Clinical governance: principles into practice

There are no simple recipes for clinical governance – good quality care depends on patient, professional and organizational development (Figure 2.1). Efforts to improve care that concentrate on one aspect of development to the neglect of others will underachieve. Similarly there are no easy to assemble models of clinical governance; however, this chapter describes one possible model of clinical governance and attempts to provide some practical guidance on what might help and might hinder its introduction and development. The following areas are covered:

- Structure of clinical governance in an organization and roles of individuals
- Underlying principles of clinical governance
- Quality improvement programmes.

Fig. 2.1 The roots of quality care in health organizations.
Clinical governance places a statutory responsibility for ensuring quality health care on the chief executives of hospitals and primary care trusts. Previously they have only been judged on how they balance the books. Clinical governance puts the emphasis back on the real priority – patient care. So now the chief executive carries ultimate responsibility for assuring quality in his or her organization, and may be the one in court if things go wrong – a powerful incentive for preventative action.

One of the first tasks for chief executives is the establishment of a sub-committee of the Trust Board to oversee clinical governance in the Trust. Previously the main Board subcommittee was for financial audit, again giving the wrong signals about what was most important in the health service. The Board subcommittee is important as it promotes involvement of non-executive directors – these are representatives of the local community who are independent of the Trust and therefore have a key role in overseeing quality within the organization and acting as a ‘safe pair of ears’. Their role is to probe and challenge standards of care in the organization as well as motivate and encourage high standards.

The Board subcommittee roles include:

- giving strategic direction and support for clinical governance arrangements in the Trust
- ensuring effective integration with other Trust priorities
- providing a supportive and objective forum for discussion on potentially sensitive and confidential issues of performance within the Trust
- approving clinical governance development plans and receiving regular reports of action plans to ensure that progress is being made
- receiving and reviewing the annual reports on clinical governance from clinical departments in the Trust and providing an independent forum for discussion and review of these reports
- reviewing the effectiveness of response to recommendations from external auditors and assessors, notably the Commission for Health Audit and Inspection.

Membership should include the chief executive, non-executive directors and senior clinicians.

The involvement and commitment of the chief executive sends an important signal to clinical staff about how seriously the hospital or primary care trust takes quality. However, clinical governance is about clinical practice and so it must be led by a clinician. In many hospitals the clinical governance lead tends to be the medical director, but it can be the chief nurse or other senior clinician. The clinical governance lead is responsible for co-ordinating and monitoring arrangements, supporting departmental clinical governance leads and reviewing their progress against objectives. They will form a multidisciplinary team of clinicians to:

- Monitor and promote the ongoing development of clinical governance within the Trust.
• Ensure multidisciplinary working in addressing the clinical governance agenda.
• Co-ordinate and prioritize support for clinical governance leads and departments.
• Review external guidance and identify required action.
• Develop strategies for monitoring performance and assessing progress.

Whereas the subcommittee of the board is responsible for the more strategic development of clinical governance, this clinical governance steering or monitoring group will be responsible for the day-to-day development and support for clinical governance in departments. Membership should include representatives of departmental clinical governance leads (perhaps on a rotating or rolling annual basis to encourage ownership and new ideas), the organizational leads for education, risk management and information services.

The leadership provided by the chief executive, clinical governance lead and the clinical governance committee is an essential component of the development of clinical governance. Rather than the old-fashioned transactional type of leadership – which relied on hierarchical systems and structures, and reactive organizing and planning – transformational leadership should be the norm. This emphasizes empowerment of staff – leading people to lead themselves – with vision, inspiration and energy rather than authority and control.

An example of a structure for clinical governance in a hospital is shown in Figure 2.2, with the important internal and external influences. In primary
care trusts, the more fragmented nature of geographically and historically isolated practices creates different problems. Figure 2.3 illustrates the complexity of the relationships between individuals and organizations that can exist in developing a structure for quality improvement in a primary care trust.

**Department or practice**

No amount of committees is going to make clinical governance happen in practice without the real involvement of clinicians on the ward or in the clinic. While the board subcommittee and steering/monitoring group can provide direction and support, it is up to individual departments to deliver the best care for patients. Each department or practice should have a specified *clinical governance lead*. The roles and responsibilities of this lead include:

- Assessing the capability and capacity within the department.
- Identifying weaknesses and deficits in current services.
- Ensuring integration of different quality initiatives and systems within the department (see Box 2.1).
- Producing the annual departmental development plan linked to specific objectives.
- Organizing and chairing departmental meetings.
- Ensuring effective communication and dissemination of information about clinical governance activities both within and between departments.
- Promoting wide multidisciplinary involvement and identifying training and development needs of staff.

**Box 2.1  Examples of clinical governance activities**

<table>
<thead>
<tr>
<th>Department</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Gastroenterology | - Rolling audit programme of management of patients with GI bleeding, undergoing colonoscopy and having TPN  
                    - Evidence-based guidelines for endoscopy and upper GI cancers developed and implemented in primary care  
                    - Risk incidents agreed, collated and fed back on a monthly basis |
| Surgery          | - Establishment of POSSUM scoring system to assess outcomes to co-morbidity of patients  
                    - Regular view of all CEPOD deaths and lessons discussed  
                    - Patient focus groups run and user representatives identified for cancer groups |
| Paediatrics      | - Education workshops and ongoing audit about drug errors  
                    - Learning points from complaints with regular review  
                    - Care pathways developed for common admissions  
                    - Audit of communication and subsequent training programme |
| Obstetrics and gynaecology | - Benchmarking of audit standards with regional hospitals  
                                - Review and improvement of patient information with Internet access  
                                - Systematic approach to CPD and staff development initiated  
                                - Clearer consent guidance for junior staff |
Regular meetings of all the departmental clinical governance leads can provide a forum for sharing lessons and improving inter-departmental communication. These meetings can also be used for training and development as regards particular topics.

Fig. 2.3 The PCT structure for quality improvement.
Many doctors are cynical about imposed change. The NHS is governed by too many unwritten rules that encourage the status quo (Box 2.2). New ideas about organizational change (such as NHS reforms) or quality improvement (such as clinical audit) have often fallen upon stony ground. However, few health professionals would disagree with the core aim of clinical governance in raising the quality of health care for patients. This is something we all want and something we all know can be improved both in our own clinical practice and that of our colleagues.

Rather than concentrating on how we can ignore the ideas behind clinical governance, we should welcome the opportunity to reduce unacceptable variations in clinical practice, improve quality and attempt to pull together the disparate strands of quality improvement (education, audit, risk management, evidence-based practice, guidelines) and connect the results of these to the planning of future services. The vast majority of doctors genuinely strive to deliver high quality services, and many health professionals have been ‘doing’ clinical governance for years, albeit in a rather fragmented, haphazard and introspective manner. Clinical governance is an evolutionary development rather than a revolutionary change. Its challenge is for clinicians to be more systematic and open about their quality assurance and harness the energy of the organization to support them.

The Institute of Medicine in the USA has proposed 10 basic rules for changing health services and improving quality of care for patients \(^4\) (Box 2.3). For clinical governance to support the application of these rules, a few underlying principles must be in place: clinical governance should be mainstream; there should be effective teamwork and leadership; collaboration and partnership are pre-requisites; monitoring of progress should be routine and available resources must be used to maximum effect.

**Box 2.2 Unwritten rules in the NHS**

- We know best
- My own work has no effect on other areas of the NHS
- Clinicians don’t need managers
- The more senior you are the more you know!
- Don’t admit to mistakes
- Even though we talk about quality we only assess on the quantity
- But I’ve always done it this way
- There are no rewards for doing well
- Everyone understands the jargon
- It is wrong to seek answers/consult others
- Don’t fix it if it’s not bust
- Doctors’ time is more valuable than nurses’
- Nothing ever changes
- Everything is changing all the time
- The past was much better

Clinical governance must be part of the main business of health care organizations. The principles of improving the quality of services and providing excellence in clinical care are not optional add-ons. It should be integral to everyday clinical practice for all health professionals. Care should be taken that clinical governance does not become a whole new bureaucracy or sidelined as a discrete activity for a few nominated clinical leads as clinical audit has been in the past. It should become a standing item on all future board, management, policy and divisional meetings rather than exist in a parallel universe. Governance should be as central to Drugs and Therapeutics Committees (through evidence-based decision making and effective

---

**Box 2.3 Basic rules for changing health services and improving quality of care**

1. **Care based on continuous healing relationships.** Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

2. **Customization based on patient needs and values.** The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

3. **The patient as the source of control.** Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.

4. **Shared knowledge and the free flow of information.** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

5. **Evidence-based decision making.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

6. **Safety as a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. **The need for transparency.** The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital or clinical practice, or choosing among alternative treatments. This should include information describing the system’s performance on safety, evidence-based practice and patient satisfaction.

8. **Anticipation of needs.** The health system should anticipate patient needs, rather than simply reacting to events.

9. **Continuous decrease in waste.** The health system should not waste resources or patient time.

10. **Co-operation among clinicians.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and co-ordination of care.

(Adapted from: Institute of Medicine Crossing the Quality Chasm. Washington: National Academy Press, 2001.)
monitoring of safe prescribing), or to local Continuing Professional Development groups (through ensuring educational approaches to address quality issues), as it is to audit or quality assurance groups.

Clinical governance is the responsibility of clinicians; however, strong leadership, commitment and direction are needed from senior managers. They will need to ensure that the outcomes of clinical governance effect required change in the planning and development of the organization. Clinical governance should provide the opportunity to reflect on the quality of the organization as well as individual clinicians, and organizational audits such as Investors in People can provide useful standards.

**WORK AS TEAMS**

One of the problems of audit was that it began as a medical activity and later attempts to tag on multidisciplinary involvement were often unsuccessful. Clinical governance must be a truly multidisciplinary activity. This is not because of political correctness, but because we no longer work as isolated or omniscient individuals. The quality of care a patient receives depends on the care of a whole chain of people, and doctors are just one link in that chain. It is often other health professionals in the chain who are in the best position to identify and correct poor practice, although they have no forum to discuss how improvements can be made.

As the General Medical Council has stressed in their guide on good medical practice, good teamwork is a prerequisite for good medical practice and attention should be paid to how to achieve this. It provides the foundation for reducing inconsistent practice (‘He’s Dr Jones’ patient so we have a different protocol’) and for increasing systematic professional development. Teams may exist within departments, such as urology or obstetrics, or may more naturally form between specialties such as Calman cancer groups. However, general medical or surgical responsibilities may lead to joint commitments for delivering the objectives of clinical governance.

Multidisciplinary collaboration within a team is important, but interdisciplinary collaboration between teams should also be promoted. Different clinical teams treating the same clinical conditions or the same patients can exist in different compartments, with little communication and considerable variation in practice. In hospitals, nursing staff who accompany medical staff on their separate ward rounds will testify to the problems of juggling different decisions made on the same patient. Often neglected groups such as out-of-hours staff should be involved.

**DEVELOP EFFECTIVE LEADERSHIP**

Joint medical and nursing clinical governance leads should be established to promote a multidisciplinary approach. The clinical governance leads for each department or team must be people who have the confidence of their colleagues and the leadership potential to provide direction and encourage
effective change. The leads will be responsible for organizing and chairing meetings, setting agendas, ensuring attendance and reporting back to the main clinical governance group. They should be encouraged to develop formal (learning sets, peer review groups) or informal links with colleagues in other hospitals or primary care groups to share ideas and promote development. Good leaders will challenge the status quo and provide direction for improving systems of care.

Although there will be a natural tendency to reflect medical dominance in the composition of clinical governance groups, responsibility should be shared within teams or departments to gain wider involvement. Different roles, such as education, audit, risk management, R&D or communication can be assigned to different clinical leads from different clinical disciplines – this encourages a portfolio approach with different staff in the department rotating between lead roles and responsibilities. This will also encourage wider ownership and understanding about quality issues.

Enthusiasm should be an essential selection criterion for these clinical governance leads. The Director of Human Resources in hospitals or primary care trusts will have an important role in supporting the training and development of new skills in leadership and facilitation. Contributions should be recognized, valued and rewarded. Incentives such as promotion, resource allocation, development funding and merit awards should be agreed. Sanctions should not be overplayed as this will alienate rather than involve people. Win the sceptics and the doubters over with successes.

**COLLABORATE**

Greater attention must be paid to encouraging closer involvement of patients and to linking primary and secondary care. Quality should be viewed from a patient’s perspective and not as separate compartments for separate destinations on the patient’s health service journey. Efforts should be made to incorporate what patients value (for example, accessibility, information and communication, interpersonal skills) as well as more technical professional values for quality of care. Patient involvement may be easier to obtain in primary care settings than secondary care where contact is often brief and irregular. Advice from general advocacy groups such as Patient Advice and Liaison Service (PALS) or Patient Forums, or specific groups such as the Stroke Association or cancer support groups may provide a starting point.

The quality of health care, whether a well-managed discharge of a patient from hospital to the required supportive environment, or the appropriateness of an emergency admission to hospital, requires excellent communication between health professionals. Communication can be strengthened through specific district meetings, such as agreeing guidelines for best practice and referral, or through more innovative steps such as developing e-mail access between general practitioners and hospital specialists to discuss individual patients.

Greater collaboration with patients and external stakeholders such as primary or secondary care trusts also provides valuable feedback on progress.
from outside the organization. It is easy for staff in a hospital or practice to become complacent and believe that everything is going swimmingly. Getting the views of service users and those outside the hospital or practice can provide a more objective and informative appraisal of standards of care inside.

**MONITOR PROGRESS**

One of the key principles behind clinical governance is that it should be a bottom-up initiative. Any authoritarian approach will not only lead to dissonance, but will be unenforceable, as trying to police so many different teams and professionals would require huge resources. However, progress will need to be monitored, and this can be considered at both departmental or team level, and at individual level.

Each department or team should have its own objectives and annual plan which will form the basis of review and evaluation of progress. In order to make improvements, each team must be clear about what it is trying to accomplish, how this will be implemented and how they will be able to demonstrate change. So objectives should be SMART (specific, measurable, achievable, realistic and timely). The more specific the objective, the more likely it is that improvement will occur.

Lead responsibilities, outcomes and timescales should be explicit. Each departmental report should be concise and follow a consistent framework to avoid the tendency of everyone sending in reams of uninformative details. A starting point for each department or team should be to reflect on examples of what has worked well in the past and why.

Priority topics for clinical governance may be obvious from team discussions; however, there may also be considerable differences in opinions. One way of deciding is by voting for topic areas. This way every member of a team has a chance to influence the final choice rather than just one or two senior medical staff deciding. Keeping the voting secret will prevent any potential for intimidation or suppression of views.

At an individual level, clinical governance must be a central part of staff appraisal and performance review. Obligations should be made explicit in contracts for future appointments and should be integrated into job plans for current staff. Appraisal of doctors will be an integral part of clinical governance, and training may be required for both appraisers and appraisees.

The initial emphasis of clinical governance should be on establishing systems for positive quality improvement rather than the more threatening and difficult issues around searching for medical failure (Box 2.4). However, tackling poor performance by developing systems of early recognition, regular appraisal and support will be needed (see Chapter 6).

**RESOURCES**

Efficient use of existing resources is important. Within the limitations of existing resources each team or department will need to review what support is
required and what skills are necessary to deliver their agenda of clinical governance. There are four key areas of resources to be considered:

1. **STAFF** There are staff in a number of areas who will have important roles to play in supporting clinical governance. These include audit or clinical governance support departments; risk management; complaints and litigation; information services and coding; library; education and training. Clinical governance support department staff should move away from conducting small, project-based audits. They have a central co-ordinating role in supporting clinical governance groups as well as collecting and collating the information which will drive change (Box 2.5, Figure 2.4). The skill mix of these staff should be reviewed regularly to ensure that they meet the future needs of clinical governance groups.

2. **TIME** The lack of time in today’s over-stretched NHS is a major hurdle to achieving success. If clinical governance and teamworking are to be taken seriously then protected time must be committed. Review the time committed to clinical duties, administrative and managerial responsibilities, teaching, research and professional development. Effective time management is essential. There may be a plethora of groups covering these aspects which can be reviewed and rationalized. Hospital doctors have the advantage over other health professionals in

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**Box 2.4  Steps for developing clinical governance**

1. Each department should hold a time out to discuss the implications of clinical governance. This should be chaired by the lead clinician and involve all senior staff. The following questions should be considered:
   - *What is the situation now in the department? What examples are there of good practice and what examples are there of poor practice?*
   - *What are the areas for improvement within existing resources? How can such improvement be achieved?*
   - *What structure and what realistic support (staff, IT, library, training, etc.) does each department need for clinical governance?*
   - *How can effective multidisciplinary involvement be achieved?*

2. Nursing and medical clinical governance leads should be chosen from each department.

3. The timing and content of clinical governance meetings should be agreed. Dedicated roles should be assigned to different clinicians to ensure shared responsibility for progress.

4. Each department should develop their own programme which includes clear objectives and targets for review that reflect local priorities.

5. Departmental programmes should be reviewed by a steering group. The key principle for clinical governance should be self-regulation but with a strong emphasis on transparency and clear reporting.

6. Training and development needs for leadership and specific skills within each department should be identified.

7. A monthly Trust Clinical Governance group comprising the clinical governance leads from all departments should be established.

8. Steps should be taken to establish or strengthen a district-wide forum for clinical governance leads from Trusts, primary care groups and the health authority.
having protected time for clinical governance and education and this time must be used effectively. Clinical governance should be seen as an opportunity for allocating protected time for other health professionals. In primary care steps should be taken to provide cover for meetings. Individual practices could be covered by neighbouring practices. Deputizing services may be able to provide cover for groups of practices to hold joint meetings.

Improving quality is not something to be done on the third Tuesday lunchtime of every month. However, protected time of about one session a week should be allocated for clinical governance leads to recognize the commitment involved. Protected time should also be agreed for departmental or team meetings during one session each month. It may be that there is some knock-on effect on waiting times or activity, but this may be the cost of ensuring a quality service.

<table>
<thead>
<tr>
<th>Box 2.5 Sources of information and drivers of change: a foundation for review and reporting by teams and departments</th>
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<tbody>
<tr>
<td><strong>Lifelong learning, education and training</strong> – identification of individual and team needs; planning of personal development programmes with local colleagues; reflection of methods used and preferred methods of learning.</td>
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<tr>
<td><strong>Clinical risk management</strong> – regular critical/untoward incident reporting; monthly examples of an adverse incident from which lessons can be learnt; review of procedures and systems to reduce risks identified. This information should be used for learning and not for blame.</td>
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<tr>
<td><strong>Audit</strong> – identification of key audit areas (e.g. national audits and confidential enquiries); feedback of individualized data; establishment of sustainable and continuous audits in key chosen areas.</td>
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<tr>
<td><strong>Evidence-based practice</strong> – dissemination and action on key reviews (e.g. Effective Health Care Bulletins); access and use of sources of evidence (Cochrane Library and Clinical Evidence).</td>
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<tr>
<td><strong>Clinical guidelines</strong> – development or adaptation (e.g. from NICE) of guidelines that are based on evidence rather than anecdote and then effective implementation.</td>
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<td><strong>Complaints and litigation</strong> – reviewing numbers and types of cases and ensuring regular feedback and discussion within individual teams.</td>
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<td><strong>Communication and record-keeping</strong> – improving documentation of care and standards of communication across the Trust.</td>
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<td><strong>R&amp;D</strong> – local research projects; dissemination of innovative practice; getting research into practice.</td>
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<tr>
<td><strong>Health outcomes</strong> – clinical indicators (e.g. mortality after MI or surgery) and clinical effectiveness indicators (e.g. CABG or hip replacement rates); development of outcomes that will reflect quality of care and can be used to inform clinical practice.</td>
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<tr>
<td><strong>Multidisciplinary and inter-agency working</strong> – collaboration with primary care trusts and the health authority; strengthening of teamworking.</td>
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<tr>
<td><strong>Patient involvement</strong> – approaches to obtain patient views and incorporation of these into future practice on an ongoing basis. This will require active participation of patients and carers in clinical governance groups.</td>
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<tr>
<td><strong>Staff appraisal</strong> – linking governance objectives with staff appraisal.</td>
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These components should be coherent rather than being separate pieces of a jigsaw (see Figure 2.4). For example, review of complaints or critical incidents should prompt a review of current practice, the development of evidence-based guidelines and training programmes to improve practice.
3. INFORMATION TECHNOLOGY Investment in information systems is crucial if clinical governance is to work properly. Today’s dependence on laborious and unrewarding case note review and data collection is not sustainable. Fully integrated patient management systems already exist in many general practices and are being introduced in most hospitals in the near future. This opportunity should be seized. At present there is much routine information entered onto computer databases which could be used to greater effect. Work should begin in improving the consistency and validity of recording and coding of this information. Key indicators should be agreed by individual teams and departments for regular feedback of performance. These could be quality indicators such as the wound infection rate or appropriateness indicators such as the proportion of patients who go on to revascularization after angiography.

Information technology also has an important role in improving access to clinical information. Knowledge databases such as Medline and the Cochrane Library can be networked to wards and clinic rooms. Clinical evidence should be available where and when decisions are being taken about patient care and not imprisoned in distant libraries.

4. TRAINING There is considerable ignorance and uncertainty about what clinical governance involves. Much effort is required to raise awareness and understanding. Departmental time outs will provide the first steps for achieving this as well as promoting wider debate and team building. Specific skills such as teaching, mentoring, negotiation, IT, critical appraisal skills or measuring health outcomes may be identified with time. Regional and national initiatives should provide some support in training and awareness. Local expertise should also be identified.

One of the problems as regards historical allocation of resources is that it has often gone to pet projects or to the clinicians who shout loudest. Clinical
governance provides an opportunity to ensure equitable distribution of resources. The senior clinical governance lead in the organization will be in a position of authority to ensure that this happens in line with local and national priorities. This strategic overview will also enable greater efforts to be made to involve patients in deciding what areas of clinical care can be improved and to promote collaboration between primary and secondary care.

One opportunity for clinical governance is to be more innovative and systematic in our approach to implementing change. Much activity has been dissipated in the past in conducting audits to show inappropriate X-ray requests or laboratory and pathology requests with little effort put into promoting change. A 15-minute outreach visit to a GP or hospital doctor may be a worthwhile investment if it improves the appropriateness of requests. Likewise a consensus meeting to agree local clinical practice guidelines may improve standards of care and free up time by reducing inappropriate referrals (see Figure 2.3).

**PROGRAMMES TO IMPROVE QUALITY**

There are no simple recipes for achieving successful clinical governance programmes. Some will work, raising the standards of care for patients and the self-esteem of professionals. Others will splutter and die, leaving only a ghost to nag. Hindsight is a great teacher and a review of the research literature about what distinguishes the successes from the failures can help to inform us about the essential components of a good quality programme (Box 2.6).

The use of a framework for clinical governance projects can be valuable. We have a structure for taking clinical histories and conducting clinical examinations, to remind us how to be thorough and systematic. Similarly, a structure or model for undertaking clinical governance work can help us to be thorough and systematic, and provides an explicit guide for all staff to understand and to follow.

**REVIEW, AGREE, IMPLEMENT AND DEMONSTRATE (RAID)**

The Clinical Governance Support Team uses the **review, agree, implement and demonstrate** (RAID) model for development of delegates from participating organizations (Figure 2.5). The aim is to challenge mindsets and traditional practices, and help staff to define new and innovative ways of delivering the best care for patients.

The review process is based on a number of key components:

1. Multidisciplinary workshops to allow all staff to explore how to improve services.
2. Involvement and discussions with all staff involved in the patient pathway of care, including the patients themselves.
3. Establishing current performance through information such as waiting times, activity, patient satisfaction, costs.
4. Review of documentation to assess how the programme of work fits in with local and national priorities.

5. Mapping of the patient pathway to provide an overview of the process of care and allow insight into what it is like to be a patient.

A summary of the review process and subsequent recommendations is then written up to describe the evidence for ‘where we are now’ and the challenges of ‘where we want to be’.

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**Box 2.6 Essential criteria for a successful quality programme**

- Recognize and build on existing effective quality activities.
- Enable professionals and managers to work together to improve quality, to be clear about their different responsibilities and to build mutual understanding, trust and respect.
- Build on and extend professionals’ skills, in a way that they believe will help them in their everyday work and careers.
- Provide training in quality methods at the time when people need the skills in their quality activities and projects.
- Give training and learning materials which do not introduce unnecessarily complicated concepts and ‘jargon’, use examples from a relevant professional service and a variety of learning methods to develop the new competencies which are required.
- Combine both profession-specific and multidisciplinary training and projects.
- Ensure projects are managed and work on organizationally important and authorized problems, follow a structured approach, and make real changes which achieve measured improvements.
- Allow flexibility for different parts of the organization to use effective methods which are appropriate to their activities.
- Provide an over-arching coherence which avoids different ‘quality language’ and which also co-ordinates different activities.
- Energize and realize people’s untapped potential, and provide a way to fulfil values and to gain a greater satisfaction from work and serving others.

(Adapted from John Ovreveit, Norwegian Medical Association, 1999.)

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**RAID model**

**Fig. 2.5** The RAID model.
The review process is a fundamental part of gaining agreement. Agreement is a gradual process that starts with the raising of awareness and understanding, and ends with ownership and commitment. Ideas that are identified for improvement can then be adopted and implemented (see Chapter 7), starting with projects that will provide quick wins and demonstrate early results in improving quality of care.

Demonstration of change is an essential part of quality improvement. It allows staff to evaluate and reflect on their performance. It also promotes expertise in and ownership of health information and can prompt review of what measures are important to collect. Information such as health outcomes, clinical indicators, access times, costs, activity and diagnostic test requests can be used over time to monitor change, or in comparison with other organizations to benchmark performance (see Chapter 9).

**PLAN, DO, STUDY, ACT (PDSA)**

The RAID model used by the Clinical Governance Support Team is based on the quality cycle first proposed by Deming in the 1950s as a systematic approach for businesses to adopt to continuously improve and respond to customers’ needs. The *Plan, Do, Study and Act* (PDSA) model (Figure 2.6) has been adopted by ‘collaborative’ networks in UK and US health services and involves a cycle of review and planning for improvements (Plan); implementation of small changes (Do); monitoring change through agreed measures (Study) and implementing further change on the basis of early results (Act).

The aim of the model is to encourage constant change, reflection and demonstrable improvement. It recognizes the dynamic nature of quality improvement, and how we learn from experience and feedback. Most im-
portantly it is a quick and simple model for testing new ideas to improve quality of care. The PDSA cycle provides an achievable stepwise approach to change:

- **PLAN** – plan the change you intend to introduce to improve patient care. Clarify the aims of the planned change and how you will measure the change. Agree the information necessary to demonstrate change (e.g. waiting times, proportion of patients on an appropriate drug, numbers of drug errors) and the timescale for measurement of this information. Start with small ideas, but if the planned change is complex, then break it down into bite-size chunks.
- **DO** – put the change into practice and measure its impact by collecting the agreed data. Keep this step as short as possible and identify any problems or barriers along the way.
- **STUDY** – review and analyse the data. Has there been change? Could things have been done better?
- **ACT** – change the plan to focus on what works and change what did not work. Go back to the ‘DO’ step and measure further change.

Both the RAID and the PDSA models provide an easy mnemonic for thinking about, implementing and evaluating change in real practice settings. They emphasize that quality improvement is a continuous evolution of small changes rather than a big bang that is too ambitious to ever take place. The cycles of change are small but clever adaptations that can happen tomorrow afternoon rather than large trials that will take years to start. Problems can be quickly identified and changed rather than wasting time waiting for long-term outcomes.

**FURTHER READING**

