

# CLINICAL GOVERNANCE

November 2004

## Bulletin

### Editorial: Appraisal, revalidation and fitness to practise

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All clinicians are accountable for what they do and must ensure that they have the right skills and competences to deliver care safely; continuous professional development therefore needs to help staff maintain their skills and acquire new ones. The requirement that all staff (including consultants) in the NHS are appraised has put this process on a more formal footing. Self-regulation of doctors is also taking a new direction with the implementation of the revalidation process, in which doctors are required to provide a 'folder'

with information on performance and regular appraisal. In this issue of CGB, key changes in the General Medical Council's fitness-to-practise procedures are outlined. Appraisal in primary care and the use of 360° appraisal also feature, as well as a range of articles on clinical governance issues. In future issues of CGB we would like to deal with infection control, out-of-hours services and extended roles; we look forward to receiving your contributions on any of these topics, as well as any relating to quality of care.

### The General Medical Council reforms: making fitness to practise fit for practice

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The General Medical Council (GMC) is in the process of implementing the most comprehensive and extensive reform of medical regulation in nearly 150 years, in order to deliver and safeguard the highest standards of medical ethics, education and practice in the interest of patients, the public and the profession. We have consulted extensively with both the

medical profession and the public on our fitness-to-practise procedures, and we have worked hard to ensure the reformed procedures reflect their views.

#### The reformed procedures

Following a review of the GMC's procedures governing fitness to practise,

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a new process has been implemented from 1 November 2004. The most significant changes are:

- The procedures will be divided into two stages – investigation and adjudication.
- The procedures will look at a doctor's fitness to practise in the round.
- There will no longer be separate streams for health, performance and conduct.
- There will be a new measure – warnings.
- There will be a new test.

The review identified an opportunity to streamline the procedures in order to provide a more efficient, transparent and independent examination of a doctor's fitness to practise. The changes started in May 2004 with the introduction of a revised disclosure procedure, which allows for more communication with the doctor's employers. Complaints are now disclosed to the doctor's employer at an earlier stage in the process, establishing a two-way flow of information to determine the right course of action. This provides both the GMC and the employer with a clearer overall view of the doctor's fitness to practise, and provides background information that previously was not often available.

## Investigation

There will be a single investigation process, involving a single test. The majority of case-work decisions will be taken by case examiners or the Registrar of the GMC. In cases where there is a clear need to protect the public interest, the case examiners will be able to refer a doctor to an interim orders panel (IOP). The IOP will consider whether it is appropriate to impose an interim order to restrict or suspend the doctor's right to practise, pending a full investigation.

The case examiners will determine at the conclusion of the investigation whether a doctor should be referred to a panel for a full hearing regarding fitness to practise. In doing so they will apply the following test:

The Investigation Committee or case examiner must have in mind the GMC's duty to act in the public interest, which includes the protection of patients and maintaining public confidence in the profession, in considering whether there is a realistic

prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration.

## Warning

The new procedures allow the GMC to issue a warning in those cases that are not considered serious enough to justify restricting the doctor's registration, but nevertheless require a formal response from the GMC in the interests of maintaining good professional standards and public confidence in doctors. A warning may be issued at either the investigation or the adjudication stage when:

- there has been a significant departure from the guidance set out in *Good Medical Practice*<sup>1</sup>; or
- a performance assessment has indicated a significant cause for concern.

## Adjudication

Another important change means that panels will be responsible for hearing all cases that are referred for adjudication. As part of the separation of functions between governance and adjudication, GMC members will not sit on these panels. Instead, independent panellists who are appointed following a rigorous assessment and training process will be responsible for hearing cases. The

panels will consider the doctor's fitness to practise in the round, applying the following test:

Do the findings we have made show that the doctor's fitness to practise is impaired to a degree justifying action on registration?

Where a panel finds that action on a doctor's registration is justified, it will have the following options:

- erasure;
- suspension;
- conditional registration;
- undertakings.

Where a panel finds that a doctor's fitness to practise is not impaired, it will have the option of issuing a warning, which will have the same effect as a warning issued at the investigation stage.

## Conclusion

The new procedures are designed to form part of an effective and distinct wider framework for protecting patients, including measures taken by the NHS and other employers.

The latest information about our reforms can be found on our website, [www.gmc-uk.org/cg](http://www.gmc-uk.org/cg), or by subscribing to receive the GMC e-Bulletin, by emailing [reform@gmc-uk.org](mailto:reform@gmc-uk.org).

## Reference

- 1 General Medical Council. *Good Medical Practice* (3rd edn). London: GMC, 2001. Available at [www.gmc-uk.org](http://www.gmc-uk.org)

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# 360° feedback: how do perceptions of doctors' attributes compare?

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- Doctors are increasingly interested in their working relationships with patients and colleagues. 360° feedback gives insight into these.
- This study analysed the views of nearly 4000 patients and 3000 colleagues on doctor performance.
- Patients' and colleagues' views appear to be more positive than doctors' views of themselves.

## Background

The introduction of NHS appraisal for doctors and the General Medical Council's proposal for revalidation require doctors to provide evidence of their working relationships with patients and colleagues. 360° feedback asks a range of people who have contact with an individual to comment on that person's performance. It can be used alongside other measurements, such as assessment, employee surveys, performance appraisals and coaching. It combines the different strengths of these tools by assessing against specified competencies, drawing on more than one source of feedback and increasing self-awareness<sup>1</sup>. Work by Ramsey *et al.*<sup>2</sup> shows that peer review of hospital physicians by questionnaires is feasible. However, Fletcher *et al.*<sup>3</sup> warn that simply collecting feedback from several respondents does not make their observations more accurate than those of one individual; validity and reliability are important.

## Development of the feedback tool

The 360° tool used in this study was developed with the Scottish Council for Postgraduate Medical and Dental Education, and was tested in general practices on Tayside. Focus groups were held to advise on the design of the questionnaire, at Trafford General Hospital and Kidderminster Hospital (now part of Worcestershire NHS Trust). Statistical tests on the

data collected with the tool since its development in 1998 show its high degree of reliability and good face and content validity<sup>4</sup>.

The tool enables doctors to collect information from their patients and colleagues via two separate questionnaires. Respondents are asked to rate on a scale how important a skill or attribute is, and how well the doctor performs in this area.

The patient questionnaire comprises 15 items covering the doctors' interaction with patients. Examples are:

- The doctor gives me enough time.
- The doctor explains if there are any risks to the treatment.
- The doctor finds out what I might be worried about.

The colleague questionnaire contains 37 items in groups based on headings from the General Medical Council's *Good Medical Practice*<sup>5</sup> (technical skills, interpersonal skills, team skills, and education and research). Examples are:

- The doctor gives appropriate information to patients and relatives.
- The doctor supports colleagues when needed.

- The doctor communicates effectively with all staff.

Doctors also complete a self-assessment questionnaire.

## A study of 360° feedback

We have analysed feedback given by 3867 patients and 2894 colleagues on 279 doctors working in hospitals and general practice.

### Doctors' views of themselves compared with those of patients and colleagues

Doctors consistently scored themselves much lower on average on all attributes than their patients and colleagues scored them. To assess the differences between groups, *t*-tests were used. The variance in means between the groups (i.e. between patients and doctors or between colleagues and doctors) was significantly greater than the variance within each group. This indicates that the variance in doctor compared with patient or colleague scores is not due to random error. If the doctors had scored themselves higher than their raters had done, it would raise concerns regarding their self-awareness.

### Box 1. Most important areas for colleagues and doctors

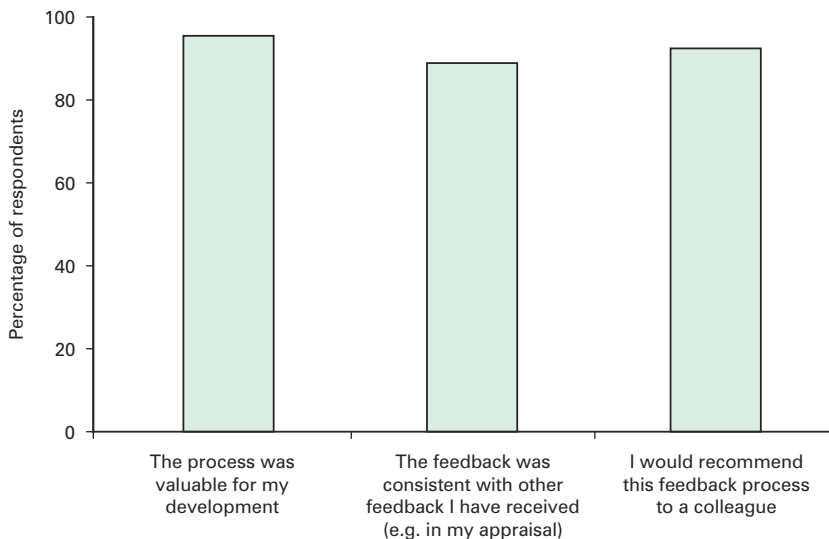
Both colleagues and doctors rated the following items on the colleague questionnaire to be the most important:

- The doctor is clinically safe and competent.
- The doctor maintains confidentiality.
- The doctor acts appropriately in emergency situations.

### Box 2. Most important areas for patients and doctors

Both patients and doctors rated the following items on the patient questionnaire to be the most important:

- The doctor speaks in a way that I can understand.
- The doctor listens to me.
- The doctor tells me what she/he is going to do.



**Figure 1.** Percentage of respondents (doctors) providing positive feedback in three areas on the use of the study tool ( $n = 52$ ).

Box 1 lists the items that colleagues identified as the most important. These were also the areas in which the doctors performed best according to their colleagues, which is good news for doctors.

Communication is the most important aspect to patients in their interaction with their doctor (Box 2); on average the doctors performed very well here. More attention may need to be focused on listening to patients, as here performance was slightly lower than on the other two items relating to communication. This feedback emphasises the importance of communication in the patient–doctor relationship.

### Feedback on the study method from doctors

The tool was evaluated by asking users for feedback. Of the 52 who

responded, all found the process was easily managed, did not take too long and was cost-effective. They would recommend it to a colleague (Figure 1). Reports received by the doctors were well presented, easy to interpret and covered relevant topics. Comments included ‘excellent’, ‘very reassuring’ and ‘solved a great headache’. These positive findings fit with those of Geake and Gray<sup>6</sup> on people’s experiences of using 360° feedback.

## Conclusion

The doctors in this study underestimated themselves compared with how their patients and colleagues perceived their performance. However, it must be stressed that doctors using 360° feedback are likely to be enthusiasts and may not be representative of the profession as a whole. At a time when increasing emphasis is being placed on doctors to provide evidence of patient and colleague relationships, 360° feedback is an easy means of acquiring that information from a number of sources.

## References

- 1 Gray A, Lewis A, Fletcher C, *et al.* 360 Degree Feedback. *Best Practice Guidelines*. London: Department of Trade and Industry, 1991. Available at [www.bps.org.uk/documents/360bestprgdlns.pdf](http://www.bps.org.uk/documents/360bestprgdlns.pdf)
- 2 Ramsey PG, Wenrich MD, Carline JD, *et al.* Use of peer ratings to evaluate physician performance. *Journal of the American Medical Association* 1993;**269**:1655–60
- 3 Fletcher C, Baldry C, Cunningham-Snell N. The psychometric properties of 360 degree feedback: an empirical study and a cautionary tale. *International Journal of Selection and Assessment* 1998;**6**:19–34
- 4 Full details of reliability and validity tests from this study are available at [www.edgecumbe.com/edge/h\\_published.asp](http://www.edgecumbe.com/edge/h_published.asp)
- 5 General Medical Council. *Good Medical Practice* (3rd edn). London: GMC, 2001. Available at [www.gmc-uk.org](http://www.gmc-uk.org).
- 6 Geake A, Gray A. 360° feedback: how was it for you? *Selection and Development Review* 2001;**17**:3–14

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# Appraisal and revalidation: how [bmjlearning.com](http://bmjlearning.com) has helped

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- Primary care professionals can use a learning website to assess their training needs.
- An assessment of learning needs is the first step in learning.
- The ability to make a personal and professional development plan online helps users plan and record their learning; it can also ultimately help in the revalidation process.
- Any e-learning site must be secure so that users can be reassured that confidentiality is maintained at all times.

Appraisal and revalidation for health professionals will start formally in 2005. However, doctors have been collecting information to inform this process for over a year now. There were concerns that appraisal and revalidation would be used to judge and possibly condemn performance, and also that health professionals would not engage in the process. Many worried that the primary aims of encouraging personal and professional development would be lost<sup>1</sup>.

Against this background, the BMJ started to think about learning. In November 2003 it launched [bmjlearning.com](http://bmjlearning.com) – an online resource to help primary care professionals with their appraisal and revalidation. The idea was that if professionals have access to learning resources based on the best available evidence, they will be able to improve quality of care. If they could record their learning systematically, they would feel more confident about appraisal. We have learned a great deal from setting up the website.

When choosing a learning website, primary care professionals place high value on:

- confidentiality;
- the ability to access learning needs assessment tools;
- the ability to make a personal and professional development plan online;
- the availability of independent evidence-based learning resources.

## Aims and objectives of [bmjlearning.com](http://bmjlearning.com)

The broad aims of [bmjlearning.com](http://bmjlearning.com) were to set up a learning website to help health professional with their learning and as a result to improve the care that patients receive.

The specific objectives of [bmjlearning.com](http://bmjlearning.com) were to set up a website that would:

- engage users in the process of appraisal and revalidation;
- be confidential;
- provide users with the tools with which to assess their learning needs;
- enable users to make a personal and professional development plan;
- give concrete examples to users of the professional standards they should aim to achieve;
- provide independent evidence-based learning resources;
- tell users about courses and conferences that are going on near them;
- reduce the paper mountain of forms.

## Engaging users in the process of appraisal and revalidation

Since November 2003, 19,700 users have registered with the website. The number of newly registered users continues to increase at a rate of about 30 per day.

The feedback has been overwhelmingly positive and there has been a large amount of it (at the time of writing 9074 individual pieces of feedback to the site). Unlike other sites, we do not insist that our users give feedback but we do encourage them to do so. Our user groups have told us that they would like to be able to give unstructured feedback – to say whatever they want, in whatever way they want to. Our support team capture all the feedback and publish it on the site as long as it does not libel anyone or give dangerous advice.

We evaluate all the feedback and use it to inform further commissioning. We use it to decide what our users want to learn about and in what format they would like the material to be provided. To this extent we have successfully engaged users in the process of appraisal and revalidation.

One of the unexpected features of [bmjlearning.com](http://bmjlearning.com) is the large number of overseas users. We have users from all continents and from 126 different countries. This internationalism has enriched the site as different users have given their own national and cultural perspectives on medical and ethical dilemmas. Another unexpected benefit is that practice nurses and managers are using the site. They also enrich the site by offering their interdisciplinary perspectives. We are currently working on the site to make it more welcoming to interdisciplinary users.

## The content and nature of the website

### Confidentiality

We have been able to guarantee users of the confidentiality of the site, although they can of course show their appraisers their plan and record it if they want. Users can thus be honest about their learning needs and their plans. We use passwords to ensure that no one else can see their needs or plans. The passwords are highly secure: the chance of someone correctly guessing one is less than one in two billion.

### Learning-needs assessment tools

We provide the seven main types of learning needs assessment tools online<sup>2</sup>. Examples of these include doctors' educational needs, patients' unmet needs and 360° appraisals (Box 1 shows how this is done online in the case of the last). We advise users that there is no definitive needs assessment tool and that they should try more than one. We advise that different types of tool (ideally some subjective and objective ones) would

## Box 1. Learning need assessment: 360° appraisal

Peer review involves getting feedback on your work from your colleagues. In a 360° review you get feedback from all the people you have contact with at work. It is a good way to get insight into how you work and behave. You may feel awkward, but many people find it a positive experience.

By having a full circle of mostly anonymised feedback, the results are more valid and representative of the experiences of everyone you work with.

You can use the feedback to identify your learning needs.

### How to start

Aim to get feedback from 5 to 11 people. Approach a mixture of colleagues, not just those you know well or are comfortable working with. Include a wide range of staff, such as junior and senior colleagues, and peers from other organisations.

### Collating the replies

Once all the forms have come back, you can start looking at the feedback. Consider these questions:

- What key points have arisen?
- Are there any patterns?
- How do you feel about the feedback?
- How does it compare with how you see yourself?
- Do you think the feedback is fair?
- Does it ring true or are you surprised with the replies?
- What areas do you want to discuss at your appraisal and include in your personal development plan?

give a better overall picture of knowledge gaps. Learners can thus move seamlessly from assessing their needs to planning their learning.

### Personal and professional development plan

We set up a personal and professional development plan on the site so that users can state their learning needs and how they plan to achieve them. Users can add learning resources to their plan, and when they have achieved their learning goals they can close this aspect of the plan.

### Concrete examples of professional standards

We explain to users that appraisal is based on the seven headings set out in *Good Medical Practice*<sup>3</sup>, which are divided into 18 subcategories by the Royal College of General Practitioners (RCGP)<sup>4</sup>. We explain to users how the RCGP defines an excellent doctor and an unacceptable one, and give concrete examples of excellent and unacceptable practice.

### Learning resources

There are 103 learning modules on the site. All of them are independent

of commercial funding. Where possible, the learning modules are based on:

- clinical evidence;
- clinical quality indicators in the new general medical services contract<sup>5</sup>;
- guidelines from the National Institute for Clinical Excellence (NICE);
- the national service frameworks.

We offer different types of learning module – some that will suit users who enjoy reflective learning and some for users who want hard facts. Some modules are very interactive and have multimedia features but others are quite simple and easy to use. The variation in style and content of the learning resources has enabled us to attract many users.

### Courses and conferences guide

Most people do not want to do all their learning online. In view of this we built a guide so that users would be able to find out what learning events are going on near them. We have an average of 200 learning events on the site.

### Reducing the mountain of paper forms

Users can assess their learning needs, plan their learning and then learn online. They can keep an entirely electronic record of all of this.

### Feedback and review

We have received a lot of feedback from our users stating that they have learned new knowledge, skills or attitudes as a result of using our modules and that what they have learned has changed their practice. Many users asked us for an additional feature whereby they can record how their learning has changed their practice, and so we added this feature.

We ask patients to review learning modules to ensure that they deal with issues that are important to patients. We ask primary care professionals to review modules to check that they use language that is used and understood in primary care. We also ask specialists to review modules to ensure that they cover common errors that are made in treating certain diseases.

### Lessons learnt

We have learned many lessons but the most important one is to base the site around the needs of patients and learners and their communities – so far this has been a successful guiding principle<sup>6</sup>.

### References

- 1 General Medical Council, Department of Health. *Appraisal and Revalidation*. See [www.revalidationuk.info](http://www.revalidationuk.info)
- 2 Grant J. Learning needs assessment: assessing the need. *British Medical Journal* 2002;**324**:156–9
- 3 General Medical Council. *Good Medical Practice* (3rd edn). London: GMC, 2001. Available at [www.gmc-uk.org](http://www.gmc-uk.org)
- 4 General Medical Council. *A Licence to Practise and Revalidation*. London: GMC, 2003. Also available at [www.revalidationuk.info](http://www.revalidationuk.info)
- 5 General Practitioner Committee of the British Medical Association, NHS Confederation. *Investing in General Practice: The New General Medical Services Contract*. London: BMA, NHS Confederation, 2003
- 6 Bates AW. *Technology, Open Learning and Distance Education*. London: Routledge, 1995

# Investigating services for palliative care

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- Health and social care professionals represent a vital source of information in relation to problems in the delivery of services. They can also indicate ways in which services might be improved.
- Focus groups provide a means of rapidly obtaining this information. The interactive and dynamic nature of discussions forces participants collectively to address issues which might cross disciplinary and agency boundaries.
- This leads to a more comprehensive understanding of current services and facilitates a needs-driven, patient-focused approach to service development.
- A key problem exposed in this study of palliative care was inadequate coordination of care between professionals and settings. Another was the avoidable use of acute and hospice beds, which was linked to delays in assessment, difficulties in accessing equipment and inadequate out-of-hours care. Crucially, such problems were seen as having an adverse effect on service users' experiences of care.

## Background

The National Institute for Clinical Excellence (NICE) has now introduced guidance on the development and improvement of services for those individuals with cancer who require palliative care<sup>1</sup>. The production of this guidance was a response to concerns about palliative care services and an awareness that across the country there were variations in the ways in which services were delivered<sup>2</sup>.

Independent of this guidance, health and social care professionals covering the population served by Central Cheshire Primary Care Trust (PCT) were aware that there might be a need to improve the delivery of local services for palliative care. However, although some concerns about current services had been expressed

(e.g. the possible avoidable use of acute and hospice beds) and some options for service developments had been proposed (e.g. an expanded use of care homes), staff were aware that they needed a better and more comprehensive understanding of both the nature and likely causes of any problems that were affecting the delivery of care. They would then be better placed to ensure that any developments in local services that were introduced were targeting local needs and problems, regardless of whether or not these developments were driven by national guidance or local lobbying.

Hence, the overall aims of the project described here were:

- to undertake a baseline appraisal of the nature, efficiency and adequacy of existing services for palliative care, from the perspective of both a user and professional;
- to obtain an initial assessment of how any problems which were affecting the current delivery of care might be tackled.

## Methods

Focus groups with health and social care professionals responsible for delivering services for palliative care were seen as the best way of quickly

obtaining a broad understanding of current problems and potential ways forward. The choice of method was also influenced by the resources and time available for the study.

From May through to July 2003, five focus groups were undertaken with staff responsible for delivering care in:

- patients' homes (two focus groups with staff subdivided according to whether they provided care in the north or south of the PCT);
- the acute trust;
- the local hospice;
- local care homes.

Box 1 lists the topics that were discussed. In the absence of direct contact with service users, focus group facilitators stressed that staff should act as 'advocates' for service users.

## Results

Around 12 professionals participated in each focus group. Table 1 summarises the key themes that emerged during discussions. Many themes were common to all groups and so might be regarded as 'whole system' concerns. The issues highlighted were seen as having an adverse effect on the efficient and appropriate delivery of services. For example, delays in

### Box 1. Topics addressed during focus group discussions

- The types of palliative care needs that they aim to meet.
- The extent to which there is avoidable use of existing services (e.g. patient care needs could be met in another setting) and the causes of avoidable use.
- The extent to which there is limited access to, or under-utilisation of, appropriate care options (e.g. lack of capacity, shortage of skilled staff, service geographically remote).
- The nature and scale of any unmet need for care (e.g. characteristics of individuals for whom access could be improved).
- Possible strategies/service options for reducing avoidable, and increasing appropriate, use of services.
- The extent to which existing (or proposed) service options meet (would meet) patient and carer assessments of the care and services that they need.

**Table 1.** Perceived problems affecting current services, by care setting

Hospice	Acute hospital	Care home	Patients' home
Delays and repetition in the completion of multidisciplinary health assessments	Delays and repetition in the completion of multidisciplinary health assessments	Delays and repetition in the completion of multidisciplinary health assessments	Delays and repetition in the completion of multidisciplinary health assessments
Difficulties in obtaining equipment for care at home	Difficulties in obtaining equipment for care at home	Difficulties in obtaining equipment for care at home	Difficulties in obtaining equipment for care at home
Problems in accessing services out of hours	Problems in accessing services and avoidable acute admissions out of hours	Problems in accessing services and avoidable acute admissions out of hours	Problems in accessing services and avoidable acute admissions out of hours
Inadequate funding for social care at home	Inadequate funding for social care at home		Inadequate funding for social care at home Inadequate user and professional awareness of service options

assessment processes, and difficulties in accessing equipment, were thought to extend patients' stay in acute and hospice beds. In addition, inadequate out-of-hours care was seen as a cause of avoidable acute admissions. Possibly of greater importance, however, was the view that such service problems were adversely affecting users'

experiences of care. The quotes in Box 2 illustrate the concerns that were raised.

### Discussion

The focus group approach provided a rapid means of obtaining a 'whole systems' assessment of prob-

lems that were seen as affecting the delivery of palliative care services. A large number of staff, from differing professions, agencies and settings, participated in the exercise and they welcomed the opportunity to contribute to the potential development of services in this way. Moreover, the format of focus group discussions forced professionals jointly to address issues that crossed disciplinary and agency boundaries and, as a result, a more comprehensive understanding of current services and service problems was obtained. The views of service users were not obtained directly; these will need to be ascertained in our on-going work in this area.

The results of such a study might reinforce existing concerns about services. In this case, prior concerns about the avoidable use of acute and hospice beds were confirmed: the main causes of this problem were seen as delays in assessment processes, poor access to equipment, and inadequate out-of-hours services. The results were also in keeping with the issues highlighted in the current NICE guidance: for example, the need to improve the coordination of care between professionals and across agencies and settings<sup>1</sup>.

The results can also increase the commitment of staff to the introduction of measures to tackle current problems. Box 3 lists some of the ways in which focus group participants thought current services could be improved. NICE guidance offers further suggestions. These inputs are now being used by local professionals responsible for the

### Box 2. Ways in which current problems were described as adversely affecting users' experiences of care

#### *Delays in multidisciplinary health assessments*

It [the assessment process] is supposed to take three working days ... it has been up to six weeks ... the [patient's] condition may have changed, so whereas before they may have been able to get back out to a more normal life with their friends ... they are stuck in care with people dying around them.

#### *Repetition in assessment processes*

I think it is difficult for the patients who have to go through it all with us and then social services come in and they have to go through it all again.

#### *Difficulties accessing equipment for home care*

A woman ... was actually desperate to come home for her birthday ... [but] delivery [of a hospital bed] was delayed ... and she actually died before she was able to get home.

#### *Problems with care out of hours*

The locum comes out who doesn't know the patient, sees someone distressed, family not coping possibly [and thinks] 'right, we'll get them back into hospital'.

#### *Inadequate funding for social care at home*

The frustration I have is that we are limited in terms of what support we can put in if people go home ... £68.25 doesn't go very far.

#### *Inadequate awareness of service options*

He [the patient's husband] firmly believed that there was going to be this 24-hour service because of the way it is explained by the people who aren't familiar with the services ... it's the way they [the patients] interpret things and doctors are well known for not being careful when they explain these things.

### Box 3. Suggested ways of improving current services

- Full implementation of the 'care pathway' approach to delivering care during the final stages of life.
- Greater use of multi-agency and multidisciplinary case conferences.
- Earlier identification of patient preferences about care.
- Earlier planning for hospital discharge.
- Improved information for patients about current services.
- Implementation of the single assessment process.
- Introduction of multi-agency and multidisciplinary sessions to raise awareness and provide education.

development and implementation of action plans to tackle current problems.

Finally, targeted audits would help to quantify the scale of problems highlighted by focus group analysis. Participants suggested the use of audits to quantify the avoid-

able bed use caused by delays in assessments and in accessing equipment.

### Conclusion

This study allowed the adoption of a needs-driven, patient-focused

approach to service development.

To complete the audit cycle, future studies will be required to evaluate the effects of those service changes that are implemented. These studies should aim to incorporate direct inputs from service users.

### References

- 1 National Institute for Clinical Excellence. *Guidance on Cancer Services. Improving Supportive and Palliative Care for Adults with Cancer: The Manual*. London: NICE, 2004. Available at [www.nice.org.uk/pdf/supppalldraftmanual.pdf](http://www.nice.org.uk/pdf/supppalldraftmanual.pdf)
- 2 Department of Health. *The NHS Cancer Plan*. London: DoH, 2001. Available at [www.doh.gov.uk/cancer/cancerplan.htm](http://www.doh.gov.uk/cancer/cancerplan.htm)

## Integrating qualitative and quantitative principles in audit: from theory to practice

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- Audit projects can effectively combine qualitative and quantitative components.
- If audits are to be the structural and functional cornerstone of clinical governance, they should address clinically relevant topics (as in this audit – determinants of violence by patients in psychiatric wards).
- Multidisciplinary staff input in both the conceptualisation and conduct of audits provides an invaluable opportunity for mutual learning and professional development.

Audit is at the heart of clinical governance. It is a process that is aimed at improving the quality of patient care<sup>1</sup>. Despite this ideological emphasis on quality, audits often focus on quantitative aspects of the structure, process or outcome of patient care and can be primarily number-crunching exercises. The audit reported here illustrates how qualitative and quantitative aspects can be effectively combined within a clinically relevant context.

Violence is commoner among people with psychiatric disorders than in the general population and is naturally a matter of concern to professionals and carers, as well as clients themselves and wider society<sup>2,3</sup>. Violence can be defined as:

a situation in which a mental health service user is either actively violent (e.g. attacking others, breaking objects) or on the brink of being so (i.e. violence is imminent).<sup>4</sup>

Various studies have highlighted the role of the physical environment of psychiatric wards (such as overcrowding and low autonomy) and the social organisation as potentially important mediating factors in violence by inpatients<sup>2,5</sup>.

### Method

We audited 28 physical environmental characteristics of 11 inpatient units at the Queen Elizabeth Psychiatric Hospital in south Birmingham: four general adult wards, three old age wards and four specialist wards –

an intensive care unit (ICU), a deaf unit, an eating disorders unit, and a mother and baby unit. The selection of the 28 environmental characteristics (see legend to Figure 2) was based on those used by the Royal College of Psychiatrists' national audit, conducted in 1998<sup>4</sup>. They covered, for example, cleanliness, lighting, space, privacy, ventilation, noise, smoking and non-smoking areas, exits, alarms and temperature.

The method of audit is outlined in Figure 1. Two teams conducted the audit, by completing a questionnaire that presented the 28 standards. Team A comprised a staff nurse, a nursing assistant and a patient; they subjectively assessed whether the 28 standards had been met. Team B comprised two doctors; they objectively assessed whether the standards had been met according to the criteria set out by the Royal College of Psychiatrists<sup>4</sup>. Raters could also record comments and opinions on the questionnaire, from which the

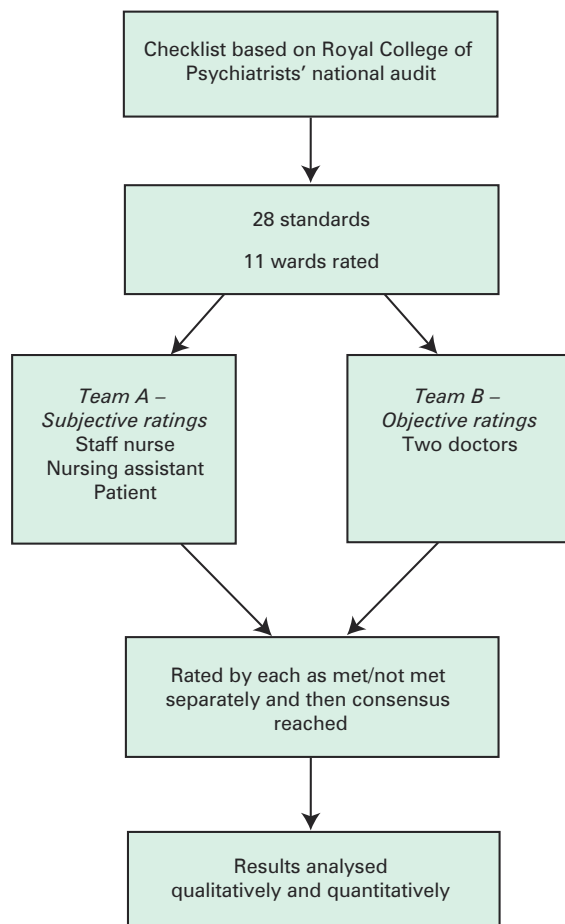


Figure 1. Method of audit.

## 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.

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qualitative data were extracted. Team members made separate ratings and then agreed a consensus rating.

We used the Formic program for analysis of results. This software facilitates the accurate capture of large amounts of data and the efficient transfer of information from forms to computer systems.

## Results

### Qualitative results

The specialist wards and old age wards were cleaner and friendlier than the general adult wards. General adult wards were the least clean, while two of the specialist units (the deaf unit and the mother and baby unit) were the cleanest. One staff nurse on a general adult ward described it as 'smelly, unfriendly and poorly designed'.

The ICU had unimpeded sight lines, whereas on the other wards the exit and entrance could not be seen from the nursing office. None of the wards had a specified reception area. The open-plan design of one of the three old age wards and of the ICU gave a perception of space. Except for the ICU, none of the other wards had an allocated safe area for severely disturbed people. On most of the wards, sleeping and day areas were separate. However, none of the wards had single-sex day areas and there was inadequate quiet space for staff and patients – particularly in the general adult wards.

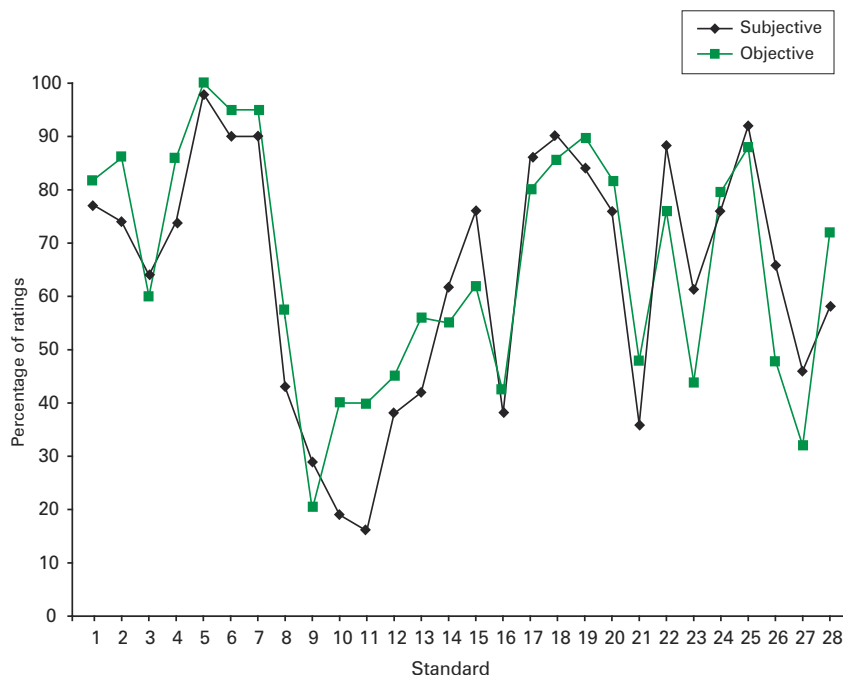
There was gross inadequacy in the provision of privacy for patients. The only ward to provide all single rooms was the mother and baby unit. One patient on that unit described it as 'home away from home'. Quiet rooms and activity rooms were also often used for ward rounds and staff hand-overs. Few wards provided locked wardrobes for the storage of personal belongings.

### Quantitative results

Across all 11 wards the proportions of the subjective ratings of team A (i.e. 33 ratings for each of the 28 standards) that indicated that the standards had been met were highest for the following:

- separate sleeping and day area (98%);
- non-smoking areas (90%);
- access to external space (90%).

They were lowest for:



**Figure 2.** Comparison of subjective (team A, three raters) and objective (team B, two raters) results: percentage of ratings across all 11 wards that indicated the standard had been met. Standards: 1, cleanliness; 2, friendly; 3, natural daylight; 4, perception of space; 5, separate sleeping and day area; 6, non-smoking area; 7, access to external space; 8, unimpeded sight lines; 9, well planned reception area; 10, separate areas for patients with police escort; 11, single-sex and mixed-sex areas; 12, adequate privacy; 13, separate 'safe area'; 14, ventilation; 15, noise levels; 16, overcrowding; 17, quiet areas; 18, smoke rooms; 19, activity areas; 20, single bedrooms; 21, safety of belongings; 22, appropriateness of ward design; 23, staff privacy; 24, exit within sight; 25, accessible alarms; 26, accessible doors; 27, safety of objects; 28, temperature control.

- well planned reception area (29%);
- separate areas for patients with police escort (19%);
- single- and mixed-sex areas (16%).

According to the doctors' consensus rating (i.e. the objective assessment), eight of the 11 wards were clean, nine were friendly, eight smelled pleasant, six had adequate natural daylight, six had fresh air and adequate ventilation, nine gave the perception of spaciousness and eight had well controlled noise levels.

A comparison of the subjective ratings and objective ratings for each standard (pooled results from all wards, team members' separate ratings) is depicted in Figure 2.

### Recommendations for change

Failure to meet a standard was most often the result of poor design and lack of space. It was suggested that the answer to most of the problems would not be to build new wards, but

rather to implement simple and practical solutions. Many of these could be addressed cost-effectively. For example, different wards were found to need different levels of cleaning, and some required only air fresheners and more ventilation.

It was suggested that wards should provide mobile phones that could be given to patients for telephone calls when they required privacy. To address the common problem of lack of rooms, minor restructuring or redesigning was recommended (e.g. the use of room dividers). To enhance sight lines, the use of CCTV cameras, more internal windows in offices and an open-plan design were suggested. Security of personal belongings could be ensured by providing wardrobes with locks.

### Clinical implications and relevance

On the whole, it was felt that if some of these relatively inexpensive recommendations were to be implemented,

the number of violent incidents would be reduced. Clinical audits like this have a key role to play within the framework of clinical governance in improving clinical practice and reducing the likelihood of undesirable and adverse effects of treatment and care.

Such multidisciplinary clinical audits with clinically relevant implications should help bridge the gap between audit and clinical practice. As supported by the findings of the present audit, further emphasis needs to be given to simple and practical ways of altering the ward environment, which will help reduce violent incidents in psychiatric wards.

### Further developments

We are planning a re-audit to look for sustained gains and, in conjunction, any reduction in recorded violent incidents. We are also considering training more multidisciplinary staff and encouraging them to participate in a range of audit projects, again with an emphasis as much on quality as on quantity.

### Conclusions

Equal emphasis was given to qualitative and quantitative aspects of the present audit, and we demonstrated the principles and usefulness of doing so. Such audits can yield important findings with clinical implications for improving the quality of patient care. If, as intended, audits are to form the cornerstone of clinical governance, they need to integrate qualitative and quantitative elements.

### References

- 1 National Institute for Clinical Excellence. *Principles for Best Practice in Clinical Audit*. Oxford: Radcliffe Medical Press, 2002
- 2 Swanson JW, Holzer CE, Ganju VK, Jono RT. Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. *Hospital and Community Psychiatry* 1990;41:761-70
- 3 Mullen P, Taylor PJ, Wessely S. Psychosis, violence and crime. In: Gunn J, Taylor PJ, eds. *Forensic Psychiatry: Clinical, Legal and Ethical Issues*. Oxford: Butterworth Heinemann, 1993: 329-72
- 4 Royal College of Psychiatrists. *Clinical Practice Guidelines: Management of Imminent Violence*. London: Royal College of Psychiatrists, 1998
- 5 Hunter ME, Love CC. Total quality management and the reduction of inpatient violence and costs in a forensic psychiatric hospital. *Psychiatric Services* 1996;47:751-4

# The use of indicators to measure clinical governance performance in NHS trusts

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- Quality standards can be agreed and processes can be developed locally to facilitate continuous improvement of the patient experience.
- The production of appropriate indicators based on local expert opinion will aid compliance with the indicators.

## Background

A great deal of emphasis has been placed on quality in the NHS. Clinical governance seeks to ensure that standards are met and that processes are in place for continuous quality improvement. The emphasis is increasingly on measuring the performance of trusts in this regard. However, this is possible only when standards are precisely described in measurable terms. The use of acceptable indicators of quality based on expert opinion or evidence will enable quality improvement in NHS trusts to be measured. In addition, allowing professionals to choose the measures that are meaningful will aid their compliance with the process.

Furthermore, appropriate indicators of quality are required to overcome inconsistencies in practice and to maintain effective monitoring of performance. Since there are no recognised indicators for improving the quality of the patient experience, many organisations remain in a state of trial and error. Although clinical governance leads are engaged and inspired, they find it a challenge to implement standards<sup>1</sup>.

The standards of quality to be measured in NHS trusts are set down in the *Standards for Better Health* document introduced by the Department of Health in July 2004<sup>2</sup>. The Department allows local discretion in the selection of relevant indicators to achieve these standards, until the Healthcare Commission produces criteria for the core and developmental standards.

To provide a focus for clinical governance and to monitor performance, a reporting framework was produced by the South West Peninsula Strategic Health Authority. It is suitable for all NHS organisations and is comprehensive while allowing for local flexibility. The main headings for each section of the framework were adapted to follow the minimum expectations outlined in *Standards for Better Health*. Thus, the framework sets minimum standards to ensure all patients receive similar levels of care.

## Methods

The perception and measurement of quality are subjective concepts that need to be operationalised to be meaningful. Therefore indicators were chosen as a method of ensuring that quality standards are met; also required was a simple means of monitoring these indicators to ensure the standards are attained and quality is improved incrementally over time.

In order to achieve this, a consensus was sought, through two focus groups with representation from local trusts' clinical governance 'experts'. These sought to determine appropriate indicators, particularly ones relating to improving the patient experience. The discussions were audio-taped, transcribed and analysed for key themes. The findings were compared with performance assessment templates used nationally.

## Results and discussion

Principal themes and comments from the focus groups, as well as a review of the nationally used templates, enabled the selection of 16 indicators to be incorporated within the South West Peninsula Performance assessment framework, along with a traffic light system of measurement to assess quality improvement. Also, to ensure the indicators chosen were meaningful and useful, they were sup-

ported by evidence of their relevance to the improvement of quality of care and integrated with other quality initiatives to promote coordination. It was important to show that process and outcome had been considered when deciding on indicators.

Three examples of indicators used within the framework are given below:

- *Indicator 4.* Analyse trends resulting from data collected over the past 12 months.
- *Indicator 5.* Identify the top three issues relating to patient experience highlighted from the trend analysis.
- *Indicator 6.* Undertake a risk assessment of the top three issues highlighted to produce at least one organisational priority area.

The indicators are evaluated using the traffic light system<sup>3</sup>. This system of monitoring is well known within the NHS, and performance in other areas of the trust's activities is monitored using it, through the annual accountability agreement. Leads wished to continue with a system they were familiar with and that was meaningful within the context of the organisation.

Engaging the leads encouraged local ownership and achieved a consensus on a direction for quality improvement. This was particularly important to overcome the vulnerability felt by some trusts when performance data were compared with those of other trusts.

## References

- 1 Sweeney G, Sweeney K, Greco M, Stead J. Moving clinical governance forward: capturing the experiences of primary care group leads. *Clinical Governance Bulletin* 2001;2(1):6-7
- 2 Department of Health. *Standards for Better Health*. London: DoH, 2004
- 3 Lewis SA, Fenton K, Saunders N. A simple traffic light monitoring system to measure progress in clinical governance: practical implications and the lessons learnt. *Clinical Governance Bulletin* 2002;3(4):11-12