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CLINICAL GOVERNANCE Bulletin

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Editorial: Communication

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The exchange of information between health professionals and patients lies at the heart of clinical practice. The time when health professionals could regard patients as passive recipients of care and assume that they had given control of their destiny to the clinician has long gone. There are many influences that have altered the situation and which will drive further change.

The role of civil society and its organisations has changed profoundly. The all-embracing municipal government running everything from buses to electricity and providing both housing and health-care for its citizens has given way over the decades to a world of 'shared power', in which citizens are given choices about nearly every aspect of their lives. Health-care has not been immune to this change. Members of the public expect that they will be treated and respected as individuals with autonomy and with the ability to question authority and decide on important matters in their own interest.

Topics for future issues

- Clinical error
- Complaints
- Clinical audit

Please share your practical examples with us, and email them to the Editors:
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Added to the increase in personal autonomy is the profound effect of information technology. The ability of anyone with Internet access to obtain a vast amount of information about medical conditions has radically changed the relationship between patients and clinicians. Indeed, the patient or carer may be more knowledgeable than the clinician. There is, however, substantial concern about the accuracy and validity of much of the information available on the Internet. The role of the health professional is therefore changed into that of an interpreter, and an interpreter needs to be a fluent communicator.

Following the events in paediatric cardiac surgery in Bristol, great emphasis has been laid on communication with patients about levels of risk. Obviously, this is at its most transparent when discussing the pros and cons of elective surgery. The difficulty of dealing with the issue of risk in either the acute situation or in long-term disabling disease is much more complex. There is no doubt that the ability of patients to access information about mortality and complication rates associated with institutions or individual doctors has increased dramatically, albeit from a very low base. Very many areas remain unilluminated, however, and the potential for growth in this respect is enormous.

Another type of communication that has implications for clinical governance is that between professionals. There can be few practitioners of long standing who have not come across situations in

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which there was sustained and damaging conflict between people who should have been working as colleagues. Non-communication between colleagues who should be collaborators damages morale and patient care. The growth of appraisal systems should reduce this major problem and professional regulators are now regarding teamwork as a central part of professional practice. One of the areas where we need to develop skills is in confronting poor professional performance. There can be no greater communication challenge than telling a colleague that his or her performance is potentially damaging patients.

Good communication and effective teamwork are essential to the success of clinical governance, so please share your practical experience with the wider NHS and send us your contribution for a future issue. In the next issue we will cover clinical errors and we would very much encourage you to submit a contribution that shares your practical experience and highlights the key lessons learnt.

Understanding how communication can support the spread of good practice

Sarah W. Fraser

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- The spread of good practice is better supported by informal and social communication than by formal, hierarchically distributed information.
- It is important to pay attention to the means of communication as well as the content of the message, and to see these as separate issues.
- Targeting the audience – deciding who they are and the most appropriate way to reach them – is essential for efficient and effective communication.
- Opinion leaders are critical to the implementation of change, and they need to be supported and provided with useful information.
- As with any improvement process, measuring the impact of information and eliciting feedback are important.

The spread of good practice happens over time and through a social process in which information and knowledge are communicated through personal networks. It is primarily a learning process, and some people learn, adapt and adopt new practices more quickly than others[1]. In most systems, once a core of around 20–30% of individuals have adopted a specific innovation, the rest tend to follow without further external intervention. (For complicated new ways of working, a figure of 40–50% is required.)

Communication is at the heart of the spreading information. A useful framework for understanding how to leverage this process is the multi-step communication model[2] shown in Figure 1.

Sender

The sender is the person or organisation initiating the communication. This can be the source of good practice, or a change agent or other authority keen to reduce variation by encouraging the copying of ideas from one individual or organisation to another.

The issues to consider include the following:

- Who is the actual sender of the information? Information sent through a hierarchical cascade process can lose the identity of the sender, and thereby cause confusion and a lack of motivation on the part of the receiver.
- What is the motivating connection between the sender and the intended recipient? Evidence suggests the target audience will receive the information more quickly and readily if they identify with the sender[3]. For example, it is more likely that a GP will adopt new guidelines on managing patients with dyspepsia if she is told about them by another GP.

Message

While the message is often thought to be the core of communications, it is closely intertwined with the way in which it is shared or transmitted. However, there are ways to help potential adopters to be attracted to and understand the message.

Evidence suggests[1] that ideas, practices and behaviours are adopted by others when:

- they are better than what currently happens (there is a clear advantage to change);
- they reflect the beliefs and values of the adopters;
- they can be understood easily and are visible to others;
- they can be tested and tried out in a way that is not too risky.

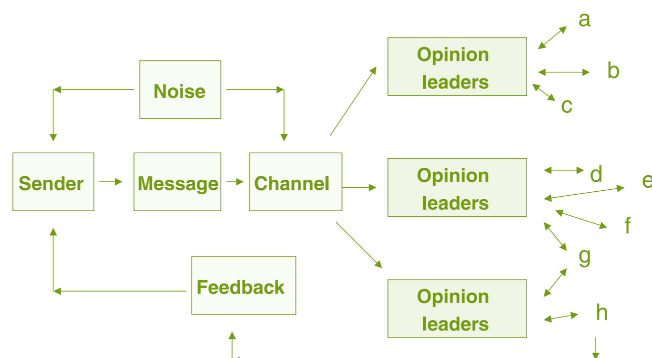

Figure 1. The multi-step communication model.

The issues to consider include the following:

- Messages need to be targeted at the audience and written or expressed in the language of the potential adopters and not the sender.
- Good ideas and practices are not initially always explicit; one of the most important tasks is to make knowledge and intuitive tasks more obvious to potential adopters.
- It is essential to explain the relative advantage of the new ideas to the potential adopter. This means first understanding their current status and then helping them see it by explaining the new ideas.

For example, where a hospital manager would like GPs to use a specific referral form, then it would help if the request made it clear why the new form was better (for the patients, the GP and the hospital) than the previous method. It helps if this is backed up with some pilot data. If GPs are encouraged to try it out and if it does not have the expected results then a willingness by the manager to go back to the old system will facilitate the testing of the form. It will help if the form is produced and shared in a way that makes sense to the adopting GP; for example, if it is in an electronic format, then it will need to work with the practice computing system.

Channel (method of communication)

Communication should involve more than just sending information to potential adopters. Most spread strategies require multiple methods of communication at different times of the process. A useful model[4] is shown in Figure 2.

The issues to consider include the following:

- Different topics will need different methods of communication to target different adopters. For example, busy nurses may have difficulty attending off-site workshops. Instead, they could be targeted by publishing an article in the *Nursing Times*.
- The method needs to attract sufficient attention to create initial awareness; without this all other communication efforts may be worthless.
- As the spread process depends on social and personal contacts, letters should be named and signed personally rather than headed 'Dear colleague' and photocopied.

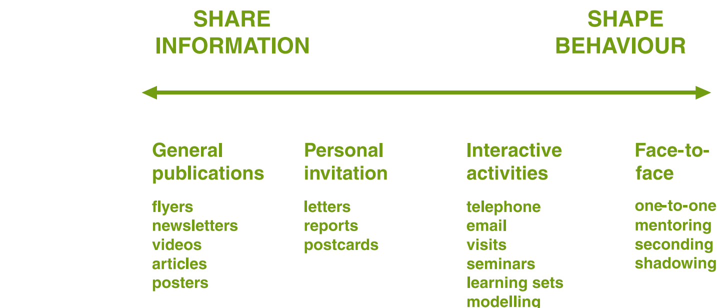

Figure 2. Communication methods matrix.

Noise

Any communication and change process is affected by noise from outside the system. There are two types of noise: system and individual noise.

System noise results from the multitude of initiatives and activities under way in an organisation. Many different people will be requiring multiple and often conflicting outputs from others. A key role for anyone encouraging and enabling the spread of good practice is to be able to help potential adopters see a way forward through these competing initiatives and activities.

The definition of what is good practice is very subjective and information received about it depends on personal perceptions. *Individual* noise consists of the prejudices and mental models that individuals have, and the effect these have on their ability to implement changes. For example, smokers tend to filter out the health warnings on cigarette packets.

The issues to consider include the following:

- It is important to find ways to integrate innovations with other individual, team or organisational objectives. Seek clarity and simplicity in the communication to others.
- Test whether communication efforts are having the desired result. Are messages getting through? Are they being distorted by noise?
- The message and method need to rise above the noise in the system. For example, sending a copy of a report, using the same branding as other reports, may not attract attention; it may be more effective to put some information on a postcard, using an intriguing strapline, and to follow this up with a one-page outline of the report before then sending out the whole report itself.

Opinion leaders

One of the key roles of senior managers and service improvement project leaders is to identify and work with local opinion leaders to accelerate the spread of innovation and good practice throughout local, regional and national systems.

The concept of opinion leaders[1] in the role of spreading good practice is that they are usually among the first to know about new ideas and their peers look to them for guidance about whether the innovations should be adopted or not (see Box 1). These opinion leaders have the respect and credibility of their peers and they have an important role in influencing the behaviour of others in the system.

Box 1. Characteristics of opinion leaders

- Higher social status
- More years of formal education
- Greater literacy
- Higher aspirations and ambition
- Tend to belong to larger groups
- Demonstrate empathy, rationality
- Exposed to and use variety of media
- Greater knowledge of innovation

The issues to consider include the following:

- Not all opinion leaders will agree with the message; find them and coach them.
- Find ways to discover who is the opinion leader for the specific topic planned to be spread. You can do this by asking the question of individuals in the system, 'Whose opinion do you respect on this issue?'
- If you do perform a structured analysis then careful facilitation may be required as the opinion leader identified may not be the person others initially expected.
- By working through opinion leaders you can cut down on the amount of 'grapeshot' messages and methods sent throughout the system

Feedback

As the system will be adapting continually through the communication process and the implementation of new practices, it is important to have a number of ways to get feedback to check how the adoption process is progressing.

The issues to consider include the following:

- Check whether potential adopters are aware of the new ideas. Namely, are they receiving the basic information, and are the methods of communication working?
- Support adopters as individuals, teams and organisations through the decision-making process; find ways to keep track of how the decision process is going.
- Check whether implementation is happening. Assess whether all or only some of the new ideas are being implemented and whether the changes are widespread or localised.

References

1 Rogers E. *The Diffusion of Innovations* (4th edn). New York: Free Press, 1995

2 Smith PR. *Marketing Communications*. London: Kogan Page, 1996

3 Thresher B, Biggin J. *Manage the Message*. London: Century Business, 1993

4 Fraser SW. Spreading good practice: how to prepare the ground. *Health Management*, June 2000

Early warning is the key: a communications perspective on serious clinical incidents

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- If in doubt, shout. Not all serious clinical incidents are obvious but it is always safer to brief upwards and seek advice.
- Early warning is essential, as this will give valuable time to plan for an appropriate response.
- Prepare early for media interest by paying attention to different audiences and stakeholder organisations. It is important that what you say matches up with what others say about you.
- Be as open as possible. The media will be more likely to accept your viewpoint and public confidence can be retained.

Nobody wants to live in the eye of a media storm. The sight of dozens of news-hungry journalists camped outside a hospital will create great unease among staff and put patient confidence at risk. So how do you avoid it?

Some form of media attention is almost inevitable after a major clinical incident but it can be managed. This is not about 'spinning' your way out of a problem. It is about presenting information in a clear and open way so that the reputation of the organisation and the wider NHS is maintained. To do this, the organisation must be clear on what its plan of action is, how that has been formulated and what the impact is for patients or the public.

When do you have a problem?

There is no single definition of a serious incident but it will be something out of the ordinary and likely to attract media and public attention. It may involve a large number of patients, poor standards of management or even the death of a patient.

Anyone who is unsure about whether a serious clinical incident has occurred should consult the regional director of public health or the regional director of communications at the regional office. The basic advice is that there should be no surprises.

In February 2001, a news agency picked up on the fact that Salisbury Healthcare Trust had provided specimens of surplus skin tissue from breast and abdominal reduction surgery to the Defence Evaluation and Research Agency (DERA) at Porton Down. The DERA stated that the skin had been used to develop protective measures for the armed forces. Consent forms did not make it clear that surplus skin would be used in this way. The issue came to light only a matter of days after the publication of the Alder Hey report on retained organs, and clearly there was potential for a major national story.

However, the swift action of the trust in notifying the director of public health at the regional office meant that advice was quickly given. The supply of skin was stopped immediately. Media activity was carefully managed through a full statement and press conference. The incident was covered by the media but clear messages were given about a change in policy and media activity was contained to one day.

Why brief?

As Regester and Larkin recognise:

> Issues management is a proactive, anticipatory and planned process designed to influence the development of an issue before it evolves to a stage which requires crisis management.[1]

Briefing the regional office allows people to be prepared for the

inevitable questions from the media and the public. For that reason it is crucial that information is shared *as early as possible*.

Detailed answers to questions can be developed and support can be enlisted from the Department of Health, particularly if the issue has national implications. The problem may begin at one trust but can finish with questions being asked of every trust in the country. Other regions may need to be involved, for example if a doctor under investigation has worked in other parts of the country.

Sharing information promotes a culture of learning and can help to prevent a repeat episode in another trust. To achieve this it is important that information is shared freely and that actions are discussed and agreed between all the parties involved – trust, health authority, regional office and Department of Health. This ensures that, when an issue becomes public, consistent and supportive messages are given out by each organisation.

East Gloucestershire Trust had the difficulty of experiencing the latest in a series of outbreaks of tuberculosis in April 2001. To make matters more difficult the source of infection was a nurse and a look-back exercise involving 1300 patients had to be undertaken. Discussions between the trust, health authority, regional office and NHS Direct meant that all parties were apprised of developments as the trust finalised its action plan to contact patients. The planned release of information was accelerated when a local paper discovered the story but, crucially, the early contact and preparation allowed arrangements to be quickly made for a press conference.

The trust was supported by the health authority and regional office in its approach. The information was presented clearly to reassure patients that the issue was being managed effectively and channels of communication were opened up for concerned patients or members of the public. NHS Direct played an important role in dealing with 'worried well' calls and allowed the trust to concentrate on patients who were directly affected.

Use communications support

Never feel you are on your own. Your communications support will have the training and experience to help in planning the response to a serious clinical incident. They will help to spot potential problems and opportunities for sending positive messages about how the incident has been handled. A serious clinical incident can be a testing experience but good communications will help to manage the challenge.

Reference

1 Regester M, Larkin J. *Risk Issues and Crisis Management – A Case Book of Best Practice*. London: Institute of Public Relations, 1997

Ten top tips for ensuring that your written messages get absolutely nowhere

Tim Albert

Tim Albert was a journalist and editor, and is now a full-time trainer. He runs courses in written communications for health professionals. Email tatraining@compuserve.com, website www.timalbert.co.uk

(1) Write first, think later

Express yourself. You are a valuable person so say what *you* want to say and don't waste any time on all that anal-retentive stuff, such as working out what you want to say, to whom, and why. Just start writing; don't worry about getting a message across. You will have a great time, your true self will emerge and you cannot fail but be impressed by the result. Readers? Who needs 'em?

(2) Try to cover as many audiences as possible at one time

The more people you target the fewer you will please, because you will be speaking directly to none of them. This technique will free up your time for more important matters, such as committee meetings.

(3) Write in committee

This is a sophisticated variation on the above. By making sure everyone on the committee is completely happy with what you are saying, you will ensure that readers find it inappropriate, unreadable, irrelevant and bland. If, after this process, you still think there is a chance of your message getting across, send it to another committee for their comments.

(4) Pepper your prose with the longest words you know

This is a good one. Don't say things like 'Smoking can kill'. Prefer 'According to several decades of research along a variety of modalities, a positive correlation between the inhalation of nicotine-impregnated gaseous material of a high calorific value is considered reasonably established'. (For further inspiration see elsewhere in this journal.)

(5) Add plenty of evidence

This excellent technique is known to insiders as the 'Cochrane recipe'. Pick as much data as you possibly can. Examine the methodological entrails in great detail, using at least two statisticians from rival institutions. Simmer gently for some time, then serve up in the longest sentences you can construct. (This technique has the added advantage of conforming to Albert's Third Law of Obscurity, namely that status rises in direct proportion to the fogginess of copy.)

(6) Ignore the professionals

Under no circumstances should you risk calling in those who have spent their working lives as professional communicators. Avoid importing ideas such as making written material interesting – with clearly stated headings, easily grasped take-home messages, and pages with all kinds of visual devices rather than lines of grey text in a typeface so tiny that no one over 54 can read it.

(7) Get angry

When you feel your blood boil over a stupid request to clean your own

coffee cups, or an unwarranted complaint about how you have treated a customer, don't hang about. Write down your reaction at once. It cleanses the anger wonderfully, and the resulting outcry from your intemperate outburst will ensure that any useful message you might have accidentally slipped in will be completely ignored.

(8) Confine your reading to NHS documents

This one is self-explanatory.

(9) Follow the structure of a scientific paper

For reasons best known to themselves, scientists have taken to their noble hearts a particular form of writing (Introduction, Method, Results and Discussion) which leaves any message until the very end. This is a simple way of ensuring that most people miss it. Expert obfuscators can go one step further with this structure and leave out any message at all with nobody noticing.

(10) Go fishing

Actually, that's probably not such a bad idea after all. It will save a lot of trees.

Six top tips for communication

Judith Thomas

Department of Health, London

(1) Objectives

Know what you want to do. Perhaps you are trying to achieve some change, or perhaps your objective is maintaining the status quo. Good communication is likely to be important for both.

(2) Audiences

Identify the main people who can make it happen, and those who can stop it happening. These are your key audiences. Work out from talking to them or talking to others what those key audiences believe and know at the moment. Are they against your proposal? Do they need more information? Are they very excited about it?

(3) Messages

Using this information, choose your main messages. Try to limit these to just a few. You will have to repeat them frequently in the course of all your communications with them. Examples might include 'It will not cost you more money', 'It has been successful elsewhere', 'It's great that you are on board, keep up the good work'.

(4) Methods

Identify the best ways of communicating with your key audiences. Use your common sense and your knowledge of them as people. Choose methods and language that fit their needs. Are they really going to read a 50-page report? Which magazines do they read? Whom do they listen to?

(5) Repetition

Do not rely on telling people just once. This is really important. People get bombarded with information, and so you will need to keep repeating your messages in different ways to get them across. The advertising industry benchmark is that people need seven opportunities to see or hear a message before it starts to sink in (unless they are looking out for it specifically). Too often communicators think that because they have said or published something once, they can stop.

(6) Evaluation

Work out whether your audiences' level of knowledge and opinion have changed and then start the cycle again.

WhoWhatWhere?

Effective teamwork and communication on the web

The Editors' Choice

Workforce Development Confederations' home page
http://www.wdconfeds.org/default.htm
Workforce Development Confederations (WDC) is a collection of organisations that aim to take the lead in developing integrated workforce planning for health-care communities based on the assessment of future requirements for skills and competence. WDC provides a forum in which to achieve this via local implementation strategies.

Department of Health: Workforce Development Confederations Guidance
http://www.doh.gov.uk/workdevcon/guidance.htm

The NHS Identity Policy
http://www.doh.gov.uk/nhsidentity

The Association of Healthcare Communicators
http://www.assochealth.org.uk/

Healthwork UK, The Health Care National Training Organisation
http://www.healthwork.co.uk/about_us/organisation.htm
This organisation aims to analyse workforce development needs, promote development and lifelong learning and work in partnership building effective relationships.

Article in the *Student BMJ*: 'How to improve communication between doctors and patients', by Cathy Charles, Amiram Gafni and Tim Whelan
http://www.studentbmj.com/back_issues/0600/editorials/177.html

Healthcare Collaborator
http://www.healthcarecollaborator.com/about/about.htm
This online newsletter offers 'you the communication strategies you need to build better working relationships with the people you count on most: your colleagues'. Although published in the US, the *Healthcare Collaborator* addresses general issues that should be of interest to health-care professionals in the UK.

For NHS communications staff
http://www.doh.nhsweb.nhs.uk/commsnet/

Managing life in the NHS: educating towards clinical governance

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- It is possible, albeit difficult, for staff groups to work in partnership to develop, support, implement and assure the quality of joint educational programmes across large areas. The Workforce Development Confederations appear to provide a forum in which to achieve this via local implementation strategies.
- Funding issues must be confronted and managed. It is likely that the merging of the educational levies will facilitate the development and delivery of programmes.
- Time and resources must be allowed for this sort of education if we are serious about the on-going professional development of NHS staff.
- Capacity issues are important if it is envisaged that all recently qualified health-care workers should participate in such a programme. Innovative ways of ensuring that multiprofessional learning is not lost will need to be explored, and this may include online provision.

Background

The need for clinical staff to acquire additional skills and knowledge to support and enhance their professional activity is now well recognised. Broadly classified as 'management issues', these are aspects of personal development that professionals within the NHS *must* acquire if they are fully to meet the needs of patients and the NHS.

Such generic skills and knowledge are common to all professional groups within the NHS. They include:

- an understanding of the values and working arrangements of the NHS;
- good communication and interpersonal skills;
- the specific abilities that enable effective team working;
- the core skills and attitudes that underpin professional practice and behaviour.

Survey study

A review of the availability of management or generic training within acute and community trusts in London was undertaken in early 1998. Information was requested from the directors of human resources at 61 trusts in the region (although information concerning management training for health-care workers in primary care and for those working in public health/health authorities was not requested). Forty-seven organisations responded (77%). Forty-two of the 47 trusts offered some site-based management training to their staff. Training in 29 different areas was provided. Most respondents indicated that the training was open to any clinical and/or managerial member of staff, although doctors rarely took advantage of any of these opportunities. Doctors participated in management training that was made available on a 'doctor only' basis, often through the postgraduate clinical tutor or through extraneous courses. The outcome of this survey indicated that there was substantial management training going on at trust level and that it had the potential to be developed into genuinely multidisciplinary, interprofessional training.

Process

A steering group was convened with the agreement of the London Regional Educational Development Group (REDG); it had high-level representation from each of the eight educational consortia and the postgraduate deans. Its brief was to explore the possibility of developing a leadership training programme for recently qualified health-care workers (within five to seven years of qualification) in the generic skills, knowledge and attitudes required to work successfully in the NHS for the benefit of patients. Four basic principles around which the educational curriculum should be developed were agreed:

- such education should be delivered, as far as possible, in the workplace;
- it should be offered as multidisciplinary and multiprofessional education;
- it should be delivered within current trust resources, since this was a refocusing of training resources rather than additional training;
- it should be appropriate for primary care, for health authority staff and for partners participating in health improvement programmes, and as such should be used to foster partnerships and encourage agencies to work across traditional barriers.

Box 1. Course curriculum for 'Managing life in the NHS : educating towards clinical governance'

Module 1. Knowledge
1. Clinical governance and the modern NHS (includes values, ethics and accountability)
2. Quality and complaints in the NHS
3. Critical analysis of data and evidence
4. Diversity and equal opportunities for staff and patients
5. Managing financial resources

Module 2. Skills
1. Presentation skills and managing meetings
2. Clinical audit skills
3. Managing life during change, leadership and working in teams
4. Negotiation and conflict
5. Appraisal and performance management

Module 3. Attitudes and personal development
1. Communicating with patients and colleagues
2. Assertiveness and influence
3. Time management and prioritising
4. Career development
5. Mentoring, supervising and supporting colleagues

Representatives from the consortia and from medical and dental education developed the educational content of the curriculum through an iterative process that considered the learning objectives and outcomes of each element of the curriculum. The curriculum that was agreed reflected the above survey and the input from senior health-care workers in the educational consortia (see Box 1).

Once the steering group had agreed the curriculum, a widespread consultation with all stakeholders in the region on the four principles (above), the approach and the curriculum was undertaken. Overall, there was widespread support, except for the third principle – that of using existing resources. Only a third of the respondents thought that this was realistic, and two-thirds stated strongly that additional funding would be required.

In response to these concerns both the postgraduate deans and the educational consortia contributed at least matched funding to pump-prime the development of the programmes.

Outcome

The aims of the programme were to deliver a comprehensive educational package to health-care workers in order that they could:

- understand that clinical governance is the context within which the NHS delivers patient care;
- learn in a multiprofessional environment with a view to improving future multiprofessional working relationships;
- undertake the education within the local working environment;
- participate in a quality-assured generic programme as they moved around the region, since much of the workforce was mobile and peripatetic.

The consultation review gave widespread support to the concept and the curriculum. The steering group agreed that the consortia should manage implementation of the programmes locally and, indeed, while adhering to the principles and aims, a number of different models were used, reflecting local requirements. In one consortium, the six local acute and community trusts formed a robust steering group which implements the programme and has proved a useful platform for promoting partnerships; in others, project managers were appointed to start the process and pull together local providers.

By December 2000, 34 modules and nearly 1300 training days had been delivered, with at least one of each having been offered in each consortia. The responses from the standardised evaluation process were entered into a central database. The responses of 208 participants (41% of whom were nurses/midwives, 30% doctors and 19% therapists) who had completed at least one five-day module to four key questions are shown in Box 2.

Box 2. Summary of key responses to the programme evaluation

- 92% (191/208) of respondents said it enhanced understanding of clinical governance
- 96% (200/208) said it was likely to enhance multidisciplinary working
- 97% (202/208) said it was likely to affect their clinical practice to the benefit of patient care
- 99% (206/208) would recommend it to a colleague

Conclusions

The educational consortia and postgraduate deans jointly developed this quality-assured regional educational programme in generic knowledge, skills and attitudes, for recently qualified health-care workers. Evaluation of the programme to date has demonstrated that it enhances learning about clinical governance, improves attitudes towards team working and is believed by participants to contribute to improved patient care.

Since April 2001, the North Thames Deanery has been incorporated into the London Deanery and five new London Regional Workforce Development Confederations have been established. A new steering group has been convened to take this work forward to ensure that the workforce within the London region has access to these programmes. Interest from at least one medical school in London suggests that there may also be scope to consider such a programme at the undergraduate level.

A more detailed account of the project will appear in Supplement II (volume 10, 2 November 2001) to *Quality in Health Care*, pages ii70–ii78.

Contributions

Clinical Governance Bulletin **is a publication for clinicians and managers working in trusts, health authorities and PCGs and aims to communicate practical examples, pool shared experience and highlight and disseminate best practice on a broad range of issues in health management. Topics covered include the following, with each issue taking one area as its main theme:**

- **Patient experience**
- **Clinical effectiveness**
- **Resource effectiveness**
- **Communication**
- **Risk management**
- **Effective teamwork and learning**
- **Effective strategy**
- **Clinical information**

Contributions that are practical and relevant to everyday practice are welcomed. They should be 500–800 words in length, with a maximum of five references in Vancouver (numerical) style. Please send your contribution, by post (with floppy disk) or email, to one of the Editors:

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The role of a clinical standards and monitoring team in supporting an acute trust's clinical governance strategy

Rebecca Broughton

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- Organisations need to make their programme of quality improvement explicit and communicate it widely.
- Support and facilitation need to be available if changes in clinical practice are to be sustained.
- National guidelines, such as those produced by the National Institute for Clinical Excellence (NICE), need to reach the clinical leader of the relevant clinical teams; a systematic approach to their dissemination is necessary and must be followed up by face-to-face meeting.
- Ensuring the participation of all staff in the quality programme is a challenge, particularly with junior doctors. To ensure their meaningful participation, training must be available. Practical training in clinical audit has led to a greater willingness to participate in clinical audit.

A comprehensive programme of quality improvement activities was identified as one of the main components of clinical governance for NHS trusts in the 1998 *Quality in the NHS* White Paper[1]. This programme had among its components:

- ensuring the clinical standards of National Service Frameworks (NSFs) and NICE recommendations are implemented;
- full participation in the current four national Confidential Enquiries;
- full participation by all hospital doctors in audit programmes;
- ensuring evidence-based practice is supported and applied routinely in everyday practice.

Supporting the above activities across the University Hospitals of Leicester NHS Trust (UHL) is a responsibility of the Clinical Standards and Monitoring Team (CSMT).

In order to support the requirement that all hospital doctors are involved in clinical audit, we have developed a rolling clinical audit programme at the Leicester Royal Infirmary (LRI) site for junior doctors in surgery, obstetrics and gynaecology, oncology, and paediatrics. The clinical teams and the CSMT identify audit projects for each rotation of doctors. The CSMT holds an afternoon teaching session at the beginning of each rotation of junior doctors and then provides ongoing advice and support for each project.

The teaching session takes on a very practical approach, whereby the doctors work through a mock audit project, identifying 'red herrings' in the audit methods and the analysis and presentation of the results.

The ongoing advice and support include identifying the appropriate audit sample, planning audit methods, designing data-collection forms, use of Formic (an automated scanning system), analysis of results and report writing. All the doctors are given dates for completion of their audits at the beginning of their rotation and have to give a presentation of their results. Each junior doctor will have a consultant supervisor for the audit project.

The most recent rotation of junior doctors were, in two of the directorates, involved in re-audits of work carried out by previous junior doctors. In the women's and perinatal services directorate, most of the audits have been of the recently developed and implemented clinical guidelines, for example those concerning the induction of labour and the management of deep-vein thrombosis.

Training and support are also available to other staff across UHL following a similar approach to the above. The CSMT holds daily 'open surgeries' at each site, where any member of staff can come and discuss a project and identify what help is available to support clinical audit and clinical effectiveness projects.

The type of advice may relate to statistics, designing questionnaires, confidentiality issues and the identification of audit standards, and varies from basic to sophisticated analysis.

As well as providing support for clinical audit projects, the CSMT also gives advice and practical help with the development of evidence-based guidelines and clinical standards, and provides training sessions on both.

The CSMT has also been involved in supporting the implementation of several care pathways at the LRI.

UHL is committed to the implementation of clinical standards across the trust and the monitoring of these standards. The CSMT is playing a large part in both these activities across the trust. It has also been involved in developing several clinical guidelines, particularly in women's and perinatal services. Because most guidelines involve several different clinical areas in the trust, effective liaison and communication are crucial.

Another initiative to facilitate the routine use of evidence-based practice has been the provision of computers

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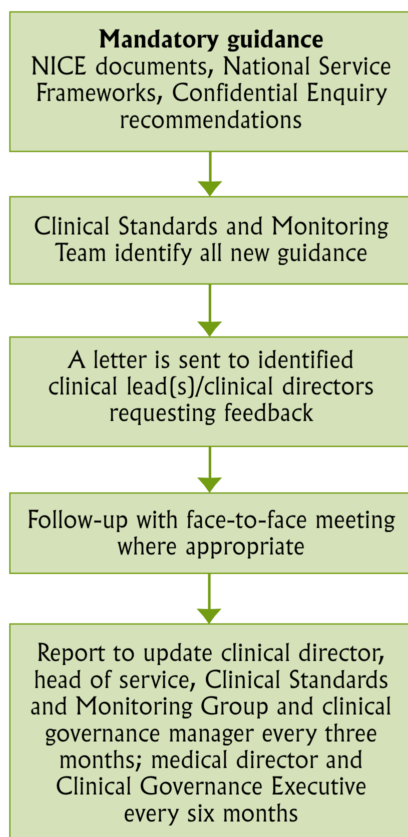


Figure 1. Flow chart showing the response to national guidance.

(with Internet access) at the LRI. These computers have been provided specifically for use by all staff for searching the literature. While we are very fortunate in having well resourced clinical libraries at each site, staff still have difficulty in finding the time to get away from the clinical area. In conjunction with the libraries, teaching sessions have been held so that staff gain confidence in using databases and generally finding 'evidence-based' clinical information through the Internet. We are also very fortunate that in the Trent Region all NHS staff have free access to Medline, Cinahl, Embase, Cochrane and Best Evidence databases through the Internet at work or from home. All these initiatives are helping to support the implementation of evidence-based practice within the trust, as demonstrated by the increasing development of evidence-based guidelines.

To support the implementation of the NSFs, NICE guidance and the recommendations of the confidential enquiries, we have developed a dissemination strategy (Figure 1).

Support from the CSMT is offered and a request is made for responses to the following questions:

- Is practice currently in line with the particular guidelines/ recommendations?
- Has a clinical audit taken place, or is one planned?
- If yes, when did it/will it begin and what was/is the time scale?
- If a change in practice is indicated, what action is planned?
- If practice is not in line with the guidance, or is not planned to be, what are the reasons for this?

This information is then fed back to the medical director and Clinical Governance Executive for the annual report.

At a recent UHL conference on clinical effectiveness, examples of how this flow chart is working were given by several clinicians and included presentations on the Coronary Heart Disease NSF, the recommendations of the Confidential Enquiry into Stillbirths and Deaths in Infancy and of the Confidential Enquiry into Maternal Deaths, and two of the NICE guidelines, namely on taxanes and wisdom teeth.

According to the *Quality in the NHS* White Paper, clinical governance will take 10 years to implement across the NHS. The majority of the work needed to implement clinical governance will be carried out by clinicians and requires the support of a clinical standards and monitoring team. That support is crucial to maintain the progress made so far and to develop current initiatives further.

Reference

1 *Quality in the NHS. A First Class Service.* London: DoH, 1998

Books of interest

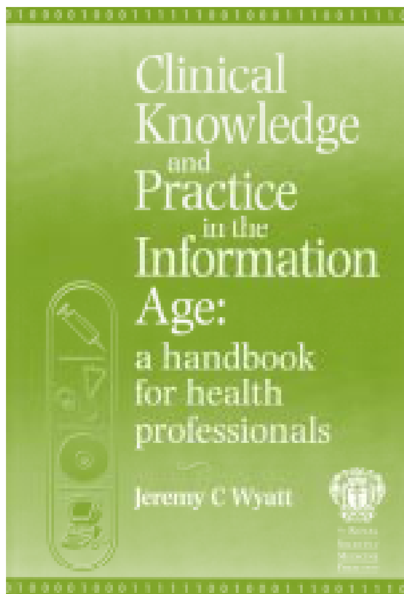
Clinical knowledge and practice in the information age: a handbook for health professionals

Jeremy C. Wyatt.
ISBN: 1-85315-483-0. pp. 93. £13.50.
London: Royal Society of Medicine Press Ltd, 2001.

Wyatt addresses clinical knowledge and clinical practice in an arena where developments in science and information technology are rapidly shifting the goalposts. He advises how best to keep up to date and informed when there are some 40,000 biomedical journals, whose number doubles every 20 years. He gives practical tips and elaborates systems and resources (for example, websites, review journals and email summary services) which will improve efficiency and effectiveness. He discusses how to make best use of libraries; how to capitalise on the expertise and learning of colleagues; how to design, implement and champion clinical guidelines; and how to develop new strategies to improve information for patients.

His book illustrates the gaps that are appearing in the traditional education and learning systems within health-care (for example, he argues that continuing medical education must work with systems which include and measure a more modern, and proven, problem-based learning approach). The gaps he finds become a base for his principal exposition – the opportunities created by the Internet and information technology. He flags the challenges which such a revolution inevitably creates – ensuring quality and validity, finding clear answers to specific questions, achieving sufficient and timely access to computers, maintaining engagement with patients while perusing screens – this is a book which sets out to raise as many questions as it answers.

Wyatt acknowledges that 'few research groups have explored techniques for managing tacit knowledge in healthcare'. There are only 'some informal networks, and a



few tools' with which to develop and share the rich mixture of experience and learning which is tacit knowledge. I would have welcomed further discussion and his insights on this aspect of learning in health-care, but, as Wyatt himself says, 'too many questions, not enough time'. In any case, he has clearly shown that if professionals pay sufficient regard to developing expertise in clinical knowledge and practice in the information age, they will discover, *a priori*, a set of skills applicable to quantifiable and non-quantifiable data which will contribute incalculable value to health-care organisations, their patients and their staff.

Susanna Nicholls
Medical Support Physician, Procter and Gamble Pharmaceuticals (UK) Ltd, Staines

Clinical governance – a practical guide for managers

Lesley Hallett and Maura Thompson. ISBN 1-903369-06-1. pp. 125. £85.00 (book and CD-Rom). London: emap Public Sector Management, 2001.

Two reviewers were invited to give their different perspectives on an important new book in the HSJ Management Academy series.

Robert Creighton

One of the more notable characteristics of the NHS is the way it spawns new terminology. Recent years have seen a plethora of novel phrases describing new initiatives. Some have turned out to be more slogan than substance, and some have proved to be short-lived. When the term 'clinical governance' made its first appearance, it may have been tempting to regard it cynically as an inspired piece of copy-writing, a grand and important concept, but more significant in the field of policy than practice. The reality, of course, has turned out to be very different. The big ideas of clinical governance are fully relevant to the realities of health-care and link directly to practical applications in the clinic and the ward. This has been well illustrated in successive issues of the *Clinical Governance Bulletin*, and now we have the publication of this handbook as a valuable guide and reference to how one 'does' clinical governance.

The book is structured around the implementation of quality-improvement projects, from the initial analysis of issues through to the assessment of the effectiveness of solutions. It offers a compendium of knowledge and tools, and refers to relevant theories and reports, addressing the key issues throughout. It fully recognises the complexity of health-care and the interlinked nature of delivery systems, both in the NHS itself and with other agencies. It rightly emphasises the cultural features that are the essence of clinical governance – for instance, openness, team working and a systems approach to quality improvement. Paramount is the importance of organisations wanting to learn and grow, and so encouraging their staff to do so too. In all this, it fully reflects current national and international thinking about change and leadership in health-care, and the text makes frequent reference to the sources of the big ideas.

The book essentially describes and comments on the approach of the NHS Clinical Governance Support Team, and therefore has the authenticity of the Team's accumulated experience. This is a great benefit, because it ensures a good supply of real-life examples and practical exercises, which intersperse the main text. There are also frequent references to further and more detailed material on the accompanying CD-Rom. Thus the book successfully avoids most of the potential dangers of empty didacticism that all such handbooks face, which should ensure that the intended audience recognises that it is grounded in reality and is able to respond positively to the lessons it seeks to teach.

Its key audience is front-line NHS managers who need to know how to apply the principles of clinical governance at local level. Included in this are managerial clinicians – heads of any kind of clinical unit – who want to improve the services they offer patients. To all such staff, this book will be a useful practical resource. There is, of course, no substitute for getting stuck in and learning from experience, and the book explicitly acknowledges this. What it does particularly well is to recognise that reality is inevitably a good deal more messy and compli-

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cated than even the best advice and prescription set out on the printed page, and it therefore aims to develop some confidence through the clarity with which it takes its readers through the processes of clinical improvement.

While the book is not particularly targeted at top-level NHS managers, it will nonetheless be useful for them as a rehearsal of the background, principles and processes of clinical governance, which are set out logically and lucidly in terms that make for relatively easy reading and quick absorption. The diet is rich, compressing a lot of material into 125 pages, and if other titles in this HSJ Management Academy Series are similar, they will be valuable across the health service.

Clare Perkins

This book and CD-Rom are intended as a companion for anyone taking part in the national clinical governance development programme, run by the National Clinical Governance Support Team, which was established in January 2000 and is now part of the NHS Modernisation Agency. It is also intended to be used by anyone who wants to develop their understanding of clinical governance.

The content of the five learning days of the nine-month national clinical governance development programme are covered within the five chapters of the book. The national programme uses the RAID (review, agree, implement, develop/demonstrate) model, a hybrid of a wide range of quality-improvement models, to enable clinical teams to bring about sustained quality improvement.

This guide enhances the current body of literature on clinical governance and will be of value to its intended audience. It may also be of value to those organising professional educational programmes locally. I was sceptical of yet another text on the subject of clinical governance that outlines the theory but is of little practical use to those trying to develop clinical governance arrangements in their clinical teams. However, I was encouraged to discover that the book and CD-Rom do provide a 'practical' guide and bring together a wide range of material into a useful resource for those implementing clinical governance.

The concept of clinical governance was introduced into the NHS with the government's 1997 White Paper *The New NHS: Modern, Dependable*. Its essence is the creation of an environment in which systematic continuous improvement and quality assurance can take place at all levels and across all areas of the NHS. This requires organisations to develop a culture that actively encourages learning, effective leadership, management and team working. Those who have been charged with the difficult and demanding task of implementing clinical governance are all too familiar with the problems of implementation and managing the process of change. This book does not skim over these challenging issues or treat them in an academic fashion, but raises and discusses them in turn, offering the reader a combination of theory and practical tools, such as the use of Gantt charts for project management, and the Myers–Briggs test for individual/team development. Important learning points are illustrated and reinforced through anecdotes and examples of case histories. There are a number of 'activities' given throughout the text to stimulate discussion, although these are probably of not much value outside a structured group-learning environment.

The guide to implementing clinical governance is comprehensive in its scope and avoids lengthy discussion of the individual components, 'the pillars' of clinical governance. It encourages readers to think widely about the practicalities and barriers to the implementation of clinical governance and directs them to other resources for further exploration.

I found the book to be well structured and easy to read; symbols, such as 'see anecdote' or 'link to Internet site', guide the reader to different parts of the text or CD-Rom. The text is not reliant on readers having access to or the ability to use the CD-Rom, which contains additional useful Internet links, the complete course materials and a listing of relevant literature.

It was interesting to note the feedback from a course delegate quoted on the inside cover of the CD-Rom: 'Down to earth, jargon free. Excellent content and presentation. Good fun and good pace. Set alight my thinking. I knew it, just didn't realise I knew it'. Most of this feedback could well refer to the guide too. My only slight criticism is that the book does have a tendency to slip into jargon on occasion, and this might be off-putting for some readers.

In summary, I would recommend that this practical guide be included as a clinical governance text on any reading list for managers and clinicians in the NHS. However, what the individual reader will not find in the book is the board-level and team support essential for the effective implementation of clinical governance.

Subscriptions and enquiries

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