

CLINICAL GOVERNANCE

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Bulletin

Editorial: Clinical networks

Myriam Lugon

Consultant, Clinical Governance and Health-Care Policy, London

The changes in the pattern of education and training, the working time directives, the difficulty with recruiting skilled staff and increasing clinical subspecialisation make it difficult for health-care organisations to maintain comprehensive local services that cover all medical specialties. By becoming part of a managed clinical network, a service can maintain access to the whole range of subspecialties and thus improve the quality of patient care. As Nigel Edwards puts it:

Networks offer a way of making best use of scarce specialist expertise, standardising care, improving access....¹

Moreover, the establishment of clinical networks can ensure that patients' contacts with the different health-care sectors are made easier and that their needs are better taken into account.

But what is a managed clinical network? A comprehensive definition was given by the Scottish Executive in one of its circulars:

linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, uncoordinated by existing professional and health board boundaries, to ensure equitable provision of high quality clinically effective services.²

Networks allow integration across different sectors and flexibility in the services they offer; they ensure collaboration between different groups and effective utilisation of resources³. The networks approach can ultimately foster innovation and new ways of working, as their establishment can engage a whole health community in the planning and delivery of a particular service, but, more importantly, because networks are focused on clinical services, they can facilitate both patient involvement and the pooling of knowledge and resources.

Clinical networks need to be underpinned by sound principles, such as²:

- clarity about the management arrangements
- a multidisciplinary and multi-professional approach
- patient representation
- evidence-based practice
- clinical audit
- training

There also needs to be effective clinical governance. Thus guidelines, audit, incident reporting and patient involvement need to be agreed by the network, as does the information the network is going to use to monitor the quality of care on a continuous basis and how this is going to be reported and to whom.

This issue of the *Bulletin* includes two papers on clinical networks, one describing their development and the other dealing with the Scottish experience. This is a topic that we will be revisiting in the future and we would urge participants in cancer networks and other collaborative networks to write about their practical experience. Other topics

Topics for future issues

- Appraisal
- Guidelines

See page 12 for guidance on the submission of contributions.

In this issue

- 1 Editorial: Clinical networks
- 2 Developing managed clinical networks
- 4 Managed clinical networks: developing a strategic approach in NHS Lothian
- 6 WhoWhatWhere?
- 6 Occupational health smart cards in the NHS: a vital tool for ensuring patient safety
- 8 Managing change in hospital doctors' working practices
- 11 Policy effects on clinical work: less change than envisaged?



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include managing change in doctors' working practices, the use of an occupational health smart card in improving patient safety, and a contribution from Australian colleagues.

Please keep sending in your contributions to share the lessons you have learnt with the wider NHS.

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- 1 Edwards N. Clinical networks. *British Medical Journal* 2002;324:63
- 2 Scottish Executive Health Department. *The Introduction of Managed Clinical Networks Within the NHS in Scotland* (MEL10). Management Executive letter, 1999. See www.show.scot.nhs.uk/sehd/mels/1999_10.htm
- 3 Gillies JM, McCarthy IP. Adaptable networks: perspectives from a business context. In: James R, Miles A, eds. *Managed Care Networks*. London: Aesculapius Press, 2002

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Developing managed clinical networks

Debbie Wall¹ and Marilyn Boggust²

¹Senior Researcher, NHS Clinical Governance Support Team, 2nd Floor, St John's House, 30 East Street, Leicester LE1 6NB, email deborah.wall@ncgst.nhs.uk, website www.cgsupport.org; ²Director, Gibraltar Healthcare Development Programme, NHS Clinical Governance Support Team, Leicester

- **Managed clinical networks are a way of coordinating seamless patient care pathways.**
- **Managed clinical networks need to cut across traditional professional boundaries.**
- **Networks need to have effective arrangements for clinical governance.**
- **Members need to agree what clinical information is to be collected, how it is going to be shared and what patient information is needed.**

The network as an organisational model

A network organisation differs from a traditional organisation in that its structure is horizontal rather than vertical. In this model, a number of organisations work together in their attempt to meet different customer or client needs. By their very nature, network organisations are dynamic and fluid; they operate through trust and strong relationships, rather than through hierarchy and bureaucracy.

A network organisation can be defined as:

A set of autonomous organisations that come together to reach goals that no one organisation can reach separately.¹

Developing clinical networks

In the health-care environment, formal, managed clinical networks (MCNs) provide a structural framework for the organisation and development of local clinical services. As an organisational model, networks are developing differently across the UK. This to some extent indicates their flexibility: a network may be established to coordinate the delivery of services in response to, for example, patient interests, particular local circumstances, the nature of a particular disease, or the need to increase effective delivery of a specialty.

In 1999, the core principles governing the development of MCNs in NHSScotland were published in a

Management Executive letter². They included:

- clear structural and management arrangements
- a statement of clinical and service improvements for patients
- a supportive, documented evidence base
- utilisation of education and training potential
- multidisciplinary and multi-professional working
- patient representation on network management
- accountability and quality assurance

As well as these principles, the application of clinical governance to network development in Scotland was highlighted and clarified in a further circular from the Scottish Executive³.

The South West London HIV and GUM Clinical Services Network, in common with other network partnerships in England, has adapted the definition of an MCN offered in the

Management Executive letter² to suit its own needs. It describes a service network as:

A collaborative partnership of professionals (both commissioner and provider) working in a co-ordinated manner, unconstrained by existing professional and organisational boundaries, to ensure patient focused high quality, effective, equitable services.⁴

Types of clinical network

There are many types of network:

- A 'hub and spoke' model of care, with an enhanced primary care service, supported by a network of local hospitals, as in Northern Ireland⁵.
- A service-focused network, cutting across organisational boundaries and including primary care, as in Scotland⁶. The service focus could be in relation to a specific disease (e.g. coronary heart disease, cancer), a particular specialty (e.g. neurology, cardiology), or it could be a functional focus (e.g. 'medical receiving' networks, such as pathology and accident and emergency).
- Networks can also be based on geographical areas, which can range from the local (e.g. connecting remote and rural health communities) to regional and national (e.g. services for rare diseases).

Other clinical networks have been set up as a way of sustaining vulnerable services and maintaining access where the requirements of training or subspecialisation would otherwise mean a complete closure of local services. Networks have also been created to make the best use of scarce specialist expertise, to standardise care and to improve access to services⁷.

Spreading the net

The 1995 Calman-Hine report⁸ established a policy framework for the commissioning of cancer services, and recommended organisation at three levels: primary care, cancer units in local hospitals, and cancer centres in larger hospitals. To meet these recommendations, as well as those of the *NHS Cancer Plan (2000)*⁹, 34 local cancer networks have been established across England. These bring together health service

Box 1. Benefits of managed clinical networks

- Potential for seamless patient care.
- Integrated care across existing professional and health-care boundaries.
- Agreed care protocols and pathways across the network area.
- Diversity of professional contributions.
- More equitable service provision for patients.
- Prevention of duplication of effort and resources.
- Multiprofessional and multisite working.
- Teamwork and collaboration.
- Flexibility and dynamism.
- Evolution and change.

commissioners, providers, local authorities and the voluntary sector. The Yorkshire Network¹⁰, for example, includes 17 primary care trusts and seven hospital trusts. It is managed by a management board with wide representation, including patients, carers and health-care professionals. In common with all cancer networks, it is linked to the Cancer Services Collaborative, which provides support through project facilitators. There are 18 cancer research networks in the National Cancer Research Network.

Following the introduction of cancer networks, a range of other condition-specific or specialist clinical networks has been developed throughout the UK. The 222 hospitals that provide critical care services in England are members of the 28 critical care networks; there are also networks in coronary heart disease (CHD) and vascular surgery. Collaboratives established by the NHS Modernisation Agency support networks in CHD and in emergency services. In addition, in Scotland, MCNs are being developed in cancer, diabetes, stroke, vascular services and CHD. Their spread is being supported by investment in a series of local demonstration pilot projects, the evidence from which can also be utilised by equivalent network organisations in England¹¹.

The benefits and future of clinical networks

The main driver for the implementation of clinical networks was the desire to deliver a seamless service for patients and to improve the overall patient experience. A report from the NHS Confederation¹² identifies what makes the establishment of networks different from other structural changes that have been used to improve patient care in the NHS:

- They have the potential to transcend traditional boundaries between primary, secondary and tertiary care.
- They provide configurations that may be more closely aligned to the patient's pathway and experience of care, rather than to institutions or traditional professional divisions, for example those between medicine and surgery.
- They may break attachment to the interests of individual institutions, which has often been a barrier to change.

The report suggests that, when establishing networks, it is essential to get the balance right between formality and informality. Although networks need some hierarchy to operate effectively, too much bureaucracy will wipe out the benefits that a network organisation is designed to bring to the service. Three different types of emerging network are described which might inform future developments:

- *Primary care* – in which primary care organisations provide a range of services that are currently provided by hospitals, including specialist consultation services, rehabilitation, investigation and some emergency care.
- *Specialist care* – these networks are already emerging in cancer, vascular surgery, cardiology, paediatrics and other specialties. The interconnections in these networks are based on non-hierarchical relationships, clinicians who work between hospital sites, shared pathways, training, development and clinical governance.
- *Diagnostic services* – networked providers giving particular support to other care networks, such as pathology and cytology.

The benefits of adopting the network model to coordinate services for patients are becoming apparent (Box 1).

Conclusions

Managed clinical networks have a key role to play in the delivery of high-quality, modern and patient-centred health-care. They are slowly developing and are challenging the way care has been organised until now. The involvement of frontline staff, the local community and patients can only lead to better and more focused services that address the real needs of the local population. This is a complex agenda that requires the establishment of formal structures with clear aims and objectives, a clear accountability framework and robust clinical governance arrangements.

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- 10 Yorkshire Cancer Network. See www.yorkshire-cancer-net.org.uk
- 11 *Managed Clinical Networks in Coronary Heart Disease in Dumfries and Galloway* (interim report). See www.show.scot.nhs.uk/mcn
- 12 Edwards M, Fraser SW. *Clinical Networks – A Discussion Paper*. London: NHS Confederation, 2001. See www.nhsconfed.net

Managed clinical networks: developing a strategic approach in NHS Lothian

Dermot Gorman¹, Sue Payne², Laura Bowers³, Harden Carter⁴ and Peter Donnelly⁵

¹Consultant in Public Health Medicine, Lothian NHS Board, Deaconess House, 148 Pleasance, Edinburgh EH8 9RS, email Dermot.gorman@lhb.scot.nhs.uk;

²Consultant in Public Health Medicine, Lothian NHS Board; ³Senior Public Health Researcher, Lothian NHS Board; ⁴Consultant in Public Health Medicine, Lothian NHS Board; ⁵Director of Public Health and Health Policy, Lothian NHS Board

- The development of managed clinical networks is a key policy of NHSScotland.
- Defined management structures, investment to support the network and a named lead clinician are seen as crucial to network development.
- While there are established clinical networks in various services and specialties in Lothian, these are at different levels of preparedness to achieve the full status of managed clinical networks, as measured against the demanding criteria set by the Scottish Executive.

Background

In Scotland, managed clinical networks (MCNs) have been defined as:

linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and health board boundaries, to ensure equitable provision of high quality clinically effective services throughout Scotland.¹

National policy has shown continued commitment to developing the MCN concept and the Scottish Executive has provided investment to establish demonstration pilot projects (such as care networks for cancer, coronary heart disease, stroke, vascular services and diabetes) and national 'formal' networks throughout Scotland. Guidance on developing local MCNs has been provided, as have criteria for MCN status (summarised in Table 1). A guide to MCN implementation² was published in November 2002.

Managed clinical networks have the ability to deliver better quality of care for patients by providing agreed standards of care, specific referral

and follow-up guidelines, and care which is delivered in the appropriate setting. They can also strengthen both audit and clinical governance and enable the system to overcome shortages in specialist staff. Thus they are seen as key mechanisms for developing services, and NHS boards are being encouraged to promote them. They cut across boundaries – be these organisational, between professional groups or geographical – and have a clear emphasis on patients, effective care pathways and quality improvement.

Within NHS Lothian, the concept of MCNs has been embraced enthusiastically. While in early 2002 SCAN (the South East Scotland Cancer Network, which involves four NHS board areas) was the most advanced network and several others were in various stages of development, MCN activity had yet to be formally recorded in Lothian.

Methods

In May 2002 we undertook a stock-take of MCN activity. This was done by using a checklist devised to document progress against essential and desirable criteria (Table 1) incorporated in national guidance¹. Clinical leaders in specialties or services known to be seeking full MCN status for their networks were asked to complete a standard pro forma.

Results

We had 20 returns. In general, networks tended to have in place a lead clinician and manager with operational responsibility, objectives for the service, multidisciplinary membership and audit and review, but robust formal documentation

Table 1. Criteria for MCN status (essential and desirable components of MCNs)

Essential components	Desirable components
Formal approval by the NHS board	
Lead clinician and manager with overall responsibility for operation of the network	Lead nurse
Written annual report for trust/health board	Quarterly reports, bulletins, newsletters, Internet site
Evidence of aims, objectives and principles governing the service	
Statements of expected clinical and service improvements, with clearly defined deadlines for achievement and accountability	
Documented evidence base governing service delivery	National guidelines (e.g. SIGN, CSBS, college) Locally agreed guidelines Research and development strategy
Evidence of multidisciplinary membership appropriate to nature of the network	Defined role and remits for members Quarterly group meetings
Representation of patient organisation in management arrangements	
Policy regarding dissemination of information to patients	Electronic patient records Patient-accessible records
Quality assurance programme evaluating service delivery in accordance with objectives approved by the Clinical Standards Board for Scotland (CSBS)	
	Policy for continuous professional development of staff
Examples of audit of service with open reviews of results	Prospective audit established with agreed data-set Summary of key findings made available to medical directors Open forum for discussions of results
Evidence of value for money	

and processes, patient involvement and patient information were less widely available. No quality assurance programmes had been approved by the Clinical Standards Board for Scotland (which is now part of NHS Quality Improvement Scotland).

Discussion

This work has increased local understanding of the national requirements for full MCN status. The development of specific criteria to measure MCN activity has allowed progress in local activities to be documented. This in turn has identified the key areas for successful development:

- defined management structures
- named lead clinician
- investment to support the network (particularly in establishing management systems, audit and educational programmes).

The findings are now being used by senior management in NHS Lothian to prioritise the specialties in which to develop specific MCNs. This prioritisation will take into

account both national policy imperatives promoting MCNs in particular specialties, such as heart disease, stroke and diabetes, as well as services highlighted in our stock-take: child and adolescent mental health services, paediatric dentistry and ophthalmology.

The challenge is to provide a local strategy that builds on the national impetus and promotes further development of MCNs in a coordinated manner and in prioritised specialties and services. Central to this is provision of a management structure to support lead clinicians in MCNs to organise meetings, prepare documentation and so on.

The link to regional planning is important and adjoining NHS boards will have an interest in working together to develop MCNs in some services.

Conclusion

This work showed that, while there were established clinical networks in various services and specialties, these were at different levels of preparedness to become MCNs as measured

against the demanding Scottish Executive's criteria. The opportunity to identify areas in which criteria for MCN status are being met was valuable; it enabled identification of specialties requiring additional effort to acquire full MCN status and facilitated allocation of resources to make that happen in a coordinated fashion.

This work has been used to prioritise resource allocation and to develop an action plan to facilitate the development of a core number of MCNs in Lothian.

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Further reading

Baker C. *Managed Clinical Networks: A Guide to Implementation*. London: Hayward Medical Communications, 2002

WhoWhatWhere?

Clinical networks on the web

Introduction of managed clinical networks within NHSScotland
www.show.scot.nhs.uk/sehd/mels/1999_10.htm

Organisational structure charts for cancer networks: West Anglia
www.wacn.org.uk/resources/pdfs/org_191001.pdf

Organisational structure charts for cancer networks: Yorkshire
www.yorkshire-cancer-net.org.uk/html/network.htm

Links to the 19 cancer network websites across England (click on 'cancer networks')
www.yorkshire-cancer-net.org.uk/html/links/index.htm

Dumfries and Galloway managed clinical network for coronary heart disease
www.show.scot.nhs.uk/mcn/

SW London HIV and GUM Clinical Services Network
www.swagnet.org/

The Editor's Choice

The NeLH Management Briefing on Managed Clinical Networks, compiled by Jane Bushby

www.nelh.nhs.uk/management/mantop/0218managedclinnets.doc

Comprehensive guidance on MCNs from the NHS South East Regional Office
www.doh.gov.uk/sttheast/managedclinet.pdf

Further sources

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Occupational health smart cards in the NHS: a vital tool for ensuring patient safety

Gabriel Scally¹ and Barbara Levy²

¹Regional Director of Public Health, Government Office for the South West, Bristol; ²Programme Manager, Occupational Health Smart Cards, Human Resources, NHS Employment Policy Branch, Department of Health, Quarry House, Leeds LS2 7UE, email barbara.levy@doh.gsi.gov.uk

- Establishing the identity and status of new medical staff, particularly locums, remains a vital task.
- Smart card software (combined with a robust system of health checks) provides a secure, streamlined and reliable system for recording a doctor's medical fitness to practise.
- The smart card project aims to cover more than 30,000 hospital doctors in training by 2004, and there are plans to extend the scheme over time to all NHS medical staff, including locum doctors, and to medical students.

There have been a number of high-profile clinical incidents where a failure to establish correctly the identity, qualifications and status of medical practitioners has exposed patients to risk and created expensive and time-consuming problems for NHS trusts. The Department of Health policy discussion document *Supporting Doctors, Protecting Patients* identified pre-employment checks and credentialing as important preventive mechanisms¹. It was suggested in that policy document that 'smart cards' might have a role. The subsequent policy document

endorsed the introduction of smart cards for doctors in training².

Smart cards in England

The NHS Occupational Health Smart Card (OHSC) project is being introduced in a three-year rolling programme to hospital trusts linked to the 14 English postgraduate deanery areas. A national steering group (chaired by Dr Gabriel Scally) is overseeing the introduction of this innovative project. The London deanery area was the first to 'go live', in November 2001, and the other

Table 1. The NHS areas in England covered by the smart card system

Year of implementation	Deanery areas
Year 1 (2001/2)	London, Kent, Surrey, Sussex
Year 2 (2002/3)	Wessex, South Western, Mersey, Yorkshire, North Western
Year 3 (2003/4)	Northern, West Midlands, Trent, Oxford, Eastern

deanery areas are following up to early 2004 (Table 1).

Progress has been made in around 100 trusts to date and across a multiplicity of hospital sites that have already adopted the system. There are up to 10,000 cards already in circulation. Following initial data input on to the cards, many trusts and staff are now benefiting from the chief aims of the scheme: to provide quality assurance for trust managers and patients, and to free up the time of occupational health units to pursue a more proactive role in promoting a healthy NHS workforce.

Benefits of the smart card system

Smart cards provide quality assurance and clinical governance by strengthening and streamlining pre-employment procedures. Health clearance is recorded using new standardised health checks agreed with occupational health clinicians; for example, only identified, validated blood samples are used. Clearance can then be shared by successive trusts as doctors move around the NHS for training purposes. This follows the more stringent pre-employment requirements introduced in June

2002³ before staff can safely treat patients in their care.

These standardised procedures are designed to free up the time of occupational health units by avoiding costly and wasteful duplication of effort with each new intake of medical staff. The smart cards will also improve the working lives of the doctors themselves, by streamlining induction procedures and providing accurate and secure storage of their personal data, including inoculation records or evidence of potential communicable diseases. Doctors in training will have easy and secure access to their personal occupational health and related data. The record can be quickly updated in the presence of authorised NHS staff. Staff have, of course, the right under the Data Protection Act to request a printed copy of the data from their occupational health unit or from the medical staffing officer.

Smart card technology modernises ways of working in the NHS. The OHSC software uses the secure NHS Net to enter, store and transmit confidential staff information from trust to trust (Figure 1). The up-to-date, photo-bearing smart cards will, over time, eliminate the need for insecure paper records.

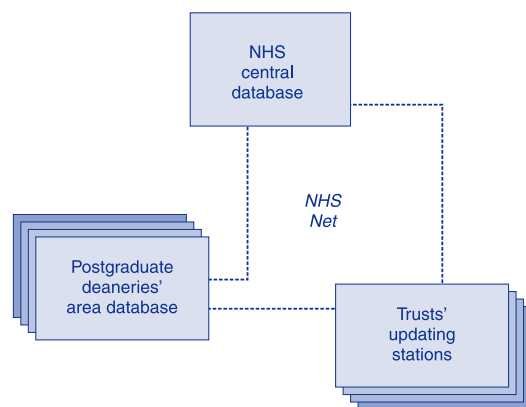


Figure 1. The NHS Occupational Health Smart Card system.

The way forward

By 2004, more than 30,000 doctors in recognised training posts across the NHS in England will be provided with personal data smart cards as they move from one NHS trust to another on their training rotations. In one trust, the occupational health unit is experimenting with using OHSC data to simplify the pre-employment health questionnaire process. In another, they are arranging for specialty open days, when junior doctors will be released from duties to attend the unit to bring their information and health checks up to date.

Conclusion

More than ever before, NHS staff are moving around the service for training and career development purposes. In response, the Department of Health is calling on trusts to review and modernise existing employment and induction practices. The option of extending coverage of the OHSC scheme beyond doctors in training – to cover all medical staff, including locum doctors – is being explored. It has been suggested that it would be appropriate to issue cards to undergraduate students in medical schools, to record health clearances conducted for safe clinical attachments before NHS training begins.

Although it is still early days for this exciting innovation, benefits can already be obtained by participating trusts and doctors. All trusts joining the OHSC project (along with post-graduate deaneries now supplying cards to those trusts) need to work together with their current doctors in training, to turn the theoretical benefits of smart cards into real ones⁴.

References and notes

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- 2 *Assuring the Quality of Medical Practice: Implementing 'Supporting Doctors, Protecting Patients'.* Department of Health, 2001. See www.doh.gov.uk/assuringquality
- 3 Health Service Circular 2002/008
- 4 Detailed information on the OHSC project is available on the Department of Health website, at www.doh.gov.uk/occupationalhealth/index.htm, or from Barbara Levy. The Department of Health is working in partnership with the contractor, TSSI, an industry leader in smart card and biometrics systems.

Managing change in hospital doctors' working practices

Soham Gangopadhyay¹ and Sandip Sarkar²

¹Registrar, Orthopaedics and Trauma, Southend Hospital, Prittlewell Chase, Westcliff-on-Sea, Essex SSO 0RY, email gangoss@aol.com; ²Consultant Orthopaedic Surgeon, Southend Hospital

- More than 80% of junior doctors have practical suggestions for improving working practices.
- Only 27% had actually put forward their proposals to the hospital administration. Junior doctors who had worked longer in the NHS had more commonly put forward their proposals.
- Only 10% of suggestions were actually implemented.
- Three-quarters of junior doctors felt unconvinced about their power to effect changes in working practices, with the more experienced doctors being less optimistic.
- Junior medical staff are the core resource for the future of the NHS and their ideas for changing service delivery should be encouraged.

The NHS Plan (2000)¹ sets out changes that will affect almost every aspect of health-care delivery, from 'the state of the wards to doctors'

contracts'. The government has also stated that:

hospital doctors are best placed to improve patient care. Hospital doctors should spearhead the modernisation of clinical specialities to ensure that money is spent where it is really needed, for the benefit of NHS patients.²

The objective of this study was to determine how junior doctors felt about the prospects for such change, based on their own experience of working within the NHS.

Methods

A cross-sectional study was performed in Southend General Hospital from April 2002 to September 2002. All junior doctors in the hospital were directly approached for a personal interview. From a total of 148, 110 junior doctors (74%) agreed to participate.

The respondents were asked to comment specifically whether they

had suggested changes that could be made to their 'working practice'. As defined by us, working practice included issues related to:

- organisation of work
- daily working patterns
- organisation of shifts/rotas
- organisation of theatre lists and clinics
- support facilities, such as phlebotomy service, emergency assistants and nurse practitioners.

It was pointed out that these issues were directly related to the provision of patient care and were therefore distinct from training needs. Nonetheless, if any of the doctors' suggested changes were implemented, they could in fact contribute to training by creating a better environment and allowing more time for attending theatres, clinics and teaching sessions.

In the interviews, seven questions were asked:

- Do you feel that there is a need for changes in doctors' working practices that would lead to an improved quality of patient care?
- Have you had any ideas that you would like to propose to change working practices?
- Have you ever put forward any of these ideas to the hospital administration?
- If so, did your proposal meet with enthusiasm?
- If so, was your proposal implemented?
- Do you feel that any proposal you put forward in the future would be seriously considered for implementation?
- Do you have any current proposals?

The respondents were asked to base their comments on previous experience.

Results

In response to the first question, all of the doctors stated that they felt

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Table 1. Numbers of doctors who had had ideas for changing working practices and who had put them to the hospital administration ($n = 110$)

Grade of doctor	Yes	No
<i>Have you had any ideas that you would like to propose to change working practices?</i>		
PRHO	13 (76%)	4 (24%)
SHO	47 (81%)	11 (19%)
SpR	12 (75%)	4 (25%)
Staff grade	17 (89%)	2 (11%)
Total	89 (81%)	21 (19%)
<i>Have you ever put forward any of these ideas to the hospital administration?</i>		
PRHO	0 –	17 (100%)
SHO	15 (26%)	43 (74%)
SpR	8 (50%)	8 (50%)
Staff grade	7 (37%)	12 (63%)
Total	30 (27%)	80 (73%)
<i>Do you feel that any proposal you put forward in the future would be seriously considered for implementation?</i>		
PRHO	5 (29%)	12 (71%)
SHO	20 (34%)	38 (66%)
SpR	1 (6%)	15 (94%)
Staff grade	1 (5%)	18 (95%)
Total	27 (25%)	83 (75%)

PRHO, pre-registration house officer; SHO, senior house officer; SpR, specialist registrar.

Table 2. Response of the hospital administration to doctors' ideas for changing working practices ($n = 30$)

Grade of doctor	Yes	No
<i>Did your proposal meet with enthusiasm?</i>		
SHO	4 (27%)	11 (73%)
SpR	0 –	8 (100%)
Staff grade	1 (14%)	6 (86%)
Total	5 (17%)	25 (83%)
<i>Was your proposal implemented?</i>		
SHO	2 (13%)	13 (87%)
SpR	0 –	8 (100%)
Staff grade	1 (14%)	6 (86%)
Total	3 (10%)	27 (90%)

SHO, senior house officer; SpR, specialist registrar.

there was a need for change in working practices to improve the quality of patient care.

Responses to the second and third questions, regarding whether or not doctors had had ideas for changing working practices and whether they had put them to the hospital administration, are shown in Table 1. Thirty doctors had put forward ideas for change. The responses they met with are shown in Table 2. Only 27 doctors felt that any proposal they might put forward in the future would be seriously considered for implementation (Table 1).

In relation to the last question, regarding any current proposals, the most common suggestions were:

- To have more medical and nursing staff.
- To have more medical emergency assistants (MEAs) and nurse practitioners trained to canulate, and to perform routine blood tests and electrocardiograms, especially out of hours, when there is only one on-call doctor to cover accident and emergency and the wards. This would enable the doctor to concentrate on actual patient

care, thereby improving its quality.

- A change of shift system in favour of the old 24-hour on-call rota system. All junior doctors felt that the new shift system was detrimental to their training and, indeed, compromised patient care by interfering with the continuity of management.

All of the doctors felt that they would be quite willing to work 72 hours a week as long as they were adequately compensated.

Discussion

There has been much recent debate regarding the need for change in the NHS. In view of this, we felt it was appropriate to find out what doctors working within the NHS felt about the prospects for such change. All of the doctors interviewed felt that there was a need to change working practice in order to improve patient care and most of them (81%) had ideas on how to bring this about. However, only just over a quarter (27%) had made actual proposals to the hospital administration.

Of the 73% who had not made any proposals, the majority (70%) stated that this was because they did not believe that they would be listened to. It emerged that doctors with more years of experience of working within the NHS had more commonly put forward their proposals to the administration. For example, none of the pre-registration house officers had put forward their proposals, while half of the specialist registrars had done so (Figure 1).

This suggests that junior doctors who had greater exposure to working within the NHS felt more empowered to try to change practices.

While 17% of their proposals were received enthusiastically, only 10% were actually implemented. All the proposals which had been implemented involved making simple changes to shifts or rotas, mainly a change of time of work for existing doctors.

When asked to comment on the realistic possibility of any future proposal being implemented, based on their own experience of working within the NHS, 75% had a negative response. This was most pronounced among specialist registrars and staff grade doctors (Figure 2). The more years they had spent working in the

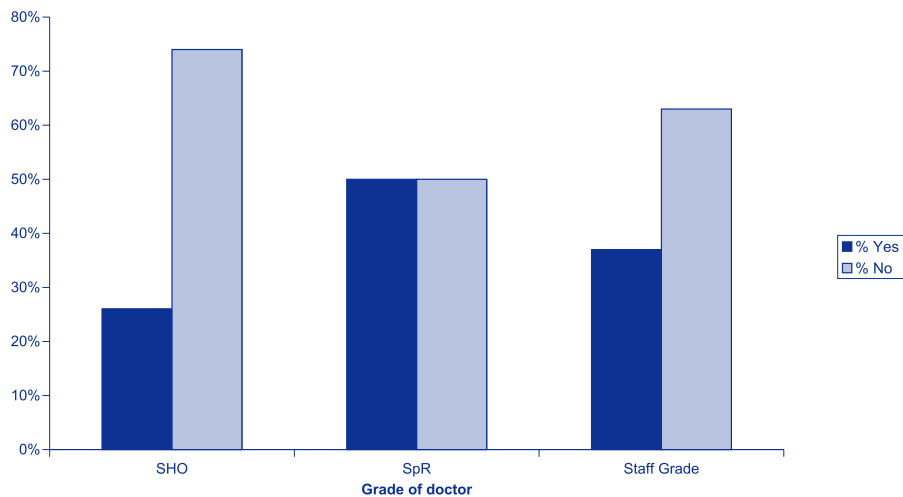


Figure 1. Responses to the question 'Have you ever put forward ... ideas to the hospital administration?', by grade of doctor. No pre-registration house officers had put forward ideas.

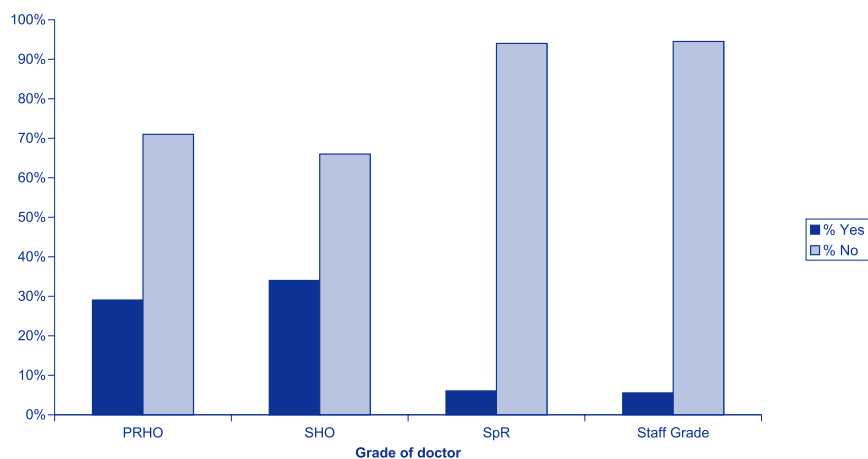


Figure 2. Responses to the question 'Do you feel that any proposal you put forward in the future would be seriously considered for implementation?', by grade of doctor.

NHS, the less hopeful doctors seemed to be about the possibility of a future proposal being implemented.

The most common proposal was an increase in staffing levels, particularly the number of emergency medical assistants and nurse practitioners, to provide support to the medical staff out of hours. Another interesting observation that emerged was the fact that all the junior doctors were against the shift system and would prefer working 24-hour on-call shifts, for adequate payment. They felt that this would improve the quality of their training as well as provide continuity of patient care.

Over the last two years, the Department of Health has issued a number of press releases regarding

proposed changes, such as increasing staffing levels³ and ensuring greater involvement of hospital doctors in the planning process. From this study involving 110 hospital doctors, there appears to be a dearth of confidence about the realistic possibility of such change, with the more experienced doctors being less convinced.

Clearly, this study has been based on a relatively small sample of doctors at a single hospital. Nevertheless, the vast majority of respondents had worked in a number of NHS hospitals, not all local.

This study demonstrates a significant problem regarding the implementation of change within the NHS. The government's proposals for clinician-led change are obstructed by the experience and expectation of clinicians who believe that their

ideas will go unheeded. That this is the case with junior doctors, who will become the independent practitioners of the future, is of particular concern. Hospital management should encourage suggestions from junior doctors and support them by putting these into practice at an early stage in their careers.

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Policy effects on clinical work: less change than envisaged?

Jeffrey Braithwaite¹, Deborah Black² and Johanna I Westbrook³

¹Associate Professor and Head, Centre for Clinical Governance Research in Health, Faculty of Medicine, University of New South Wales, Sydney, NSW 2052, Australia, email j.braithwaite@unsw.edu.au; ²Associate Professor, School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales; ³Associate Professor and Deputy Director, Centre for Health Informatics, Faculty of Medicine, University of New South Wales

- Many people view policy as a top-down phenomenon, imagining that policy makers devise it while staff at lower levels implement it. In fact, clinicians have considerable discretion over whether and how particular policies are adopted.
- We analysed nine emergent key policy drivers in Medline (the health and biomedical database) and then asked 25 clinicians in focus groups whether, from their experience, these drivers were affecting their practice.
- Participants reported that their practices were not changing to the extent one might have expected from the rapid growth in the citation of papers on these policy drivers.
- The study suggests that change sponsored by clinical governance initiatives may be harder to realise and is more generational in scope than many people think.

Major policy initiatives advanced by top-down reformers in recent years include clinical guidelines¹, quality-of-care strategies² and the involvement of doctors in management³. Each is

advanced as another force in altering the work of GPs and specialists, and affecting health-care delivery.

In contradistinction to this top-down view stand the policy implementation theorists. Lipsky⁴ advanced the notion of street-level bureaucracy, arguing that professionals – who are decision makers but at street level rather than within the top layers of a hierarchy – have considerable autonomy in carrying out policy pronouncements. They modify, recast or negate policy objectives through local decision making. Accordingly, policies are enacted largely if clinicians decide to do so, and they determine the circumstances of implementation.

Which account is more compelling? We sought to show how policy initiatives are reflected in the literature over time and to assess clinicians' views regarding the impact of these on their work.

The study

A literature analysis identified nine major putative policy drivers (Table 1). A Medline search of the occur-

rence of key words and phrases representing these policies was undertaken at four-yearly intervals between 1988 and 2000.

Three focus groups, with a total of 25 Australian doctors, were conducted in 2000 and 2001. There were 14 males and 11 females. Their average age was 42 years and the average length of clinical experience was 16 years. Participants were asked how health-care reforms affected their clinical work, and specifically about the impact of the nine policy drivers. Discussions were taped and content-analysed.

Table 1 shows the appearance of new and growing policy issues in the literature. The rates of citation increase for the drivers for change were substantially greater than observed over the entire Medline database, which is a good indication of the pressure on clinicians to change. Some of the policy drivers are central to clinical governance and they increased markedly in that period, including 'clinical guidelines', 'clinical pathways', 'health outcomes', 'evidence-based medicine' and 'quality improvement'.

Table 1. Nine drivers for change and the rate of increase in citations over four-year intervals, 1988–2000

Policy driver for change	No. of citations in 1988	No. of citations in 1992	Increase factor, 1988–92	No. of citations in 1996	Increase factor, 1992–96	No. of citations in 2000	Increase factor, 1996–2000	Overall increase factor, 1988–2000
Quality improvement	1799	3257	1.8	4006	1.3	2999	0.8	1.7
Clinical guidelines	10	176	17.6	1363	7.7	2446	1.8	244.6
Length of stay	665	1121	1.7	1793	1.6	1733	1.0	2.6
Evidence-based medicine	0	0	–	209	–	1587	7.6	7.6
Managed care	200	488	2.4	2850	5.8	1258	0.4	6.3
Telemedicine	0	46	–	256	5.6	395	1.5	8.6
Rationing	49	395	8.1	511	1.3	363	0.7	7.4
Health outcomes	22	71	3.2	201	2.8	299	1.5	13.6
Clinical pathways	0	2	–	316	158.0	152	0.5	76.0
All Medline citations	367,552	393,129	1.1	423,910	1.1	451,651	1.1	1.2

Participants' responses to the question 'How and in what way over the past five years have health-care reforms affected your clinical work?' could be grouped according to three themes:

- not much change is occurring (e.g. 'Clinical behaviour is still exactly the same as it was 10 years ago...')
- there is more pressure on the system (e.g. 'There's pressure to see lots of patients quickly' and 'There is more awareness that the system's under pressure ... that it is unsafe')
- patients are more educated, demanding and litigious (e.g. 'There is less money to go round ... patient demands are up and they're more educated ... therefore clinicians are squeezed in both directions').

The responses to specific policy drivers demonstrated that the adoption of and the effects of evidence-based medicine, telemedicine, health outcomes, quality improvement and clinical pathways were not as great as might be assumed on the basis of their increasing popularity in the

literature. Some illustrative comments include the following:

No one measures holistic health outcomes.

People are a lot more aware, but the take-up depends ... on motivation, time, and experience.

Quality assurance, CME points encourage people to keep up to date ... they have some effect.

Most GPs are practising as they see fit.

Rationing is foreign to most practitioners.

The profile [of evidence-based medicine] is higher, but practice may not be thorough.

Discussion

There are detectable trends in policy ideas in the literature, perhaps reflecting fads and fashions. Yet clinicians reported that clinical work is not changing to the extent envisaged by those who contribute to the Medline literature. Two explanations are possible: either the contributors to the literature overestimate the effects of reform, or practitioners underestimate the effects of change

initiatives. The latter is unlikely, and both may operate. The most parsimonious account is what sociologists label 'normative'. The literature appears to reflect how contributors would like the system to be rather than how it is, and clinicians, getting on with the job, affect markedly the whether and how of policy implementation.

Lugon is thus justified in asking whether clinical governance is more rhetoric than reality⁵. There are both plenty of evidence and a myriad of examples of strong commitment to the tenets of clinical governance in health systems like those of Australia and the UK. Yet our clinicians' reports suggest that changing deep-seated culture and embedded practices may be more generational in scope than many commentators think.

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Contributions

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.

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Dr Myriam Lugon, Editor, *Clinical Governance Bulletin*,
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