

# CLINICAL GOVERNANCE

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## Bulletin

### Editorial

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#### Performance management and the use of information

Clinical performance indicators should be used as a vehicle for performance improvement. If they are accurate enough, they can be used as a reliable proxy to determine both the quality and outcomes of clinical care. In the NHS, however, currently captured data tend to be focused on waiting times and financial issues rather than measures of quality<sup>1</sup>.

The Commission for Health Improvement (CHI) reported that 'the information the boards see tends to be about waiting times and financial performance figures' and that 'there is insufficient value placed on information by senior staff'<sup>2</sup>. Information is crucial to identify how well services and teams perform. Information technology (IT) should be used to capture relevant and accurate clinical information that will help clinical teams understand how well they are doing and identify opportunities for improvement. Current IT systems do not produce relevant information at the press of a button, so organisations need to find ways to ensure that qualitative and quantitative data (e.g. claims, complaints, incidents, complications, clinical indicators, health and safety issues) are gathered, analysed and made available to the relevant services. This information will become increasingly important both for the early identification of problems<sup>3</sup> and to inform consultant and team appraisal and revalidation portfolios. Currently available data are not enough and the NHS needs to find meaningful and measurable clinical and patients' outcomes to develop a more comprehensive and patient-centred performance management process. The avail-

ability of such information is going to be increasingly important, both to improve patients' experiences and to make the revalidation process more meaningful.

The Healthcare Commission has stated its intent to move towards common assessment for both the NHS and the private sector. Maybe the NHS could learn from the private sector, where 'good quality clinical information is the currency of its business and is comprehensively captured at the point of patient care by clinically knowledgeable staff'<sup>4</sup>.

In future issues we would like to cover the experience of primary and secondary care organisations in performance management and how the process has helped improve service delivery and patient care. Clinical governance processes have now been in place for many years but what effect have they had on the patient experience? While CHI has assessed and rated a large number of health-care organisations, it has dealt mainly with structure and process. The *Bulletin* would like to hear from organisations that have used these to improve the outcomes of care. There must be a lot of examples, so we are looking forward to receiving your contributions.

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### In this issue

- 1 Editorial
- 2 The development for a primary care trust of procedures for monitoring the performance of general practitioners – an evolving process
- 4 Patient appraisal of a service: a pragmatic approach
- 6 Improving patient understanding of hip and knee arthroplasty: a prospective study of the role of experienced, dedicated nurse practitioners in the pre-admission setting
- 9 Demystifying infusion confusion
- 11 Connections and common ground – clinical governance and learning disabilities



# The development for a primary care trust of procedures for monitoring the performance of general practitioners – an evolving process

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- A process for monitoring the performance of GPs should be supportive of them.
- Procedures should be described in a clear and understandable working document.
- Flowcharts enable the process to be mapped in detail and fully understood.
- Performance management for GPs should be supported by the primary care trust's clinical governance framework.
- The process should ultimately link with GP appraisal and revalidation.

## Background

As part of the NHS programme for *Shifting the Balance of Power*<sup>1,2</sup> responsibilities for managing the performance of GPs have been devolved from health authorities to primary care trusts (PCTs) (fully so since April 2003). To begin the transition process, Rushcliffe PCT established a General Medical Practitioner Performance Review Group in July 2001, which adapted procedures previously used by the local health authority.

In spring 2002, the National Clinical Assessment Authority (NCAA) published a guidance handbook<sup>3</sup> on structures, processes and support systems for the management of GP performance. This highlighted the need for PCTs to develop new procedures for monitoring the performance of GPs, and formed the basis of the work described here.

## Key principles

It is important that any process for monitoring the performance of GPs is seen to be supportive of them and helps them to improve their practice, rather than being in some way punitive. Key principles which were applied in the development of

the local procedures were that the process should be:

- described in a clear and understandable working document;
- transparent, fair, objective and effective;
- designed to monitor and improve performance and protect the public;
- proactive as well as reactive;
- designed to identify issues before they become problems;
- supportive of GPs – for example with the provision of education, training and remediation;
- part of and supported by the clinical governance framework of the PCT.

## Understanding the process

The first step in developing the procedures was to map and understand in detail the process recommended by the NCAA, including an understanding of the key organisational structures and responsibilities involved. The structures discussed below ensured that responsibility for decision making remained with the PCT and was separated from assessment and support.

### Performance Decision-making Group (PDG)

The PDG is a confidential subgroup of the PCT board. (The existing Performance Review Group in Rushcliffe adopted the NCAA nomenclature and became the PDG.) The Group monitors the performance-related information and is responsible for all decisions taken in response.

### Performance Advisory Group (PAG)

The PAG provides advice and access to specialist support for local assessment and remediation for under-performing GPs, on behalf of the PDG. It is able to draw on a

broad range of expertise and experience from across the district. The structures and membership for the local PAG are still under review but it is likely that it will be a deanery-based resource.

### National Clinical Assessment Authority (NCAA)

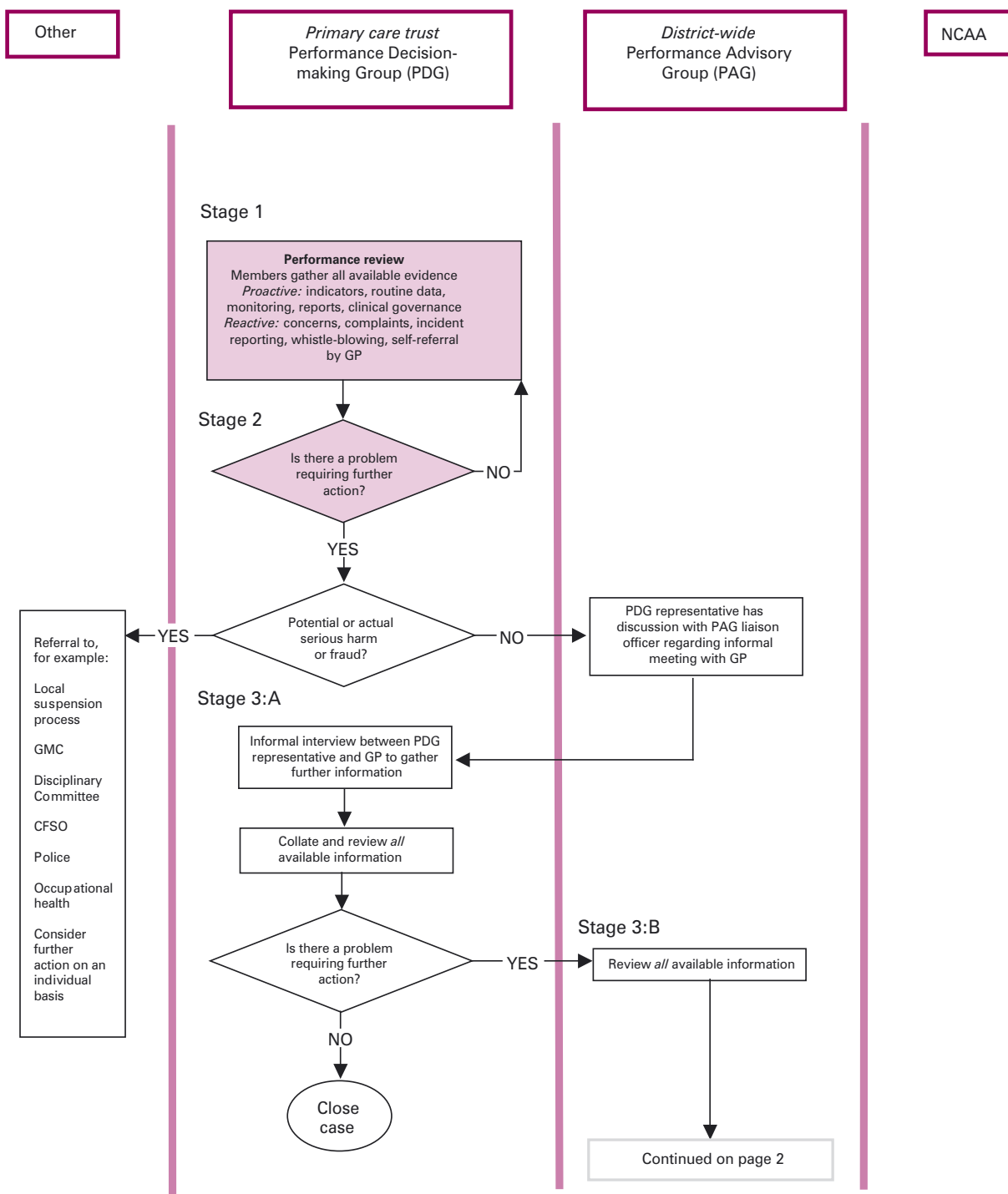
The NCAA will provide advice at any stage in the performance review of a GP, and will receive referrals from the PDG for formal assessment where, for example:

- local systems are not considered appropriate;
- local procedures have not resulted in a satisfactory outcome;
- a comprehensive, global assessment is required.

Although NCAA assessment forms part of the local, supportive process, referral to the NCAA would never be the first option for handling concerns.

## Mapping the process

In order to understand the GP performance management process fully, a detailed process flowchart was produced after wide consultation with key people (e.g. local GP representatives, PDG members, an NCAA advisor, the GP tutor and deanery representatives). The flowchart, a sample extract of which is shown in Figure 1, identifies key areas of responsibility, activity and process flow between the PDG, PAG, NCAA and 'other' (i.e. referral out of the local GP performance monitoring and support process into other separate but parallel processes, such as disciplinary procedures). The flowchart provides a detailed description of the stages recommended in the NCAA handbook and provides a useful working document for quick reference, to enable the PDG to follow the appropriate procedures



**Figure 1.** Sample extract from the process flowchart: the process flow between the various groups and agencies involved in the review of GP performance. The vertical columns indicate areas of responsibility. The shaded areas at stages 1 and 2 represent ongoing, routine monitoring that takes place as part of local clinical governance arrangements.

for monitoring GP performance and implementing remedial action.

### Written procedures

After the process had been mapped, detailed procedures were written for each process stage; these were cross-referenced to the flowchart to ensure

that the process would be understood.

The draft procedures were presented to general practice teams at a multi-practice, multi-professional quality improvement forum in January 2003, for comment and fine-tuning before submission to the PCT Professional Executive Committee

and board for approval, adoption and implementation in April 2003. The same model has also been adopted by the other three PCTs in Nottingham.

### Performance indicators

No set of currently available indicators can provide a comprehensive

assessment of general practice care and no indicators in use elsewhere, or proposed for use with these procedures, have been validated as 'diagnostic' of under-performance. Certainly no single performance indicator, from routinely available data sources, is specific or sensitive enough to label a GP or practice as 'under-performing'. The term 'indicator' is important and the indicators are used as a guide to understanding possible reasons for under-performance rather than as targets.

A range of performance indicators are used to identify differences between practices. A pattern of deviation from local norms on a number of these should trigger exploration and provide a starting point for dialogue between the practice and those responsible for clinical governance. Some of these indicators include:

- prescribing data – including controlled drugs and drugs of dependence;
- access to services;
- complaints;
- childhood immunisation activity;
- participation and performance in the clinical governance agenda.

The clinical governance programme is well developed within our PCT and for over four years has provided a broad selection of comparative data between practices.

### An evolving process

The process for monitoring GP performance is supported by the PCT clinical governance framework, which promotes and facilitates systematic and continuous quality improvement in service delivery, within a culture of team working, sharing and learning<sup>4</sup>.

The process continues to evolve and is currently undergoing review to strengthen links with GP appraisal and revalidation. The local processes of both GP appraisal and performance monitoring are designed to be supportive and to help improve quality. Having clear links between the two should help to ensure all aspects of GP performance and development are considered in GP appraisals (which are signed off by the PCT for GP revalidation) and enable GPs to make use of the support and resources available for their professional development.

Since their implementation, the procedures have proved to be helpful. They will be subject to regular review, so that lessons can be learned from cases as they are processed. The procedures also have the potential to be adapted to apply to other contractor practitioners, for example dentists, to achieve a consistent approach to the monitoring of the performance of providers of health-care services for the PCT.

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## Patient appraisal of a service: a pragmatic approach

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- Patients' views of clinical teams can inform the assessment of a multidisciplinary team and can contribute to revalidation.
- The questionnaires available for this purpose proved too complex. We therefore developed and validated a simpler, five-theme questionnaire.
- Patient satisfaction with a particular service or multidisciplinary team is best assessed with a personally administered questionnaire.
- Positive feedback must be used constructively to change practice.

### Background

As part of the introduction of the consultant appraisal/revalidation process, the Guy's and St Thomas' Trust undertook research into the optimum means of achieving 360-degree appraisal of doctors. This has been based on questionnaires derived from the pioneering work of Ramsey in the USA<sup>1</sup>. Initial pilots using a 10-theme questionnaire and complex scoring system were found to be inappropriate for the British scenario<sup>2</sup>. Doctors did

not like handing surveys on themselves to patients, and the postal return averaged 50% but varied from 2% to 80%. There was a problem with language and also lack of clarity as to who was completing the questionnaire. Patients felt the instrument was too long and they found the scoring system cumbersome.

Consequently, we produced a simpler, five-theme questionnaire with a four-point scoring system (poor, fair, good, very good) (see Table 1). This was validated in a large directorate<sup>3</sup>.

**Table 1.** Results from the patient questionnaire ( $n = 25$ )

Theme	Statement to rate	Mean rating <sup>a</sup>
1 Respect	The team treats you with respect and consideration	3.9
2 Personal perspective	They encourage you to tell your story and ask questions	3.8
3 Clarity and simplicity	They use words that you can understand	3.8
4 Involvement in treatment decisions	The team discuss treatment options with you and your family	3.7
5 Communication	The team continues to keep you fully informed throughout your illness and treatment	3.9

<sup>a</sup>Patients rated all items 1 = poor, 2 = fair, 3 = good or 4 = very good.

To correct the problems highlighted above, we interviewed patients after their outpatient consultation. This arrangement meant that language was not a problem as interpreters were available, and we could be certain that it was the patient who was providing the answers.

We therefore decided to test whether the new questionnaire would facilitate the incorporation of patients' views in the assessment of a multidisciplinary team, as required by new national cancer guidelines and cancer networks.

## Methods

Twenty-five consecutive patients (from two clinics) treated at the GKT Cancer Centre for upper gastrointestinal cancer were approached in the surgical or oncology outpatient department by a nurse specialist and asked to complete the questionnaire and hand it back before they left. The nurse specialist was present to help if required.

Patients were asked to give their views based on their experience of the whole patient pathway and

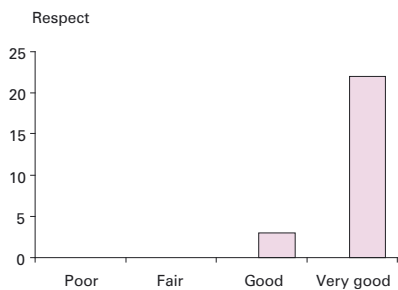
multidisciplinary team. Those surveyed included individuals receiving both palliative and curative treatment, with any combination of chemoradiation, surgery, stenting and therapeutic endoscopy. The questionnaire is shown in Table 1.

## Results

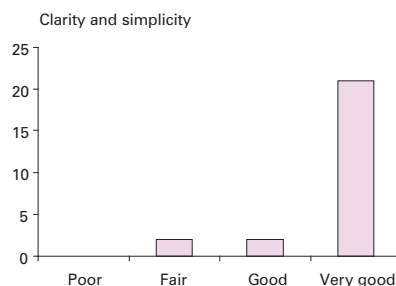
All patients and their families were happy to complete the questionnaire and found the questions and scoring system easy to understand. Figures 1–5 show the results for each theme. The mean scores are reported in Table 1.

Free text comments from patients were invited on the questionnaire. The only complaints received related to a perceived lack of ward staff, who were thought to be working under pressure. The comments were supportive, not critical of individuals.

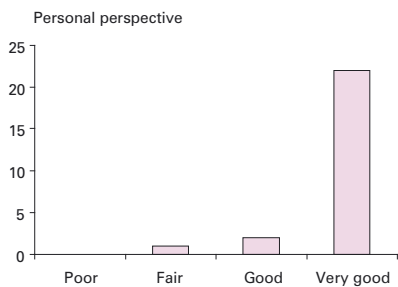
The results were discussed at the multidisciplinary team meeting and action was taken to try to make improvements, particularly in communication and especially in the first outpatient consultation, when more time was needed to allow patients to express themselves.



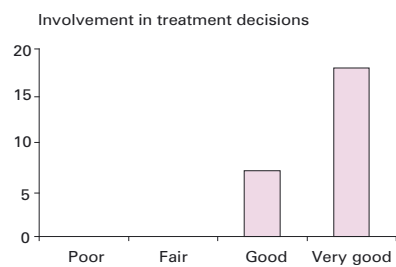
**Figure 1.** Distribution of patient scores for theme 1, 'The team treats you with respect and consideration' ( $n = 25$ ).



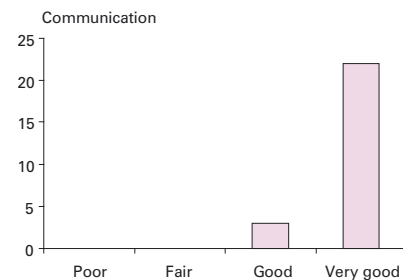
**Figure 3.** Distribution of patient scores for theme 3, 'They use words that you can understand' ( $n = 25$ ).



**Figure 2.** Distribution of patient scores for theme 2, 'They encourage you to tell your story and ask questions' ( $n = 25$ ).



**Figure 4.** Distribution of patient scores for theme 4, 'The team discuss treatment options with you and your family' ( $n = 25$ ).



**Figure 5.** Distribution of patient scores for theme 5, 'The team continues to keep you fully informed throughout your illness and treatment' ( $n = 25$ ).

## Discussion

We feel the questionnaire provides a simple, pragmatic solution to the assessment of patient satisfaction. It was well received by patients, and avoided 'over-surveys'. Even though the results appear to be excellent, they should not breed complacency, but rather should be used constructively to improve practice and the patient journey.

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# Improving patient understanding of hip and knee arthroplasty: a prospective study of the role of experienced, dedicated nurse practitioners in the pre-admission setting

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- Patients are willing to commit to major surgery even though they are unable to recall specific associated complications.
- Pre-admission clinics for lower-limb arthroplasty run by experienced nurse practitioners have a modest beneficial effect on patients' recall of information on the possible complications and expected benefits.
- Patient recall of information related to possible complications and expected benefits is likely to be multifactorial.

## Background

Increasingly, nurses are performing duties that were traditionally carried

out by junior doctors. This has been mainly due to a reduction in working hours for junior doctors as a result of the European Working Time Directive (EWTD). Pre-assessment of patients for scheduled joint replacement surgery is one such area.

Approximately 45,000 total hip replacements (THRs) and 35,000 total knee replacements (TKRs) are undertaken within the NHS in England and Wales annually. These are commonly performed operations for pain and disability resulting from hip and knee joint disease. The benefit to patients' quality of life, in terms of a pain-free, independent lifestyle, and their cost-effectiveness for private and public health-care systems have been well recognised.

Pre-assessment clinics have been recommended by the British Orthopaedic Association (BOA)<sup>1</sup>. These involve physiotherapists, occupational therapists and nursing staff in patient education and the planning of rehabilitation. The aim of this study was to compare the effect of experienced nurse practitioners with that of pre-registration house officers (PRHOs) in patient education at pre-assessment clinics, vis-à-vis their recall of information on the possible complications and expected benefits.

## Methods

In the outpatient clinic, patients were evaluated for joint replacement surgery and listed for the same,

**Table 1.** The patient questionnaire

Question asked	Possible response
<i>Patient's preparedness to give written consent</i>	
Have you received sufficient information?	Yes/No
Have you had the opportunity to get further information?	Yes/No
Have you obtained additional information?	Yes/No
List sources of further information.	Free text
Are you sufficiently well informed to sign written consent?	Yes/No
<i>Patient's understanding of associated complications</i>	
Are you aware of any complication associated with replacement surgery?	Yes/No
List any complications you are aware of.	Free text
<i>Patient's expectations of likely benefit from hip or knee replacement</i>	
What do you expect the benefits of replacement surgery will be?	Free text

following counselling regarding the benefits and disadvantages of surgery, including the potential complications. Patients were admitted for surgery several months after being listed in the outpatient clinic. Two weeks before admission for surgery they underwent their pre-assessment.

Before their admission, all patients were seen in a pre-admission clinic for the recording of their history, clinical examination and preoperative tests, conducted either by a PRHO or by an experienced nurse practitioner. The PRHOs were junior doctors with minimal understanding of either THR or TKR, whereas the

experienced nurse practitioner was able to spend considerable time with each individual patient to explain the basic technical details, associated complications and expected benefits. The nurse practitioner was also able to answer patients' specific queries in the run-up to admission for surgery.

Seventy-nine patients admitted for either THR or TKR were asked to fill in an anonymous questionnaire on their understanding of the procedures for which they had been admitted (Table 1). Gender and age were also documented. Questionnaires were completed after admission to the hospital but before the patients gave

their written consent to the operation.

Differences between groups were tested for statistical significance ( $P > 0.05$ ) using the chi-squared test.

## Results

The first 43 patients were seen by PRHOs (mean age 70.0 years, range 36–89) and the remaining 36 by the nurse practitioner (mean age 70.4 years, range 49–85). All patients were fully able to understand and respond to the questions asked. Six patients did not give their age but were still included in the analysis. There were

**Table 2.** Assessment of patient education after pre-assessment clinics run by a nurse practitioner or pre-registration house officer (PRHO): numbers (%) of patients endorsing questionnaire items<sup>a</sup>

	Nurse practitioner group (n = 36)	PRHO group (n = 43)
<i>Patient's preparedness to give written consent</i>		
Sufficient information received	35 (97.2)	39 (90.7)
Other opportunities available	20 (55.6)	37 (86.0)*
Other sources listed	14 (38.9)	14 (32.6)
Ready to sign written consent	36 (100.0)	41 (95.3)
<i>Patient's understanding of associated complications</i>		
Aware of complications	25 (69.4)	30 (69.8)
Able to name one	20 (55.6)	19 (44.2)*
dislocation	4 (11.1)	4 (9.3)
deep-vein thrombosis or pulmonary embolism	7 (19.4)	11 (25.6)
infection	10 (27.8)	12 (27.9)
loosening	0 (0.0)	1 (2.3)
limb length discrepancy	0 (0.0)	1 (2.3)
pain relief	7 (19.4)	7 (16.3)
<i>Patient's expectations of benefit</i>		
Pain relief/more mobility	8 (22.2)	18 (41.9)
More mobility	19 (52.8)	16 (37.2)
Better quality of life	0 (0.0)	2 (4.7)
None	2 (5.6)	0 (0.0)

<sup>a</sup>See Table 1.

\* $P < 0.05$ .

43 women and 36 men. Fifty-one had been admitted for THR and the remaining 28 for TKR.

All but two patients (both from the PRHO group) felt ready to sign the form giving their written consent for surgery (Table 2). Thirty-five of the patients seen by the nurse practitioner felt that the amount of information received up to and including the pre-admission had been sufficient, compared with 39 of those seen by a PRHO. This difference was not statistically significant. Twenty patients in the nurse practitioner group and 37 in the PRHO sought educational opportunities in addition to their hospital visits, to obtain further information on the proposed surgery, and this difference was statistically significant. Fourteen in each group had actually made use of these resources.

Nearly 70% of patients in each group (25 in the nurse practitioner group and 30 in the PRHO group) were aware that there were recognised complications associated with the operation for which they had been admitted (Table 2). Of these, 20 (80%) in the nurse practitioner group and 19 (63%) in the PRHO group were able to list at least one of the major complications of arthroplasty, a statistically significant difference.

The benefits of arthroplasty as perceived by patients are summarised in Table 2. No statistically significant differences were noted between the two groups in this respect.

## Discussion

Increasingly, nurse practitioners are replacing junior doctors in duties previously considered to be the preserve of medical graduates. Nurse practitioners have the opportunity to build on experience and a bank of knowledge over time. This translates into benefits for patients and has been observed in other medical specialties<sup>2,3</sup>. Our study specifically compared the two personnel groups to assess the potential benefits of nurse practitioners providing the education of arthroplasty patients, in terms of their awareness of the possible complications and expected benefits.

Our findings show that there was only a modest improvement, if any, in patient recall of major associated complications. Over two-thirds of each group knew that there were potential complications but only 56% in the nurse practitioner group and 44% in the PRHO group were able to

recall at least one. The proportions in each group able to recall complications of deep-vein thrombosis or pulmonary embolism, dislocation and infection were not statistically different. Only one patient in the entire sample was able to recall the most common complication requiring revision surgery, namely aseptic loosening.

The primary aim of joint replacement is to relieve pain. Improved mobility and a better overall quality of life are considered an added bonus of successful surgery. The proportions of patients in the two groups who appreciated the primary aims of surgery were not statistically different.

Different strategies have been reported in the published literature for improving patients' recall of surgery. These have had varied results. For example, Langdon *et al.* used printed literature to improve patients' recall from 38% to 48%<sup>4</sup>. Using a similar strategy, Turner and Williams reported no significant improvement<sup>5</sup>. The overall opinion of the value of printed or audiovisual material for preoperative patient education appears to be one of scepticism. Many authors report no improvement in patient recall but concede that it constitutes an important article of proof of the attempt to educate patients about the risks and benefits of surgery before written consent is obtained.

## Conclusion

Our study shows that patients admitted for lower-limb arthro-

plasty appear to be willing to provide written consent in spite of being unable to recall associated complications discussed in detail during pre-admission clinics.

Modest improvement in patient recall of the possible complications and expected benefits from arthroplasty accrued from the pre-admission being conducted by an experienced nurse practitioner compared with the traditional PRHO 'clerking'. Importantly, however, this supports the opinion of many authors that assessment and management by nurses, adequately trained to take on the responsibilities of junior doctors, is not to the detriment of patient care.

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## Quality Improvement Travel Fellowship 2004/05

Sponsored by the Forum on Quality in Healthcare

The RSM Forum on Quality in Healthcare organises and supports an annual Quality Improvement Travel Fellowship. It is intended to provide an opportunity for a person working on quality improvement in health-care in the UK, who would not normally get such an opportunity through their work to travel either nationally or internationally to study the theory and practice of quality improvement in health-care. It is open to anyone working in health-care, and there is no requirement to be a member of any particular profession or organisation.

The closing date for applications this year is 12 noon on Friday 30 July 2004. Shortlisted applicants will be invited to attend the Award ceremony on 28 September 2004, at which the successful applicant will be announced. Once an award has been made, the recipient is asked to prepare a budget and timetable outlining in more detail how he or she plans to use the award. The budget may seek funding of up to £1500. The timetable should also show the award being used within a six-month period.

For an application form and further details, please contact Helen Jinks, Academic Department, Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE. Telephone: 020 7290 3943. Email: [quality@rsm.ac.uk](mailto:quality@rsm.ac.uk)



# Demystifying infusion confusion

**Chris Quinn**

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- **Over half of all reported incidents involving infusion devices are not related to the device itself.**
- **Infusion devices are associated with a higher incidence of user error than any other type of device.**
- **Remedial action should therefore be focused on the end user and management issues.**
- **A 'learning competency' framework for these devices is under development. The framework should lead to an accredited, nationally applicable qualification.**

## Background

Infusion devices are used extensively across NHS acute and community settings by nurses, medical staff and specific patient groups. They accurately deliver prescribed intravenous drugs and solutions over a set time. Increasing numbers of incidents involving infusion devices are being reported to the Medicines and Healthcare Products Regulatory Agency (MHRA, after the merger of the Medical Devices Agency and the Medicines Control Agency in April 2003). Over 6770 incident reports involving either infusion or transfusion were collected between 1990 and 2000; the outcomes of these incidents ranged from uncomplicated blood loss to patient death.

The National Patient Safety Agency (NPSA) sponsored a project to establish the root causes of incidents involving infusion devices and to find means to prevent their recurrence, and this article reports that work. An expert reference group was established to provide guidance to the project, which began in May 2002. This group had representation from a range of organisations and national agencies.

Four stages of review were incorporated into the project:

- a review of the literature and national data to see whether there were any existing solutions;
- the identification and development of solutions;

- the testing and evaluation of developed solutions in pilot sites;
- roll-out to the wider NHS.

## Review of the literature and national data

The literature review found little evidence of the existence of solutions, but suggested the following for consideration when developing them.

- A human factors approach to design is recommended.
- 'Usability' was more important than 'functionality'.
- Purchasers should drive industry, not the other way around.
- End users should be involved at the earliest stage of the development of infusion devices.
- The role of the patient in intravenous therapy (IVT) should be reviewed.
- Any issues or concerns raised during the training of people in the use of infusion devices should be forwarded to the manufacturers.

Review of the MHRA's data on adverse incidents over the period 1990–2000 showed that:

- There was an increasing annual trend in the numbers of reported incidents involving infusion devices.
- Of the 1495 investigations carried out, 53% showed that the cause was not related to the infusion device (the cause was not established – see below).
- Nineteen per cent of incidents could be attributed to user error. This is almost treble the figure for all other types of device (7%).

The MHRA data collected did not establish the root cause of an incident if there was not a problem with the infusion device. As more than half of the adverse incidents reported were not established as a device fault, this suggests that solutions should focus on the end user and on management issues.

## The patient perspective

The NPSA researched patient experiences with infusion devices. Twenty-five in-depth interviews were carried out with patients recruited from a range of national organisations. A number of issues were highlighted:

- Few participants were given any choice about using a pump.
- Most participants wanted to be well informed about all aspects of their treatment but were not.
- Few participants had been specifically informed about pump safety issues (such as the alarms or the need to avoid the use of a mobile phone in the vicinity of the device while it is being used).

## Solutions development

The project team found that uncontrolled purchasing and management of infusion devices, in the absence of competency-based training, had contributed to the cause of the infusion device incidents. Solutions would need to address standardisation, evaluation, centralisation and staff training if patient safety was to be improved. Four solutions were developed:

- a checklist for decision making in relation to the purchase of infusion devices, to promote standardisation;
- a usability evaluation questionnaire, to facilitate the sharing of evaluation information;
- the development of a business case for centralisation;
- e-learning to help trusts to train staff in the use of infusion devices.

## Solutions testing and evaluation

To evaluate the effectiveness of the proposed solutions, two key baseline assessments were designed. These were used in six pilot sites across England and Wales. The first established

existing practice in purchasing and decision making. The second assessment focused on data such as stock numbers, range of devices used, the costs of both the devices and the associated consumables, patient incident data and maintenance data. Both assessments would provide the scope for local action.

The solutions were evaluated against these initial baseline assessments six months after implementation (November 2003). The findings from the pilot sites were remarkable:

- the average number of infusion devices per pilot site was 1065;
- the average range of stock per pilot site (i.e. different types of device in stock) was 31 (range 13–48);
- the average device utilisation was 35% (i.e. 65% of stock was idle for most of the time);
- the average cost of an infusion device was £1518;
- the average total stock cost was £1.6 million.

The only notable variation in this regard between the pilot sites concerned the size of stock, which tended to reflect the size of the pilot

site. The figures indicated that £1 million of stock (690 devices) was idle for most of the time. The proposed solutions have been shown to improve quality yet at the same time reduce the costs. The website given under 'Further information' provides more information on the economic appraisal.

In the baseline assessments, 321 incidents were reported in all sites:

- between 12 and 196 incidents were reported at each site;
- 96 (30%) concerned over-infusion episodes;
- 21 (7%) concerned under-infusion episodes;
- 59 (18%) involved user error;
- 12 (4%) involved failure of the device;
- 10 (3%) involved patients tampering with the device.

It is noteworthy that the MHRA receives only around 700 reports concerning incidents with infusion devices annually and yet the six pilot sites recorded almost half of this figure. There are 189 acute trusts in England and Wales, and so it is clear that there is substantial under-reporting nationally.

## Roll-out to the wider NHS

Overall, the evaluation of the solutions was extremely positive and clearly helped the pilot sites to focus on their key local issues. The solutions were due to be rolled out to the wider NHS in March 2004 and will be promoted through a NPSA 'safer practice' standard.

## Ongoing work: e-learning in the use of infusion devices

The NPSA is working closely with the NHSu (the corporate university for the NHS – see [www.nhsu.nhs.uk](http://www.nhsu.nhs.uk)) to develop an e-learning solution. The NHSu will fund this development and is looking to deliver it by late autumn 2004.

The e-learning will promote a national competency framework of learning and will cover the knowledge, skills and assessment ('blended learning') associated with the use of infusion devices. This learning will be accredited through the City & Guilds examination board, and so the qualification will sit within the national qualifications framework. Because the training will follow national standards, the qualification will be transferable, which will make the training more efficient. The training itself will be designed to be flexible and to recognise the existing skills of trainees.

### Further information

For further information on solutions or other information on infusion devices visit [www.pasa.nhs.uk/infusiondevices](http://www.pasa.nhs.uk/infusiondevices). This one-stop website is hosted by the NHS Purchasing and Supply Agency but has links to all key areas.

## 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.

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# Connections and common ground – clinical governance and learning disabilities

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- Quality of services is a key feature embedded in clinical governance and learning disability strategies.
- Learning disability Partnership Boards have a crucial role in delivering clinically governed services.
- There are opportunities for shared learning between mainstream and specialist learning disability services when the users of these services are involved.

The NHS Plan (2000)<sup>1</sup> set a clear vision for the future and created an agenda for health and social care services. Central to the Plan is the drive to modernise welfare provision to ensure that people in receipt of services have the best care. Clinical governance offers a framework for ensuring accountability arrangements are in place for connecting and coordinating different elements of service quality. Concurrent with this, and at the heart of policy on learning disability services, is the 2001 white paper *Valuing People*<sup>2</sup>, which is based on key principles of rights, independence, choice and inclusion, and emphasises improvement to enable people with learning disabilities to lead fulfilling lives.

Little has been written to date that explicitly connects clinical governance and learning disability services. This article highlights some of the key connections and common ground, and identifies challenges for people working within health economies in roles that influence the experience of people with learning disabilities when they use services. As a starting point, we focus on the central theme of 'quality' and then explore the involvement of service users.

## Quality

Quality is a key driver throughout all government initiatives and is clearly reflected in both the clinical governance agenda and *Valuing People*. *Valuing People* identified a range of

areas in which it was expected that learning disability services and other providers would deliver their services differently. These areas included:

- accessing mainstream health services;
- improving employment opportunities;
- supporting people to have more choice and control over their lives.

It is essential that other providers in the 'mainstream' NHS – including acute hospitals, primary care trusts, and maternity, mental health and children's services – deliver effective services to people with learning disabilities. The intention, as stated in *Valuing People*, is that the general health-care needs of people who have a learning disability will be met in the same way as for the rest of the population.

## Partnership Boards

There is also a responsibility levelled at all Partnership Boards (see Box 1) to deliver new and modernised services within a clear quality framework. Clinical governance

### Box 1. What are Partnership Boards?

'Learning Disability Partnership Boards are structures designed to bring together public, voluntary, independent and the wider local community in order to implement *Valuing People* at the local level.'<sup>3</sup>

Partnership Boards are non-statutory in nature and as such their success relies upon establishing and maintaining robust and powerful partnerships between stakeholders that work towards achieving the vision of *Valuing People*.

frameworks should outline how an organisation will deliver safe, effective care that focuses upon the needs of people who use the service. Common ground underpinning both of these frameworks is:

- continuous quality improvement;
- measuring and managing quality;
- user satisfaction;
- value for money.

Fundamental to this is the need to place people who have a learning disability at the centre not just of services but of their lives. Partnership Boards offer a forum for different organisations to work through these complex issues and the opportunity to join up governance from different services and organisations.

A challenge for primary care, hospital and mental health trusts governing learning disability services will be to use Partnership Boards effectively, to ensure clinical governance frameworks include and are meaningful to people who have a learning disability.

## Involvement of people using services

A further challenge will be for the different governing organisations to join up in a cohesive and straightforward way so that shared governance arrangements enhance the accountability of services, rather than opening up potentially competing and confusing lines of accountability. It is important to involve people who are using the services in such arrangements.

The involvement of service users and carers within mainstream hospitals and in the context of clinical governance includes patient representation through patient advice and liaison services (PALS), patient and public involvement forums, 'expert patients' and patients' juries. A challenge to many people reading this article will be how to ensure each of

## Box 2. Questions for those in trust governance leadership roles

- How does your clinical governance framework address the needs of people who have a learning disability?
- To what extent does your clinical governance framework integrate with the governance arrangements of other organisations governing local learning disability services and the workforce?
- What partnership arrangements with the learning disability Partnership Board are in place and how do they work in practice?
- What opportunities have been identified to consult effectively with people who have a learning disability?
- How effective is your trust at working with other agencies to achieve positive outcomes for people who have a learning disability?

these services is both inclusive and responsive to the needs of people who have a learning disability. This should include not only involvement in their own care delivery but also involvement at the level of the unit, department and whole organisation, as well as involvement in planning and strategy.

Experience suggests that people who have a learning disability are rarely included in key NHS consultation processes; the recent national consultation exercise *Fair for All, Personal to You* is an exception to this<sup>4</sup>. It could be argued that hospital staff should consult with people who have a learning disability. For example, including people with learning disabilities in consultation about a new hospital building would be likely to highlight ways to make the building more accessible that would also benefit other patient groups.

A number of hospitals have adopted guidelines developed by

learning disabilities services to make information more accessible. This has led, for example, to appointment letters being sent out that are more easily understood, to the advantage of many other patient and carer groups. Hospital and community staff should consult with local learning disability services about opportunities to involve people with learning disabilities. In a local primary care trust, for example, the PALS manager regularly consults with an established user involvement group, which is supported by local authority staff, on issues of importance for the primary care trust.

Within learning disability services a number of additional ways exist in which people who have a learning disability and their carers can be involved in decisions about planning and strategy. These include Partnership Boards, service users' 'parliaments', regional and national forums, the national taskforce, as well as local self-advocacy groups and involvement groups. All of these exemplify significant partnerships between those who use the services and those who develop and deliver

them. They are the ground-level manifestation of joined-up thinking.

Box 2 lists some key questions for those in trust governance leadership roles. Conversations that explore these questions – and the development of systems and structures that support solutions – will be another step towards a more equitable society, with choice for all to ensure high-quality care is delivered in the most effective and efficient way possible.

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