SECTION EIGHT
CO-ORDINATION AND ALIGNMENT

This section considers:

- the need for a clear focus to clinical governance improvement actions
- co-ordination and alignment of the elements of clinical governance across the PCT
- sharing priorities for clinical governance action across the local health economy.

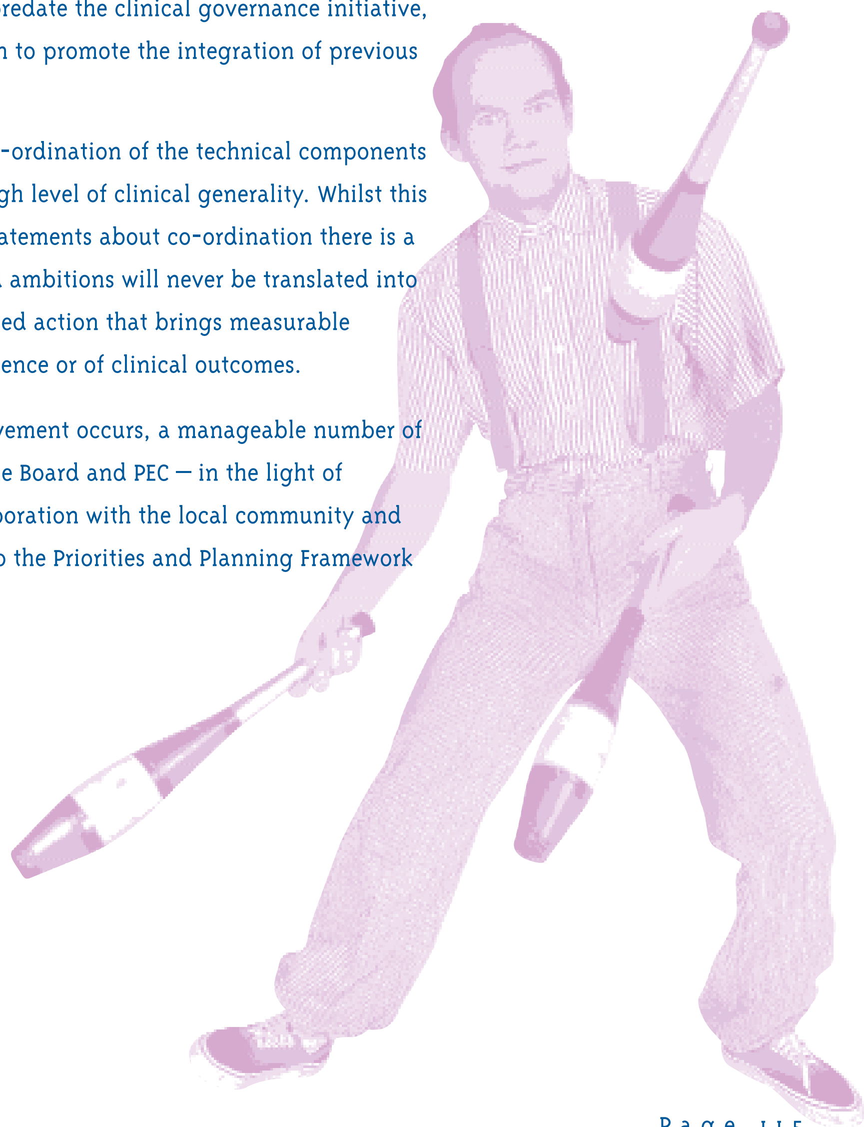
Co-ordination and joined-up thinking

Clinical governance is an integrating principle. One of its key precepts is that the elements of clinical governance will have the greatest impact upon the quality of care if they are coherently inter-connected and targeted.

Many of the components of clinical governance predate the clinical governance initiative, and one objective of clinical governance has been to promote the integration of previous separate and unco-ordinated initiatives.

This degree of coherence is unlikely to occur if co-ordination of the technical components of governance is considered in abstract or at a high level of clinical generality. Whilst this approach can give rise to well-meaning policy statements about co-ordination there is a very real danger that such general intentions and ambitions will never be translated into systematic, concrete and system-wide co-ordinated action that brings measurable improvements in the quality of the patient experience or of clinical outcomes.

To ensure that measurable and significant improvement occurs, a manageable number of key clinical priorities should be determined by the Board and PEC — in the light of national and local clinical priorities and in collaboration with the local community and the health economy. They should link explicitly to the Priorities and Planning Framework and be highlighted in the Local Delivery Plan.



These clinical conditions or topics can then provide a primary and concrete focus for systematic appraisal and attention in relation to audit, risk management, and the other technical components of clinical governance. They should provide a focus of attention within the commissioning process and should suggest key targets for the development of seamless care across the local health and (where appropriate) social care economy.

'Clinical governance represents the systematic joining up of initiatives to improve quality.'

Halligan and Donaldson, 2001

Key learning from the pilot programme

Although most PCTs believe that they understand the underlying principles of targeting, co-ordination and alignment that should underpin clinical governance, many had difficulty in pointing to concrete evidence that clinical governance initiatives had been purposefully targeted at local priority clinical conditions in order to generate improvements in the quality of the patient experience or of outcomes of care.

Most also found it difficult to generate robust evidence that the constituent elements of CG had supported or informed each other – not least because many PCTs lacked professional and/or managerial expertise and/or capacity in relation to a number of the discrete 'technical components' of clinical governance – let alone their concrete integration and alignment.

Across all PCTs in the pilot programme the section on Co-ordination and Alignment was scored at 5.5 on the progress scale (range 3.5 to 7.5).

Although more recently formed PCTs were likely to find this more challenging than those that had more time to develop, the difference was less than in almost all other sections The 25 PCTs that were under a year old when they completed the questions scored an average of 5.3, whilst the remainder scored an average of 5.7.

It was clear from the pilot that those PCTs that had made the most progress in generating concrete evidence of quality improvement and of service redesign were those that had, in collaboration with their local health economy and their SHA, identified clear strategic clinical priority conditions. These conditions often derived from NSFs but could also reflect very local clinical priorities.

Conversely, those PCTs that had no clear clinical priorities struggled to show evidence of progress in quality assurance or quality improvement.

This was compounded by the fact that many PCTs are lacking in functional expertise, or specific clinical or managerial capacity, in the technical aspects of clinical governance, such as clinical audit, education and training or risk management.

Nationally, many PCTs urgently need 'how to' support on a number of the discrete technical components of clinical governance, and support in learning how best to combine these discrete elements in order to maximise the return on their investment of precious time, energy and commitment.

Targeting the energies of a health community – setting Clinical Governance Priorities

PCTs are responsible for an extraordinary diversity of needs, tasks, functions and clinical conditions. It is impossible to do everything at once and the energy of a PCT community and its partners should be focused so that there is clarity and consensus about investment of scarce time and resources. Introducing co-ordinated improvement will demand prioritisation, clarity, persistence and partnership.

> 'PCTs will be expected to work closely with other PCT and NHS Trusts locally to ensure that services are provided in support of patient need and across organisational boundaries.'
>
> *Department of Health, 2001*

It may be helpful to target a manageable number of high-priority clinical conditions and to make these the concrete elements of care that are systematically analysed and targeted from the perspectives of clinical governance.

These priorities should not merely be derived from the national priorities discussed below. The PCTs public health functions are crucial in enabling it to determine accurately local clinical priorities. Relevant factors in determining local priorities are likely to include:

- frequency/incidence of a condition within the local patient population
- seriousness of a condition
- attendant clinical or other risk factors
- cost (in terms of time and money) related both to diagnostic and treatment phases
- potential cost savings to the PCT (or its partners within the health economy).

Criteria that were originally developed to focus the implementation of research findings have equal validity in identifying potential clinical governance priority topics or conditions.

> 'Criteria for deciding priorities for implementation should include burden of disease, the potential benefit that might accrue from improvements in care, the strength and generalisability of the evidence, and the feasibility of implementation. Measures of cost effectiveness are also bound to play a part.'
>
> *Haines and Jones, 1994*

In choosing between local options that satisfy these criteria, Boards and PECS will need to have due regard to the national priorities set out in the Priorities and Planning Framework (2003-2006).

'**Priorities for the Next Three Years:**

- Improving access to services: through better emergency care, increased booking for appointments and admission and more choice for patients.
- Focussing on improving services and outcomes for:
  - Cancer; CHD; Mental Health; Older People
  - Improving life chances for children
  - Improving the overall experience of patients
  - Reducing health inequalities
  - Contributing to the cross-government drive to reduce drug misuse.'

Department of Health, 2002b

Agreed overall priorities can then be incorporated into the Local Delivery Plan.

Securing widespread ownership of Clinical Governance Implementation Priorities

Explicit local ownership of and commitment to a timetabled programme of focussed clinical governance improvement priorities is essential.

'What engages people is the process of working together – clinicians and managers working to redesign patient pathways,' says Ms Kennedy from the Primary Care Development Team. Overcoming the reluctance of some GPs and consultants to become involved can be crucial to significantly improving patients' journeys through the NHS.'

Health Service Journal, 2002

This requires consultation with and active debate not only amongst the PCTs own staff group but with:

- the patient population
- the local community that the PCT serves
- the SHA
- clinicians and managers in partner organisations within the provider network in the local health and social care economy.

'PCTs must be able to work closely with one another. They must develop strong links and networks, mirroring patient pathways and clinical teams to ensure that services to patients are seamless and client groups have a clear point of contact for their views at all levels.'

Department of Health, 2001

Developing local Integrated Care Pathways

Having established clinical priorities, the principles of clinical governance must be systematically applied. An Integrated Care Pathway is clinical governance in action at the level of the patient condition and reflects the concern of the new Commission for Health Audit and Inspection (see Section 7) to consider the entire patient journey, not just the organisationally located 'episode of care' alongside 'best value' in the use of resource.

> 'Development and implementation of integrated care pathways (ICPs) offers the prospect of both better quality multi-disciplinary care and better deployment of resources.'
>
> *CHI, 2002*

The development and management of a clinically governed and effective pathway demands:

- listening actively to the needs of individual patients(and their carers)
- mapping the patient journey and seeking to minimise and manage points of transition
- systematic audit of current clinical realities across the pathway to provide a robust bench mark and to identify clinical and other risks and highlight deficiencies or discontinuities
- a systematic review of the research literature and of the evidence base in relation to the specific clinical condition/care pathway
- a systematic analysis of the adequacy of the staffing and other resources necessary to produce systematically safe and high quality care
- a thorough analysis of the current competence of all staff in working within the pathway (including their supervision and support needs) in order to determine educational and development priorities
- an analysis of costs and the potential for cost savings
- the consensus based generation of an evidence based local care protocol or guideline
- the formal adoption of this protocol or guideline by the PCT and by all of the organisations involved in the pathway
- a clear definition of leadership, responsibility and accountability for the overall pathway and for each element within it
- a staged implementation plan – including an effective communication strategy and explicit evaluation criteria.

This is a perhaps the most challenging and most vital element within the clinical governance implementation agenda.

> 'Redesigning clinical processes requires skills in patient engagement, in process mapping and in remodelling care systems, often across organisational and professional boundaries.'
>
> *Department of Health, 2002a*

Ensuring active patient involvement

Specific priority clinical conditions provide a concrete focus for the PCT's efforts to ensure active patient involvement – and can produce significant lessons that can then be applied more widely. it is possible to explore the extent to which patients and their carers are already active partners in the planning and implementation of every stage of the care that the PCT and its partners provide (patient involvement is considered in more detail in Sections 5 and 10). Structured dialogue with individual patients can explore, and record evidence of, for example:

- the 'humanity' of the care that they have received
- positive experiences
- difficulties encountered with staff, systems or practices of the PCT or other providers.

Mapping the patient journey

Weaknesses in care provision are most likely to occur at the interfaces between intra- or inter-organisational systems.

'When patients enter secondary care, they already have a relationship with primary care, and will return to primary care, once their visit or stay is completed. Primary care professionals have a unique perspective on, and involvement in, the patient journey.'

The National Primary Care Development Team, 2002

Identification and management of these interfaces will ensure, from the patient's point of view, a smooth, apparently seamless, flow of care. This is a significant aspect of the new CHAI audit and inspection process (the new CHAI criteria are considered in more detail in Section 7).

The skills of process mapping, and flow charting make it possible to:

- map the patient journey (perhaps with the use of 'Patient Trackers')
- identify the different parts and processes of the PCT which are involved in delivering care
- identify the other partner organisations in the local health (and social care) economy who contribute to the totality of the patient experience
- pay particular attention to points of transition or transfer which may occur:

Such mapping exercises make it possible to negotiate, pilot and evaluate new forms of partnership between patients and their carers. It is then possible to take simple and concrete steps to improve aspects of patients' experience - or to consider more fundamental and radical redesign of the pathway (see Section 19 for a more detailed consideration of the issue of co-ordination of care and the management of transitions).

REFLECTION

Can you identify an example of a local Integrated Care Pathway?

Using clinical audit to generate a 'baseline' and to monitor and generate evidence of progress and improvement

Clinical audits can be undertaken (both within and across system and organisational boundaries) at the outset of this process, and at appropriate intermediate points when change actions have been implemented (see Section 12 for a more detailed consideration of Clinical Audit). The initial audit will determine a 'baseline' (for example, in relation to compliance with an evidence base) against which improvement can be measured. The PCT can then compare the investment of time and cost to evidenced benefits.

Identifying, managing and minimising clinical risk

Staff of the PCT, its practices and partner organisations can take steps to identify and predict clinical and other risks that may arise. The PCT can then manage and minimise these risks within each organisation – and at the points of transfer of responsibility between them (see Section 10 for a fuller consideration of these issues). Important guidance is available from the National Patient Safety Agency (in relation, for example, to medication errors) and from the Controls Assurance Support Unit (in relation to systematic approaches to risk management and minimisation).

Data collection and intelligent information generation

The generation and intelligent use of clinical data is a key developmental priority for PCTs (see Section 9 for a more detailed consideration of the generation of 'intelligent information' from data). The work of Primary Care Collaboratives has highlighted the critical importance within implementation of systematic and regular measurement and analysis of data, if improvement efforts are to be embedded and sustained.

> 'Rigorous, regular measurement has been central to the improvement work in Collaborative practices. The discipline of examining and understanding the data at practice level each month enables practices to target their ongoing care effectively.'
>
> *The National Primary Care Development Team, 2002*

This emphasis upon the use of 'intelligent information' to generate improvements in care is central to the concerns of the new CHAI (see Section 7).

Through their focus on a manageable number of priority clinical conditions, PCTs can systematically explore the quality, consistency and integration of exiting data gathering in relation to:

- diagnosis and treatment of a particular condition
- the smooth (or disjointed) two way flow of information about patients both within the PCT and with its commissioned provider organisations
- the smooth two-way flow of information to patients.

Important, evidence based and transferable lessons can be learned from this analysis. The PCT can then look at specific improvements that can be made across the system and at

ways of transforming raw data into information which can be used to improve:

- the quality of the process for clinicians and the care network
- the quality of clinical information that reaches the Board and PEC
- outcomes for patients.

and thus translate this data into 'intelligent information'.

Important guidance and support to PCTs is available from the Primary Care Information Board and from the experience of measurement gained by the Primary Care Collaboratives.

Supporting and monitoring the work of clinical staff

Pro-active engagement of staff in the identification of risk will also provide the opportunity to identify how staff across the care pathway are supported and supervised in their delivery of care (see Section 11 for a fuller consideration of these issues). Any gaps or confusions as to lines of clinical accountability must be identified and resolved.

Researching the literature and securing evidence based care

The research literature in relation to the target condition can be systematically explored – and the evidence which should inform practice can be highlighted and made available, in an accessible format, to all of the clinical staff involved in care – across the boundaries of the care network.

The process of developing and implementing local protocols or clinical guidelines from research evidence must be4 based upon research evidence (not opinion) and national guidance. The PCT Board and PEC should carry out an appraisal of the final guideline/protocol before implementation, using a validated appraisal tool such as the St Georges instrument used by NICE.

Where gaps in the evidence base are identified appropriate NHS bodies can be alerted. Where deficiencies could be made good by local pilot research activity, the need can be factored in to the PCT and the care network's Research Governance frameworks and plans (see Section 14 for a fuller consideration of these issues).

Identifying and responding to competence deficits and developmental needs

Well-constructed audit can also explore the competence base of clinical and other staff engaged in the delivery of care at all levels (individual, team and system level). This process can help to target the PCT's education and training activity at its clinical priorities and at robustly-evidenced competence deficits and inter-professional developmental and learning opportunities (see Section 13 for a fuller consideration of these issues).

Co-ordination and alignment in action – the work of the Primary Care Collaboratives

The work of the Primary Care Collaboratives provides compelling evidence that focus and collaboration are powerful allies to improvement — particularly when they are allied to purposeful data collection, measurement and the generation of 'intelligent information'.

In the first instance they have concentrated much of their effort upon:

- Improving access to primary care
- Improving care for patients with proven coronary heart disease
- Improving access to routine secondary care services (capacity and demand management).

'The improvement model can be used to introduce changes to traditional ways of working n a safe, gradual and purposeful way. ...Collaborative teams were asked to start work by looking at a single problem specialty. In many cases it was a specialty with long waits where GPs from Collaborative practices felt they might play a direct role in influencing change, where there were already links with clinicians in secondary care that were keen to improve services or where improvement initiatives were already underway.'

The National Primary Care Development Team, 2002

Participating PCTS have demonstrated significant improvements in the safety, the quality and the underlying process and pattern of care that can be achieved —.sometimes in a timescale that can be measured in months rather than years.

'Practices that have gained most from the advanced access model have worked systematically through all of its components. .... To date, the average waiting time to see a GP in Collaborative practices has reduced by 62% .... Wave 4 practices have been achieved a 64% reduction in waiting times in just 10 months.'

The National Primary Care Development Team, 2002

In addition to the primary gain to patients that has flowed from this work, there have been significant secondary benefits to the PCT community.

'Advanced access has helped many practices free up capacity so that they can develop other work. Moving appropriate work to nurses from doctors, or from nurses to other members of the team, has meant that people have been able to concentrate on priority areas such as elderly care or chronic disease management or pursue other interests.'

The National Primary Care Development Team, 2002

They do however add an important proviso:

'Practices that have implemented advanced access have demonstrated that the system is sustainable but that this can only be achieved by proactive, ongoing management. They key is in recognising that advanced access is not an endpoint but a dynamic process'

The National Primary Care Development Team, 2002

The same principles have been applied with equal success to the management and treatment of CHD. The Collaborative's approach to improving care of patients with

coronary heart disease (CHD) is based around clinical evidence on the effectiveness of medication and best practice in delivering care. Their Framework includes the following key components:

'Develop and maintain a valid CHD register

Implement agreed protocols for care

Use computerised templates for collecting patient information

Identify systems for call and recall of patients

Develop nurse-led care for CHD patients.'

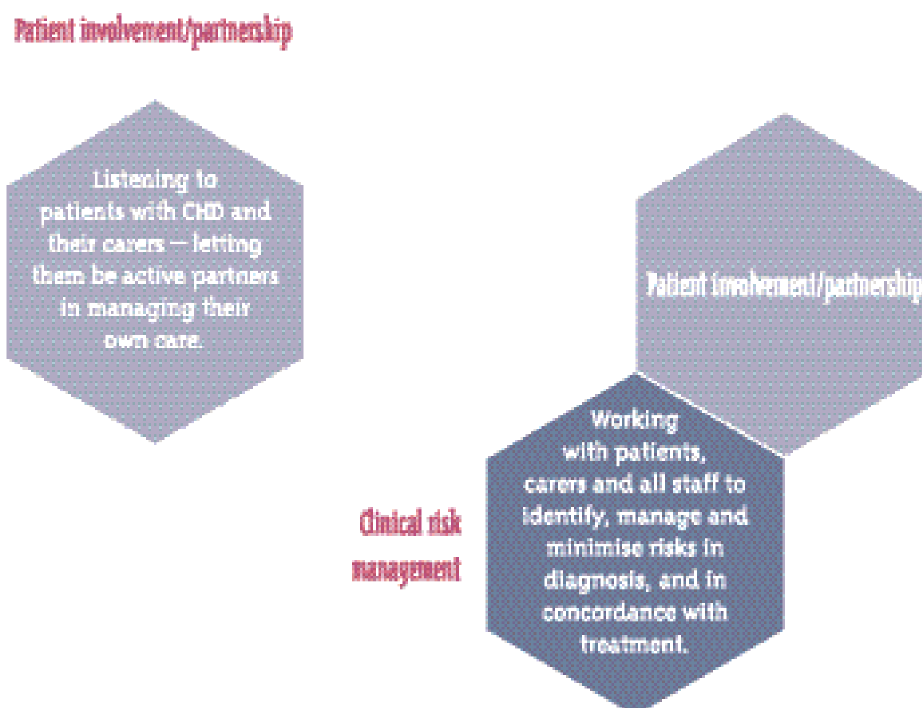
The National Primary Care Development Team, 2002

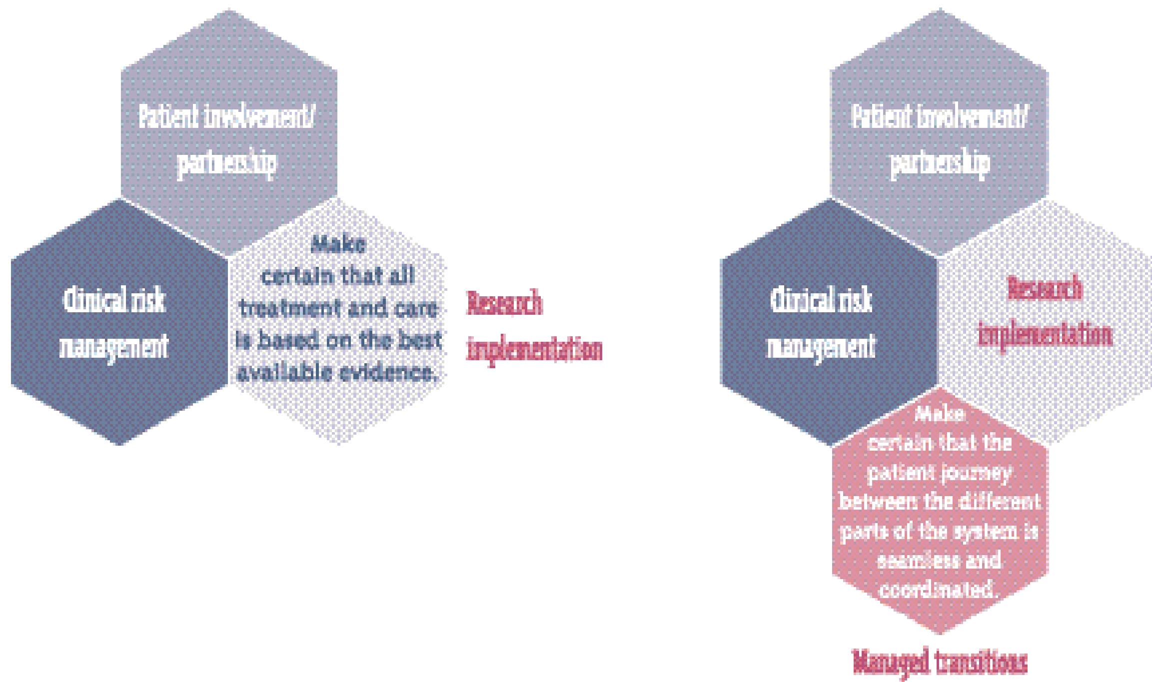
The results achieved have been equally impressive – and set a standard that all PCTs should seek to match or to better.

'A comparison of PCTs that were part of the NPCC with those that were not involved has shown a four-fold difference in the reduction in mortality from CHD during the same period.'

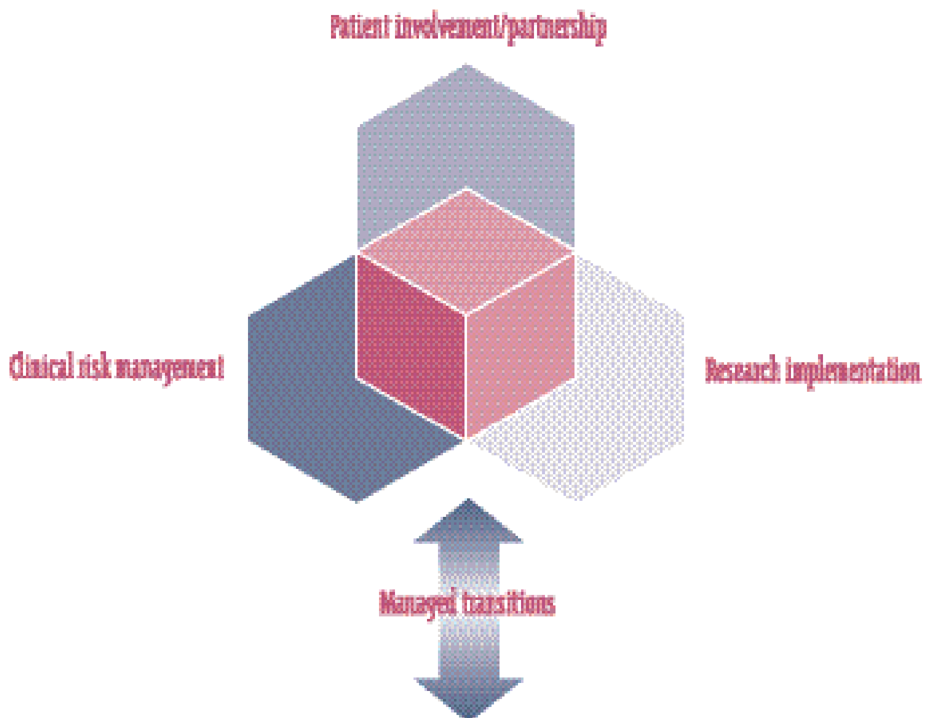
National Primary Care Development Team, 2002

In addition, this work has shown that major changes and improvements in the patterns and models of care – and fundamental service redesign – will be a natural by-product of systematic attempts to bring together the key precepts and technical elements of clinical governance (see diagrams below).





Patient involvement/ partnership
Clinical risk management
Make certain that all treatment and care is based on the best available evidence.
Research implementation
Patient involvement/ partnership
Clinical risk management
Research implementation
Make certain that the patient journey between the different parts of the system is seamless and coordinated.
Managed transitions



Patient involvement/partnership
Clinical risk management
Research implementation
Managed transitions
Fourfold improvement in patient outcomes and service redesign

Priorities for action

Now that you have finished reading through this section, please identify three key clinical conditions or topics that could provide a concrete focus for the co-ordination and alignment of the component elements of clinical governance, and then compare them with the checklist below.

1

2

3

Checklist: Identifying clinical priorities

1 Have the Board and PEC actively considered both national targets and local need in order to determine key local clinical priorities that will deliver a 'best value' return to the local community?

2 Have these discussions and decisions actively involved the Patient forum?

3 Have the outcomes of this deliberation been discussed with all key clinical and other staff within the PCT and has 'ownership' been secured?

4 Have these potential clinical priorities been agreed with the SHA and with key clinical and managerial staff within the local health economy?

5 Has a systematic analysis and mapping exercise taken place with patients who suffer from the prioritised condition. Has their voice been actively heard?

6 Has a systematic integrated care pathway been developed that includes:

- a A co-ordinated approach to care across organisational boundaries
- b A baseline audit of current clinical and patient reality
- c A systematic exploration of the evidence base of best practice
- d A systematic analysis of the 'fitness for purpose' of all staff and teams dealing with the priority condition
- e An education and training strategy to deal with any deficits identified?

7 Are there mechanisms to capture robust evidence of the clinical effectiveness of care and of the quality of the patient journey across the entire 'patient journey'?

References

CHI 2002. *Emerging Themes*. www.chi.nhs.uk

Department of Health 2001. *Shifting the Balance of Power within the NHS: Securing delivery*, London: DH

Department of Health 2002a. *Managing for Excellence in the NHS*, London: DH

Department of Health 2002b. *Improvement, Expansion and Reform: Priorities and Planning Framework 2003-2006*, London: DH

Haines, A. and Jones, R. 1994. Implementing findings of research. *British Medical Journal*, 308, 1488-92

Health Service Journal 2002. Raising the game in primary care. *Health Service Journal*, Supplement 14 November

National Primary Care Development Team 2002. *The National Primary Care Collaborative: The First Two Years*, Manchester: NPCDT

Resources

Commission for Health Improvement's aim is to improve the quality of patient care in the NHS. Information on the CHI assessment framework and on support tools can be found at their website. www.chi.nhs.uk

National Institute of Clinical Excellence – the NICE site contains details on the Institute, its ongoing work programmes, the methodology and processes it uses, the guidance it has issued to date, copies of all press releases and the minutes and papers from its Board meetings. www.nice.org.uk

NICE Guidance on home v hospital haemodialysis can be found at: www.nice.org.uk/cat.asp?c=36752

NICE Guidance on drugs for early thrombylosis in the treatment of acute myocardial infarction can be found at: www.nice.org.uk/cat.asp?c=38399

NICE Guidance on management of type 2 diabetes – management of blood pressure and blood lipids can be found at www.nice.org.uk/cat.asp?c=38551

'What makes a good stroke service and how do we get there? – key factors in developing high quality care' can be found at:www.doh.gov.uk/nsf/good-stroke-serv.pdf

Patient safety is featured on the website www.qualityhealthcare.org

St Georges Instrument, developed by the Healthcare Education Unit of St Georges Medical School, can be accessed at www.hms.ac.uk/depts/phs/hceu/clinguid.htm

The Department of Health Improvement Leaders' Guides are available free via the NHS Response orderline: 08701 555 455, quoting the appropriate code.

Series 1 (code MAILGBV1): *Process Mapping*, *Matching Capacity and Demand* and *Measurement for Improvement*.

Series 2 (code MAILGBV2): *Involving Patients and Carers*, *Managing the Human Dimensions of Change* and *Sustainability and Spread*.

Code MALGCO: *Setting up a Collaborative Programme*

Rating the PCT's current stage of development

Please rate the PCT's current stage of development in relation to the following questions. Remember to use the Response Sheet provided for your answers.

8.1 To what extent have the Board and PEC agreed key clinical priorities?

8.2 To what extent have these priorities been agreed across the local health economy?

8.3 To what extent are the component elements of clinical governance aligned with these clinical priorities?

8.4 To what extent is there concrete evidence of the improvements in the quality of care in relation to these priorities?