CLINICAL GOVERNANCE Bulletin

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Editorial: Clinical governance – rhetoric or reality?

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It is now five years since the introduction of the concept of clinical governance in the government white paper *The New NHS: Modern, Dependable*[1]. Quality should now be embedded in the culture of every health-care organisation. This should be evidenced by the systems and processes of clinical governance, which themselves should deliver, in a timely and comprehensive fashion, information which represents explicit, clinically robust measures of quality throughout each organisation.

So to what extent have health-care organisations managed to make clinical governance a reality? Apart from the clinical governance reviews undertaken by the Commission for Health Improvement (CHI), there is little analysis of the implementation of clinical governance in the NHS, as the original baseline assessments are not in the public domain. From what is available, it appears that substantial variation between institutions is commonplace. Health-care organisations must be able to confirm not only that they have robust systems underpinning each of the components of clinical governance, but also that there is consistency and integrity throughout the organisation, resulting in a reproducible picture of the quality of care. This overall culture of quality should be identifiable, via these measurements, to patients. Finally, health-care organisations must use this information to identify where and how improvements can be made.

There are currently over 130 clinical governance review reports on the CHI website[2] – the majority of which are of acute trusts. A random selection of 22 reports published since June 2002 has been examined to try to identify where organisations are at. Two elements of clinical governance were looked at in detail– patient and public involvement, and the use of clinical information – as they still appear to be a challenge.

There is no doubt that there is strong commitment to clinical governance within the NHS and a genuine desire to improve the quality of patient care. The involvement of patients and carers in the process is, however, still in its infancy; while there are many areas of good practice, patients and their carers do not always have the opportunity to be involved in planning and shaping service development, to contribute to the formulation of policies, or to participate in clinical audit, and so on. For many organisations, there is still a need to develop a coordinated approach to the involvement of patients, carers and the public in

Topics for future issues

- Patient involvement
- Guidelines
- Clinical networks

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In this issue

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planning and monitoring services; organisations should draw on the experience of those trusts that have successfully begun this process. Examples of notable practice include patient focus groups for specific conditions, semi-structured interviews to elicit the patient experience of hospital care, patients' involvement in the design of specific services, patient-held records, multi-agency patient and public open days to raise awareness among the local population, and support groups for patients with specific conditions. Patient involvement will be the subject for a future issue of the *Clinical Governance Bulletin*.

The use of and access to clinical information to monitor clinical and organisational practice appear also to be a challenge for many organisations, as is progress in the implementation of the Caldicott requirements[3]. While the NHS is actively pursuing the implementation of the electronic patient record, attention needs to be given to using what is available now, and making it available to clinical teams. Indicators are of use only if they are actually used to improve clinical performance[4]. Relevant information is also not always either accessible or understandable to patients, and few organisations have to date managed to establish an information network across the primary–secondary care interface. Examples of good practice in the use of information do exist, such as an integrated information system providing useful data to support quality improvement, an information technology system supporting the patient advice and liaison service, and the production of individual anonymised patient data as feedback on performance. There is, however, still a long way to go to a cohesive approach to the use of information and to the systematic involvement of relevant stakeholders in determining what information needs to be used to assess the patient experience so that meaningful clinical indicators can be developed.

Progress seems to have been made since the introduction of the concept of clinical governance if one looks at the scoring given by CHI to organisations for the different components of clinical governance, although no comparative information is available. However, this progress is not systematic and not consistent across the NHS; organisations do well in some aspects and not in others; the integration of quality systems still has some way to go. Organisational culture is the single most important factor in predicting the quality of the institution but a tool to measure 'culture' does not yet exist.

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The implementation of clinical governance needs to be evolutionary, consistent and sustainable; it also requires a 'just' culture at all levels. There needs to be an integrated approach to quality; quality requirements and the patient perspective need to be taken into consideration in all day-to-day activities, whether the work be on waiting lists, service reviews, outpatient scheduling or meeting NHS targets, for example. This is the rhetoric that needs to become a reality. Only then will clinical governance progress at a more consistent pace.

In this issue of the *Bulletin* we cover issues such as training needs analysis for clinical governance and a risk assessment strategy for falls in the elderly. Future issues will cover patient involvement and guidelines but contributions on all aspects of clinical governance are welcome. Please share your practical experience with the wider NHS so that the lessons you have learnt can benefit others. I look forward to receiving your contribution.

References

1 *The New NHS. Modern, Dependable*. London: Stationery Office, 1997
2 www.chi@nhs.uk
3 NHS Executive. *Protecting and Using Patient Information. A Manual for Caldicott Guardians* (HSC 1999/012). Leeds: NHS Executive, 1999. Updated in 2000 to incorporate new guidance
4 Hittinger R. Using clinical performance indicators to achieve clinical governance. *Clinical Governance Bulletin* 2002;3:4

Implementing a fall risk assessment strategy for older people: issues and outcomes

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- The distribution of older people who are at risk of falls is not uniform across care settings.
- Organisations need a strategic approach to the support of clinicians managing the risk of falls.
- A valid and reliable tool for the assessment of the risk of falls plays a key part in identifying individual risk.
- Aggregated fall risk data can be used to identify those clinical teams that are caring for a patient group with a high proportion at risk of falling, and thus facilitate appropriate targeting of resources.

Background

The incidence of older people falling is a growing problem that is highlighted in the recent National Service Framework for Older People[1]. In a hospital environment, the main burden of preventing and

managing falls on a daily basis is placed on the nursing staff. The reasons underlying older people falling are complex and may have a physiological, behavioural or environmental component. Often these factors may be interrelated, which makes planning interventions difficult.

The clinical assessment of fall risk needs to be augmented by an organisational strategy which can help to identify those clinical settings in which larger proportions of patients are at high fall risk. Clearly, those settings which carry the greater risk should be provided with more fall management resources. The routine collection and feedback of audit data can support this process, and so enable clinicians to make evidence-based decisions about the level of care that is provided.

Community Health Sheffield NHS Trust offers a range of services for older people. The Services for Older People and Rehabilitation Division provides services in four settings: inpatient dementia, inpatient non-dementia, day hospital dementia and day hospital non-dementia. Of all untoward incidents reported in this Division, falls and 'found on floor' are by far the most common. At the outset of this project, it was not known how clinical teams responded to the issue of older people falling. Therefore, it was decided to carry out an investigation to identify methods of fall risk assessment and the interventions employed.

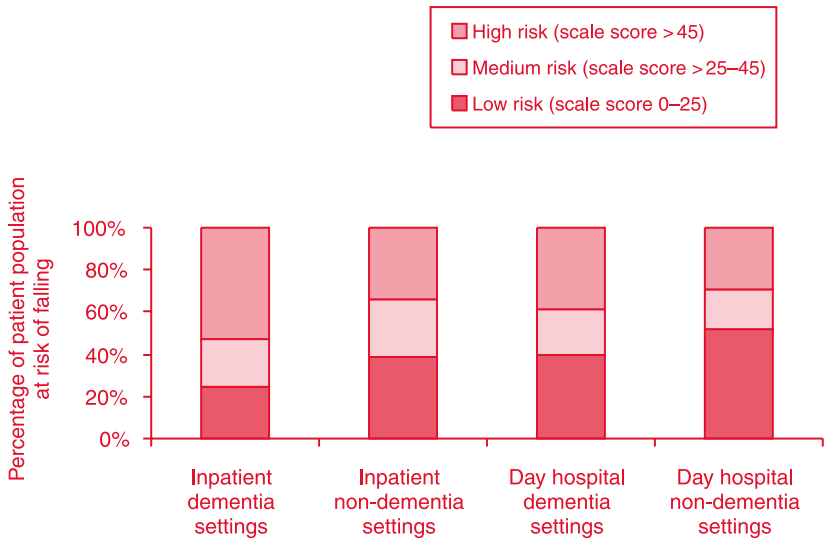

Figure 1. Baseline aggregated risk profile for the Services for Older People and Rehabilitation Division, as assessed using the Morse Fall Scale, April 2000.

Method

Stage 1: pre-audit

We carried out a pre-audit survey of current practice in relation to the assessment of fall risk. Fall assessments in use appeared not to be evidence based, and their validity and reliability were questionable. Following discussion with clinical nurses and managers, we proposed to introduce a more valid and reliable assessment of fall risk.

Stage 2: selecting a tool for the assessment of fall risk

An appropriate risk assessment tool was selected from the literature. The Morse Fall Scale[2] has been evaluated in surgical and acute medical settings, and has been validated in a geriatric setting[3]. Although the scale has not been validated in a dementia setting, it has, however, three major benefits that made it a pragmatic choice.

- *Ease of use*. It has been reported by those familiar with the scale that it can be completed in under 1 minute[4].
- *Relevance*. It was considered that the medical settings in which the scale had been validated were broadly comparable with older-adult clinical settings within our Trust when compared on the basis of age, gender and likelihood of physical co-morbidity.
- *Rigour*. The research methodology was well developed and the methods of implementation were clear.

Stage 3: implementing use of the Morse Fall Scale

The named nurses in each clinical setting were asked to assess each of their patients using the Morse Fall Scale. Fall risk data were then aggregated to provide fall risk profiles for each clinical setting. This identified those clinical areas where nurses were caring for patients at a high risk of falling. The issue of what constitutes 'high risk' on the scale is addressed through the process known as calibration.

Stage 4: calibration of the scale in each setting

Morse recommends that cut-off scores for high, medium and low risk be individually set for each unit/ward. These scores can be adjusted depending on the incidence of falls on each unit. Eventually each unit should arrive at cut-off scores that allow it to protect its patients at risk, while not being over-restrictive with those patients at less risk. Scores on the scale are used in conjunction with, but should not take precedence over, individual clinical judgement about the point at which risk reduction measures are used. General managers were involved in the debate about calibration in their setting. This was because managers had to be satisfied with the level of risk the *organisation* was taking by not providing risk reduction interventions for all patients.

Results

- Wards varied in the percentage of patients at high risk of falling. High fall risk was identified in dementia inpatient settings. Fall risk profiles for the four key settings in our Division are displayed in Figure 1. In order to enable a comparison of the *aggregate* fall risk in the four major patient settings in the Division, baseline high-, medium- and low-risk cut-off scores were identified from the literature[3].
- Fall management equipment was found to be distributed on an ad hoc basis across settings.

Implications and lessons learned

- A sum of money (£20,000) was identified to enable the purchase of fall management equipment (hip

guards, bed alarms, etc.). This has been targeted at inpatient dementia settings.
- Clinical staff have recognised the advantage of being able to present locally derived audit data in support of requests for additional resources.

Discussion

As a consequence of audit activity in relation to falls, 'falls management' now enjoys a far higher profile within our organisation, and previously held opinions about the inevitability of older people falling and being injured have been challenged. In our Trust, clinical nurses feel empowered by being able to influence decisions about resource allocation, which affects their everyday work.

References

1 *National Service Framework for Older People*. London: Department of Health, 2001
2 Morse JM, Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. *Canadian Journal on Aging* 1989;**8**:366–77
3 Morse JM. *Preventing Patient Falls*. Thousand Oaks: Sage, 1997
4 McCollam M. Evaluation and implementation of a research-based falls assessment innovation. *Nursing Clinics of North America* 1995;**30**:507–14

Supporting the development of a strategic approach to effective services: a framework for directorates

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- The development of an 'effective services agenda' has enabled us to coordinate research and development, clinical effectiveness and audit, evidence-based practice, user involvement in evaluating services and ensuring appropriate responses to national guidance papers and reports, such as guidance from the National Institute for Clinical Excellence.
- This effective services agenda is an integral part of our clinical governance strategy.
- We have developed a template for directorates to use to implement the agenda.
- The directorates have the support of the Effective Services Department in the development and implementation of their plans.

The 'effective services agenda' of the Wolverhampton City Primary Care Trust encompasses research and development, clinical effectiveness and audit, evidence-based practice, user involvement in evaluating services and ensuring appropriate responses to national guidance papers and reports, such as guidance from the National Institute for Clinical Excellence (NICE). It is an integral part of the Trust's clinical governance strategy.

The need for a programme template

There is a danger that the separate elements of the effective services agenda may become detached from the strategic development of healthcare. The potential downfalls are many and diverse:

- Clinical audits may not be linked to known national or local priorities.
- Their findings may not be acted upon.
- People's interests or abilities may not be best matched to project and strategic needs.
- Projects may not have agreed deadlines and slip to the point of non-existence.
- Research questions arising from audits are often not linked to the research agenda, and vice versa.
- Research programmes may fail to link to the strategic development of services.
- Recommendations from national guidance papers may not be implemented and subsequently monitored across service areas.

To help overcome such possible weaknesses, we have a 'programme template' to facilitate a strategic, relevant approach to planning and undertaking effective services activity. The template (Table 1) and the process for its implementation have been agreed by the Trust's Clinical Governance Board.

The planning process

Within clinical directorates, multidisciplinary groups complete the plan in line with the cycle of the financial year. The prompts in the template (Table 1) for the plan require that the group clearly defines the project and why it is seen as important. The rationale for the project can be based upon local or national priorities, and immediate service improvement is not seen as the only consideration. Activity planning should also support innovation, long-term developments and interests. It is, however, important that the group can identify and justify an outcome for each project. New projects can be added during the course of the year but they need to be completed in terms of the template – which ought to prevent

Table 1. The planning template for developing a strategic approach to the effective services agenda

Action	Rationale and expected outcomes	Person/people responsible	Deadline	Progress/outcome (to be completed later in the year)
List each project that will be undertaken	List why each project is being undertaken, how it links to priorities and what the expected outcomes of the project will be	List who will be the lead person/people responsible for each project	What is the deadline for for completing each project?	Monitor the progress of of each project during the year

distraction from issues that seem pressing in the heat of the moment but which, upon deeper reflection, cannot be given more justification.

Having agreed the strategic projects, directorates identify appropriate leads for each. Multidisciplinary working, part of the ethos of the Trust, is sought in the projects of the plan. Multi-agency working is equally encouraged. We also prefer for projects to reflect the nature of service delivery by being 'patient/user-centred'.

Including a deadline and providing space for monitoring the progress of projects within the template is a means of ensuring that projects do not slip and disappear. This is overseen by the directorate but is reported through the Trust's clinical governance structure.

A covering note sets out the rationale behind the template as well as the process for developing plans, and gives mock examples of possible projects. Each directorate has the support of the Effective Services Department (which has expertise in research, clinical audit, etc.) in the planning process and its subsequent implementation.

Once a draft plan has been formulated, it is initially agreed by the directorate's general manager and clinical director. Plans are then considered by the Trust's Effective Services Steering Group and reported to the Clinical Governance Board. At any stage, the plans can be referred back for clarification and/or amendment.

Desirable outcomes

Having these plans has helped to raise awareness of the importance and potential of effective services activity in improving the quality of care. We have been able to develop a more coherent, strategic view of the effective services agenda across the Trust. In addition, setting out a clear list of activity appears to have acted as a catalyst for encouraging more projects in each directorate. The plans have also helped directorates to clarify links across their activities, quality improvement and the whole clinical governance agenda.

The organisational support given to the process has been crucial. The resources for facilitation and the authority of senior clinicians and managers have paid dividends and will continue to do so. We are currently working to use the plans to develop more strategic links across directorates and with partner organisations.

Developing a systematic reporting template has helped to pull together information and activity that were often dispersed and frequently only 'in heads'. Trying to plan coordinated activity then becomes difficult, and if individuals with key information leave the organisation the information is most likely lost. With these plans, project continuity and positive outcomes are more likely to be achieved even if personnel change.

Training needs analysis for clinical governance: a practical example

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- To deliver high-quality care in line with the principles of clinical governance, health-care professionals must have certain core competencies.
- In order to develop an effective training programme, health-care professionals engaged in direct patient care should be asked what competencies they need.
- A useful framework for identifying training needs groups skills into four distinct domains: interpersonal; technical; professional accountability and development; and clinical care delivery.
- Using this framework with a representative sample of clinicians can be an effective way in which to identify the core skills required to deliver quality care, to highlight gaps in current training provision and to develop competency-based training to fill these gaps.

Background

Clinical governance promotes continuing professional development (CPD) for all health-care

professionals to ensure that they have the competencies (skills, knowledge, attitudes and behaviours) required to deliver high-quality care[1].

Wakefield and Pontefract Community Health NHS Trust always invested heavily in the training and development of its health-care professionals. Successive 'Investors in People' awards and year-on-year results from the annual staff opinion survey attested to the excellence of the training and development opportunities available. Despite this, the Trust was keen to ensure training met the needs of the clinical governance agenda and that the training programme adequately reflected the needs of health-care professionals engaged in direct patient care.

These aims, together with the concern that, despite the annual training needs analysis process, training was delivered very much via a 'top down' approach, initiated a project (Figure 1) to discover the core skills required to deliver high-quality care from different perspectives. The Trust's Quality Evaluation and Development (QED) Department undertook the project.

Core, priority and specialist skills

An extensive review of both local and national work on clinical competencies suggested that the core skills required by clinicians could be grouped into four skill domains:

- interpersonal
- technical
- professional accountability and development
- clinical care delivery

This framework was used with a representative sample of qualified

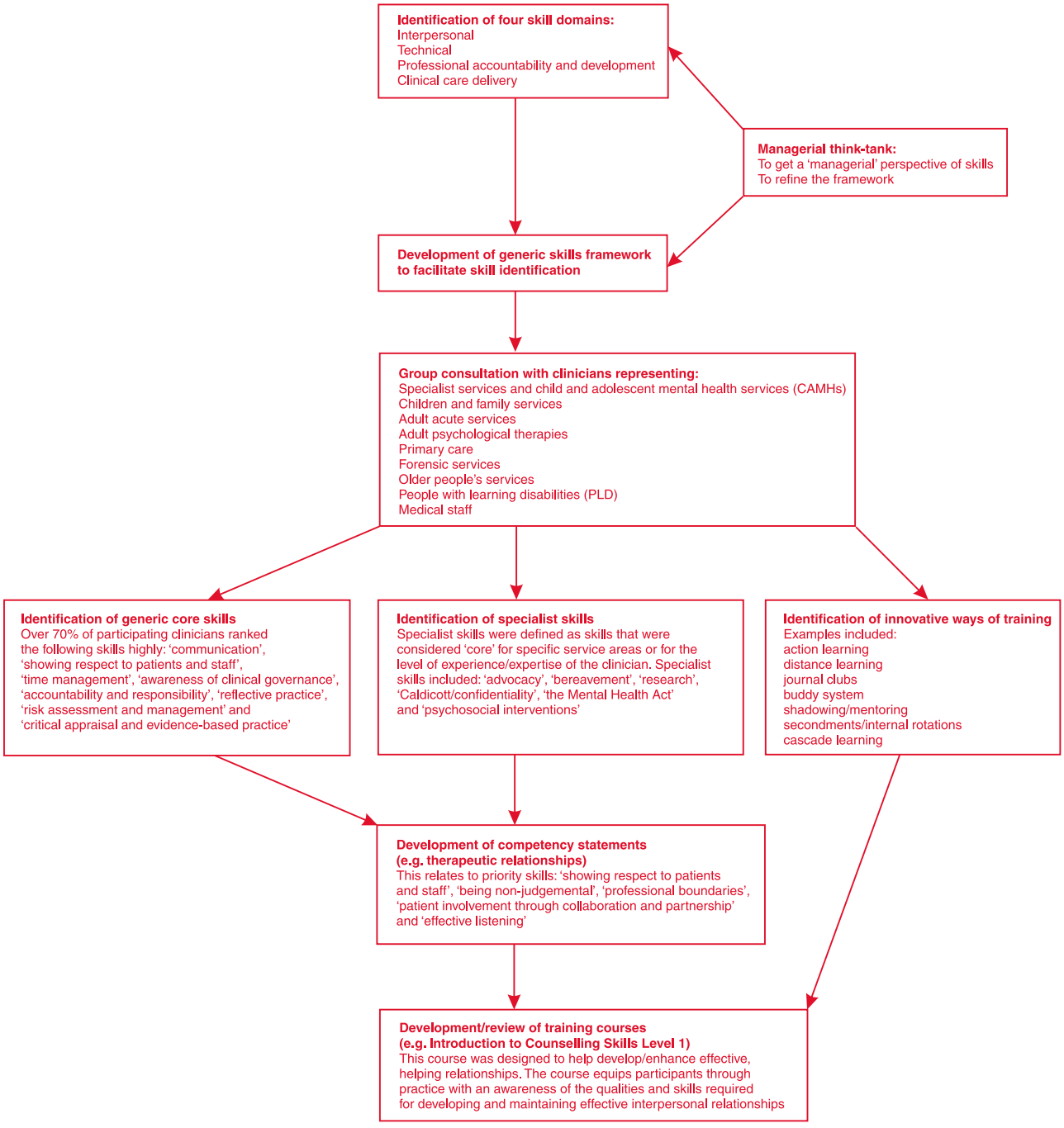

Figure 1. Summary of the process.

Table 1. Therapeutic relationships: one example of how priority skills were translated into competency statements with associated performance criteria

Competency statement	Performance criteria
Engages in, develops and disengages from therapeutic relationships through the use of appropriate communication and interpersonal skills Practices in a fair and antidiscriminatory way, acknowledging differences in beliefs and cultural practices Involves service users and carers in developing their individual care programmes or packages	Utilises a range of effective and appropriate communication and engagement skills, such as effective listening Maintains and, where appropriate, disengages from professional caring relationships, which focus on meeting the patient's or client's needs within professional therapeutic boundaries Maintains, supports and acknowledges the rights of individuals or groups in the health-care setting Acts to ensure that the rights of individuals and groups are not compromised Respects values, customs and beliefs of individuals and groups Provides care that demonstrates sensitivity to the diversity of patients and clients Contributes to the development of culturally sensitive packages of health-care

clinicians who were engaged in direct patient care and who spent at least 50% of their time in clinical practice.

Participating clinicians were asked to consider the need for training around the skills listed in the framework, from both an individual and a service perspective, and then to rank the skills in order of priority. Analysis of these rankings identified the priority skills for individual clinicians and services. Facilitated group discussion produced a consensus view of the high-, medium- and low-priority skills required across all Trust services. Specialist skills (skills that were essential for specific services or for specific levels of responsibility) were also identified. The final task of the group discussions was to brainstorm innovative ways of training in the future.

From skills to competencies to training

Clinical competency is defined as having the skills, knowledge, attitude and behaviours required to deliver quality care. A small representative group of clinicians, managers and developmental staff, all of whom had a keen interest in the development of competencies, was formed to translate the priority skills identified into competency statements with associated performance criteria (see Table 1 for an example). All the competency statements and their associated performance criteria were critically examined with reference to the literature[2] to ensure their relevance and applicability to practice.

The current training programme was then reviewed to ensure that the courses provided addressed the competencies identified. Existing course programmes were modified and new courses were subsequently developed. For example, the Introduction to Counselling Skills Level 1 course was developed in response to the need for staff to demonstrate competencies around therapeutic relationships.

Discussion

A wealth of information about core and specialist skills was obtained and it was encouraging to note that the skills identified fully supported the values and principles of the Trust. The 'bottom up' approach was valued by clinicians, ensured the relevance of the training subsequently developed, and determined the need for training in key areas. Effective training to support the delivery of high-quality patient care will be achieved only by addressing the competencies required by clinical staff, from their perspective.

Despite some acknowledged limitations, the method proved highly effective at identifying the core generic skills required across all clinical areas, at highlighting gaps in current training provision and in developing competency-based training to meet these gaps. The method could readily be used in other organisations. Service users' and carers' perspectives could also be taken into account in the future.

Further developments

The next steps are:

- to develop a self-assessment and feedback tool for staff and managers to identify training needs
- to develop competency-based job descriptions
- to review the staff appraisal and CPD systems, including the documentation and the training available for appraisers
- to provide a framework within the performance management and training needs analysis processes that will ensure the identification of the core skills required to deliver quality care, on an annual basis
- to use the method to identify the training needs of unqualified clinicians and of our service users' and carers' groups.

References

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

2 Northern Centre for Mental Health, Northern and Yorkshire Regional Education and Workforce Development Sub-group for Mental Health. *A Competence-Based 'Exit Profile' for Pre-registration Mental Health Nursing*. Durham: Northern Centre for Mental Health, 2000

WhoWhatWhere?

Clinical governance on the web

Clinical Governance Research and Development Unit (CGRDU)
http://www.le.ac.uk/cgrdu

Commission for Health Improvement
http://www.chi.nhs.uk/

European Society of Quality in Healthcare
http://www.esqh.net/

Institute of Healthcare Management
http://www.ihm.org.uk

National Institute for Clinical Excellence
http://www.nice.org.uk

The Audit Commission
http://www.audit-commission.gov.uk

UCL Clinical Risk Unit
http://www.patientsafety.ucl.ac.uk

The Wisdom Centre
http://www.wisdomnet.co.uk/default.asp

The Editor's Choice

Clinical Governance Support Team (CGST)

http://www.cgsupport.org/

The CGST has three main aims: to support the development of clinical governance in the NHS; to raise the profile of and provide information about clinical governance; and to create, capture and spread ideas and good practice in clinical governance.

Contributions

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