empty litter bins, removal of clinical and non-clinical waste, removal of wilting flowers and other debris, and lack of graffiti in public areas, lifts, staircases and toilets all attest to the creation of a positive environment and culture. These are signs that the staff take pride in and are engaged with the institution.

8. Customer service

Bright and well posted signs in an institution, as well as helpful staff, are always reassuring to patients as they navigate the complexities of health-care provision. The observance that all staff members are prepared to offer assistance when members of the public appear lost or distressed is also consistent with a broadly positive environment.

Conclusion

We believe that a positive institutional culture, which can be assessed by the use of the cultural indicators

summarised in this article, can help to create an environment in which the quality of health-care can be improved, made more efficient and be more focused on patients. Such an environment will help the recruitment and retention of talented staff and lead to higher levels of patient and societal satisfaction with the services provided.

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Time for change: a way to increase staff adherence to guidelines in mental health

Andria Hanbury¹, Louise Wallace², Michael Clark³ and Delia Cushway⁴

¹Research Officer, Wolverhampton City Primary Care Trust, Coniston House, Chapel Ash, Wolverhampton WV3 0XE, email Andria.Hanbury@wolvespct.nhs.uk; ²Professor of Psychology and Health, and Director of Health Services Research Centre, Coventry University; ³Research and Development Coordinator, Wolverhampton City Primary Care Trust; ⁴Programme Director of Clinical Psychology, Coventry University

- There has been a proliferation of guidelines on patient care (e.g. the National Service Frameworks).
- Within mental health care, the prevention of suicide is a key target and one of the standards in the National Service Framework for Mental Health.
- Nationally, staff adherence to a suicide prevention guideline from the National Service Framework has been variable.
- Interventions to increase staff adherence are of variable effectiveness.
- It is proposed that interventions will be more effective if they are targeted and derived from a robust theory of staff attitudes and behaviour that is able to take the local context into account.

Background

Within mental health care, the National Service Framework¹ details national standards and the associated evidence-based guidelines. One of the standards concerns the prevention of suicide; it incorporates the recommendations of the Confidential

Inquiry into Suicide and Homicide by People with Mental Illness². One of these recommendations concerns the need to make face-to-face contact with a service user within seven days of discharge from secondary care, which is commonly referred to as the seven-day contact guideline, following the finding that suicide is most common in the first one to two weeks after discharge. Nationally, adherence to this guideline has been variable, which implies that some services are putting their users, and their reputation, at risk. Increasing adherence to this guideline is of paramount importance.

Interventions to increase staff adherence

The effectiveness of interventions to increase staff adherence to guidelines is influenced not only by the type of intervention but also by the context in which the guideline operates³. Theoretical frameworks may be valuable both for gaining an understanding of the local context and for developing targeted interventions to tackle specific barriers to adherence.

It was therefore decided to explore factors that affect adherence to the seven-day contact guideline within Wolverhampton City Primary Care Trust, using a theoretical framework. The findings from this exploratory study will be used to develop a targeted intervention to increase staff adherence.

The theory of planned behaviour⁴ was chosen (see Figure 1), from the field of health psychology. It proposes that the main factor determining whether someone performs a given behaviour or not is their intention to do so, and that intention is in turn predicted by the person's attitude towards the behaviour, social pressure to perform or not perform the behaviour, and perceived degree of control over performance of the behaviour.

To gain an understanding of the local context and to explore factors affecting adherence to the guideline, semi-structured interviews were conducted with eight mental health professionals, one from each of the eight community mental health teams in the trust; they included doctors, nurses and occupational therapists.

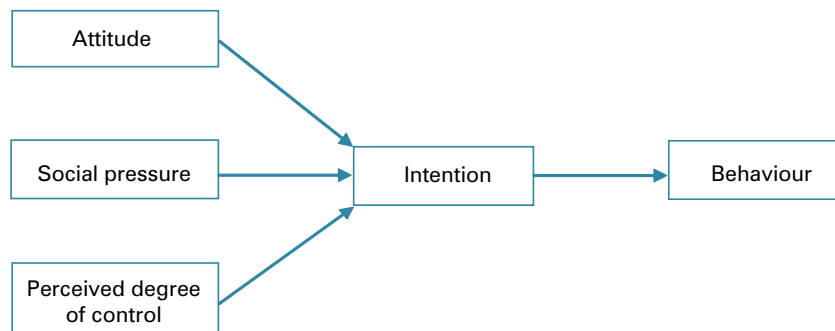


Figure 1. The theory of planned behaviour.

Questions were framed around constructs of the theory. For example, to explore *attitudes* towards the guideline, staff were asked ‘Can you suggest any consequences of not adhering to the guideline (for the service user, yourself or the trust)?’; to explore *social pressure* to adhere, they were asked ‘To what extent do you feel other staff regard the guideline as important?’; and to explore *perceived control* they were asked ‘Do you feel there are any obstacles to adhering to the guideline?’

Interview results

The main factors influencing adherence to the guideline appeared to be:

- lack of consensus concerning the purpose and importance of the

guideline, which led to scepticism about its value on the part of some staff;

- poor communication between inpatient and community teams regarding discharge dates, which made it difficult for staff to make the contact within the specified seven days;
- lack of adequate training in the operation of the guideline, which led to misunderstanding of the guideline and inaccurate reporting of adherence;
- social and cultural norms operating within the primary care trust, including a potentially risky ‘tick-box culture’, whereby corners are cut (e.g. telephone contact is made rather than face-to-face contact, in order to appear to fulfil requirements).

The development of a questionnaire to measure factors affecting adherence

Having identified the main factors affecting adherence from the staff interviews, a questionnaire was developed and administered to all mental health professionals who worked in community teams within the trust. As with the interviews, questions covered factors that affect adherence and were framed around the constructs of the theory of planned behaviour. The data will be analysed to identify the factors that most significantly predict staff intention to adhere to the guideline, and an intervention targeting these will then be delivered within the trust.

For example, if lack of consensus concerning the importance of the guideline were found to be the most significant factor influencing adherence, active educational training focusing on the importance of the guideline, and its supporting evidence base, could be provided and would be more likely to increase adherence than, for example, a reminder system. Audit data on adherence will be compared before and after the intervention is delivered, to establish whether there is a significant increase in adherence.

Conclusion

A range of factors affect staff adherence to the seven-day contact guideline. In order to change staff behaviour, interventions need to be targeted on specific barriers to adherence and need to take the local context into account. Theoretical frameworks may be valuable tools with which to explore factors that

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affect staff behaviour and to guide the development of targeted interventions.

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The value of integrated workforce planning across the local health and social care economy: a case study

Jane Winter¹ and Lyn Meehan²

¹Assistant Director, Social Care, North East London Strategic Health Authority, Aneurin Bevan House, 81 Commercial Road, London E1 1RD, email jane.winter@nelondon.nhs.uk; ²Workforce Development Manager, Regeneration Team, North East London Strategic Health Authority

■ The skills required of the community workforce need to be considered in order to deliver high-quality care to older people and to support the management of chronic disease within a local health economy.

■ The training needs of care workers in three London boroughs has been addressed through the development of a care homes training collaborative, which is led by the strategic health authority's workforce development function.

■ The creation of a training and development partnership of local agencies (the acute trust, primary care trust, the local authority social services department, the Learning and Skills Council, the local strategic health authority, JobCentre Plus, and training and service providers) could be the forum to address modernisation issues such as the identification and acquisition of the skills to manage chronic disease.

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The Care Standards Act 2000 posed a real challenge but also created an excellent opportunity for innovative and collaborative working with the care home sector. The requirement for care workers to achieve National Vocational Qualification level 2 (NVQ2) and managers of homes to reach NVQ4 enabled large funders of skills acquisition – such as the Learning and Skills Council, Job-Centre Plus and the strategic health authority – to work with the sector not just to meet training needs but also to stabilise the sector by maintaining its bed base.

In three boroughs of north-east London, a care homes training collaborative (CHTC) has been running since 2002. It has been funded in part through the Learning and Skills Council and is led by the strategic health authority.

This two-year project is outcome driven and requires the achievement of a large number of NVQs, as well as qualifications for assessors. It includes the provision of specific modules and the development of a model of work-based learning through the use of training facilitators and assessors.

Why was the CHTC established?

A core function of the workforce development directorate of the strategic health authority is to 'lead the integration of workforce planning across the health and social care economy'¹. The residential care

workforce is employed predominantly in the independent sector, where systematic workforce development data are not centralised or readily available². It was agreed that working collaboratively presented an opportunity to systematise the collection of data on the workforce, so that, when combined with information on the workforce of the local the NHS trust and local authority, service planning would be enhanced. In the event, home managers were willing to provide the information as their contribution to the partnership, particularly because computerisation of their staff information was useful for many other purposes, including inspections.

What are the achievements so far?

Mapping the workforce

Forty-five care homes were participating in the CHTC. These had a total of 1259 beds; 28 (62%) had fewer than 30 beds and 24 (53%) were owned by single-handed operators.

All care workers completed a basic skills assessment in literacy and numeracy, a personal development plan, an individual action plan and learning record, and an NVQ skills audit. These tools have generated a profile of the workforce.

Approximately 90% work as care assistants, often in senior roles. They are more likely to be female, aged between 25 and 50 years,

and to belong to black or black British/African ethnic groups, born outside Britain. Previous educational achievement is generally low and English is typically a second language. Almost without exception, role development was identified as important; most viewed this to be within the care sector at a higher grade or entering nurse training. Significantly, male staff perceived their role progression to be to that of care home manager or owner. The older worker was less likely to see the value or relevance of further training.

The personal development plans have proved to be very insightful. For example, common themes to the value-based statements and motivational factors mentioned in the workers' plans include:

- honesty;
- respect;
- health (their own);
- the value of life (for older people);
- family commitments (more important than work);
- equal opportunities (for staff);
- caring for the sick and frail (older person).

Developing the training

Three main training providers were contracted to deliver the NVQs.

For each of these three providers, a training facilitator (see below) has lead responsibility. Monthly meetings between the training providers and the training facilitators enable joint monitoring of care workers' progress and performance. Training facilitators maintain close relationships with care workers and give tutorial support.

Training providers have found the support from facilitators invaluable and have particularly appreciated their chasing up non-attendees and ensuring issues are dealt with swiftly and effectively. All providers felt the facilitators supported the work of the NVA assessors and contributed to the retention of care workers in the programme and their achievement.

The effect on quality of care is beginning to be seen, and care workers are gaining confidence to challenge existing approaches to care. It has been particularly meaningful to be told that, before looking at the module 'Fostering people's equality, diversity and rights', care workers had not thought that 'older people had the right to choose when they got up or went to bed' or that 'older people have different experiences to us, but just as valuable'.

The modules have been creatively developed and integrate basic skills and information technology skills while still focusing on the knowledge

underpinning the NVQ programmes. The training is delivered in the care home in partnership with the training facilitators.

The role of the training facilitator

The primary role of the training facilitator is:

- to undertake a training needs analysis within the care home;
- to support and evaluate the implementation of the training;
- to meet the outputs as defined by the project.

On average, each facilitator has a case-load of 10–12 homes and offers support and guidance to approximately 80–90 care workers.

For the care homes the facilitators have developed and provided:

- care home profiles and action plans, which can be used for inspection and commissioning purposes;
- workforce development plans and individual training and development records;
- an information technology infrastructure;
- team building, particularly in the context of a sustainable learning culture;
- management and leadership skills;
- problem solving, with supporting policies and procedures;
- business planning and quality assurance;
- teaching of topics required to fulfil the induction and foundation standards;
- career advice and guidance;
- policy writing and the provision of advice and guidance.

Steps towards integrated workforce planning

As with all such projects, the value of the CHTC is to effect change and improve the quality of services. Its success has led to the creation of a training and development partnership in each of the three local authority areas; these have the remit of producing a workforce strategy for the health and social care economy, and a training and development plan, which becomes the commissioning document for the strategic health authority's workforce development department. The care homes

Contributing to CGB

The audience is predominantly practising clinicians and managers, so please make your article as practical and relevant to everyday practice as possible.

Length: 500–800 words plus a maximum of five references in Vancouver (numerical) style.

Illustrations: where appropriate, use tables, charts, summary boxes etc. to present information, and to break up the text.

Web links: where possible, provide web and/or email addresses for further information – e.g. Department of Health reports or circulars, publications, societies, etc.

Presentation and submission: On the first page include the article title and author names and addresses (including email addresses); please also indicate which author is responsible for correspondence about the article and proofs. Start the article with three to five brief bullet points summarising the key lessons learned. Use plain, unjustified text throughout, with subheadings in bold upper and lower case.

Please send your contribution, by email (or by post with floppy disk), to:

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are becoming linked into these partnerships. A typical partnership will be between the acute trust, primary care trust, the local authority social services department, the Learning and Skills Council, the strategic health authority, JobCentre Plus and training and service providers. With these relationships developing, the ability of the local economy to respond to modernisation issues in a whole-systems way is possible, for example in meeting the needs of people with chronic disease.

We know the same method of training support will work for the even more fragmented domiciliary care workforce, as in December last year we launched a domiciliary care training collaborative in an inner London borough. Innovations for that project include the piloting of a paperless NVQ and the integration of English as a second or other language with the NVQ instruction, as the care workers in the 10 independent

agencies were from different ethnic groups.

Conclusions

Care homes will respond to a collaborative approach, where they can additionally use the process to address other issues besides training (e.g. recruitment and retention, and relationships with commissioners). The popularity of this way of working was reinforced by an external interim evaluation³. Feedback from care home managers gathered in face-to-face and telephone interviews revealed that:

- 92% are confident that the project will benefit their organisation;
- 100% believe the project will lead to a more skilled workforce, improved client care and sustained staff training and development;
- 92% believe staff will be more motivated, although only 50% felt

there would be a reduction in staff turnover;

- 75% are satisfied with the training their staff are receiving;
- 83% are satisfied with the frequency and timing of visits;
- 75% rated the impact the project was having on their organisation as very good or excellent.

Local partnerships of agencies with a remit to increase the skills base can transform the local health and social care economy. Strategic health authorities are ideally placed to coordinate these developments.

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WhoWhatWhere?

Guidelines on the web

Guidelines are being developed by many teams to improve patient care and to encourage the practice of evidence-based medicine. A number of organisations have developed guidelines from rigorous assessment of the research evidence.

Agency for Healthcare Research and Quality
www.ahrq.gov

Canadian Medical Association
Infobase: clinical practice guidelines
<http://mdm.ca/cpgsnew/cpgs/index.asp>

Medical Journal of Australia's guidelines site
www.mja.com.au/public/guides/guides.html

National Institute for Clinical Excellence
www.nice.org.uk

Department of Medicine, University of California, San Francisco: primary care clinical practice guidelines
<http://medicine.ucsf.edu/resources/guidelines/>

Scottish Intercollegiate Guidelines Network
www.sign.ac.uk

Why not email us your suggestions?

If you know of any useful websites please email the editor.

Topics for future issues

The topics we would like to address in future issues include:

- Performance management
- Working together
- Quality versus quantity
- Improving patient experience
- Guidelines implementation

Clinical governance has now been in place for many years and while it has in the main concentrated on ensuring that systems and processes are in place, there must be examples of improved outcomes. If you have such examples please send in your practical contribution.

We would like to run a series of top tips for successful implementation from different professional and managerial perspectives and from different levels in health-care organisations. Contributions are also welcome to this series. There should be five or six top tips in bullet point form; they can cover what has made a project a success or any aspects of clinical governance; we would also welcome contributions on how barriers to implementation have been overcome.

The editor