Bandolier *Extra*

DELIVERING BETTER HEALTH CARE 2

> Seeing the wood for the trees. Taking a systematic approach to implementing change in clinical practice.
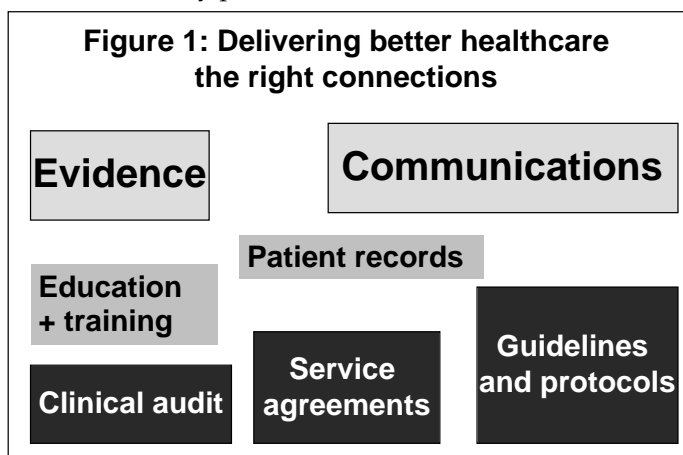>
> **Michael Dunning, Editor, ImpAct**

The first paper in this series described some traps that people fall into as they look for ways to improve clinical practice. Building on that background, this second paper suggests a systematic approach to implementing change in clinical practice. It ends with some pointers to the development of clinical governance.

The paper is based on a programme of workshops - Delivering Better Health Care - developed in the West Midlands region in 1999 and 2000. The work was funded by the Partnership for Developing Quality. Thank you (Linda Dunn and Chris Homer) for your support. The workshop was designed to give participants a broad practical understanding of the influences on and the tasks involved in implementing change in clinical practice.

The Starting Point

The separate aspects of achieving change are familiar to most people in the NHS. Change is a way of life. The terms used form a common language. People talk freely about clinical guidelines, care pathways, clinical audit, critical appraisal, patient involvement etc (see Figure 1). Getting the right connections and balance between these separate activities is essential. Experience has shown that achieving these connections and this balance is not easy. In the first paper we identified things that can go wrong. Often this is simply because people do not have a good grasp of the work overall. They may spend too much time on the familiar, such as the preparation of guidelines and not enough on the unfamiliar: those they perceive as difficult.

Figure 1: Delivering better healthcare the right connections

Evidence

Communications

Patient records

Education + training

Clinical audit

Service agreements

Guidelines and protocols

The work in the West Midlands built on the success of the established model for critical appraisal training (CASP) workshops. These short two-hour sessions concentrate on getting the fundamentals over to participants. We wanted to explore whether we could design and deliver a similar short (two hour) session that could plant in people's mind a practical picture of the task of implementing change in clinical practice. A two-part programme was designed for a multi-disciplinary group of about fifteen people from each NHS Trust including clinicians and managers. Ideally, participants would be drawn from different levels within the organisation. An opening session, to present information about the task, was followed by small group discussions on a local implementation issue. The aims were to:

♦ Create groups of people in organisations with shared understanding of implementing change in clinical practice.

♦ Be practical and draw on real examples to illustrate the task.

♦ Support the development of clinical governance in NHS Trusts and Primary Care Groups.

Build on work on critical appraisal in the Region.

There are countless educational opportunities that seek to tackle all aspects of implementation and individual activities such as the formulation of clinical guidelines or the preparation of project plans. We were not trying to replicate these training opportunities. Our starting point was the belief that most people had some knowledge of managing change, but they would benefit from a better understanding of the overall process.

♦ Pilot trials indicated support for idea behind the workshop. On-going evaluation was positive, participants:

♦ Valued having time with other members of their organisation for discussion about clinical issues including multi-disciplinary approaches.

♦ Felt they gained an understanding of the planning process and time scales for preparation, planning, sustaining and delivering a change initiative.

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- Liked the opportunity to rationalise the ethos of managing change in a less than ideal world.
- Reported a better understanding of clinical governance and evidence based health care was reported.

Nevertheless changes seemed necessary and more time was needed. The session proved to be too busy and too short. We were trying to handle too much detail in the limited time available. We subsequently tried a more focused model for the workshop: this was better received. This paper is based on the concise version of the session. The third paper in this series will describe the more detailed version and be based around a series of slides that could be used in a workshop setting.

The starting point for the session was a set of four questions :

1   What do you need to know? - the knowledge which should influence the work.
2   What needs to be done? - a broad picture of the range of tasks involved.
3   How to make it happen? - the range of skills and scale of resources required.
4   Where can you find help? - don't be alone, seek advice and share experiences.

What do you need to know?

Interest in evidence-based practice has sparked many questions about clinical behaviour and the ways to influence people. Anyone starting out to implement change needs to be familiar with the wide range material now available - but not necessarily all of it! It is sensible to be aware of the main points from this literature and aim to keep up to date. A framework of four types of knowledge) can help you recognise what you don't know!

1   Evidence: from research on changing clinical behaviour
2   Theory: models of behaviour change
3   Lessons: about change management
4   Experience: from implementation projects

First, **evidence** from research on questions about changing professional behaviour. It is a complex field with many significant research programmes in hand. It is an international activity with collaboration through the Cochrane Collaboration bringing together people from across the globe. This work is starting to point to change strategies that have been proven to work - and importantly those that don't.

Second, **theories** about behaviour change and the way people learn. Many people may be familiar with is the work of Rogers who suggested a classification of people such as innovators, early adopters, early majority, late majority and laggards. Other work has explored how people learn and what motivates them to change.

Third, **lessons** from studies of change management and initiatives to improve the quality of services. Many of these come from non-NHS settings but have useful lessons. They point to the need for clarity of purpose and a systematic approach.

Fourth, **experience** which has been learned by those leading and being involved in implementation projects. All of these confirm the complexity of the process and the need for flexibility as the work is taken forward.

Where can you find this knowledge?

A useful summary of what is known from research and the theories of change can be found in an effectiveness bulletin produced by the Centre for Reviews and Dissemination at York University in 1999 (http://www.york.ac.uk/inst/crd/ehc51.htm). It also provides an extensive list of other references. Check out also our Bandolier links, and ImpAct, and the extensive management stories on the site.

For lessons about change management a helpful series of papers were published as a supplement to Quality in Health Care entitled Organisational change: the key to quality improvement in late 1998.

Experience, evidence and everyday practice, the final report from the Promoting Action on Clinical Effectiveness (PACE) Programme was published by the King's Fund in 1999 describes the lessons from sixteen local implementation projects.

This is not intended to be an exhaustive list - but it offers a start. Some other references are set out below - but this is a continually changing scene. Keep in touch with the literature.

What does all this tells us?

The wealth of material shows that implementing change is possible, but it is a complex business that takes time, resources and stamina. The important points are:

- Know where you are starting from.
- Build on what works, such as educational outreach and reminder systems.
- Multi-faceted approaches are more likely to be successful.
- Good project management is essential.

What needs to be done?

Clarity about what needs to change is a pre-requisite for success. Two dimensions require attention. First, an analysis of current practice to determine the gap between what is done now and the practice indicated by research evidence. Clinical audit is the key here but bear in mind that what is needed is a broad understanding of what needs to change - not extensive detail of current practice.

Second, an assessment of the likely attitudes of those you may seek to change: it will help you decide how best to involve and work with them. The Rogers analysis talks of identifying laggards, innovators etc. Others talk of the merit of identifying barriers or a contextual analysis. The important point is to determine where to start and identify whom is likely to support your initiatives and work with you in

the initial stages - and who might oppose you! Early success is a good morale booster. Remember pharmaceutical companies devote significant resources to understanding their market. This task should be much easier for people working in the NHS.

While the assessment of the people likely to be affected by the work is in hand it is important to assess how the initiative will affect current services: will it prompt a need for more or less of something. Experience has shown that tackling these resource consequences may be as time consuming as changing clinical behaviour. There is little point in encouraging GPs to refer patients for physiotherapy if that department is already under severe pressure. A link with planning and budgeting timetables and the early engagement of the appropriate managers in the discussions will help.

Making change possible

People cannot change unless they have space and the time to understand and absorb the evidence you are promoting. Research has shown that (simply) circulating information is normally ineffective. Design of suitable training and education programme should take account of the needs of those you seek to change. Do not expect people necessarily to attend organised training sessions, unless you have taken action to make attendance easy for them. It may be more sensible to take the training to the workplace. Educational outreach programmes are well proven.

Finally, it is sensible to be flexible and plan for the long term. No matter how well implementation programmes are planned, they are unlikely to adhere to timetables. People may not react as expected and support may come from unexpected quarters. Allow for this. As the process is costly in terms of time and resources it is important from an early stage to explore how the changes you are implementing will be sustained in the longer term - after the project spotlight has faded. Make sure that patients' records reinforce the changes you are implementing. How will you hand over responsibility to those charged with monitoring clinical standards?

Delivering Better Health Care: What needs to be done?

♦ Be clear what and who needs to change
♦ Tackle resource consequences
♦ Provide practical training and education
♦ Be flexible and plan for the long term

How can you make it happen?

Choice of project leader is critical and should be guided by the need for someone with a reputation with his or her peers - rather than necessarily their position within the organisation. It is helpful if they have:

1 **Experience** of managing change in the health service - an understanding of the range of activities involved.

2 **Awareness** of the emerging research evidence about changing clinical behaviour.

3 **Knowledge** and understanding of local organisational policies and structures and working relationships.

Given the complexity of the task and the range of activities involved, the recruitment of a team with the necessary skills should be an early task. The analysis of what and who needs to change will indicate the skills required. It is important to assemble the right team rather than simply rely on colleagues - people with whom you feel comfortable. Managerial and clinical skills will be required.

The scale of change required could be a reliable indicator of the resources required to make the change happen. The support and commitment of senior staff within the organisations will help ensure that sufficient people and resources are available to deliver the project's objectives.

Keeping people in touch

Communications must be taken seriously. Agree at an early stage a communications strategy to let people involved know what is happening. It's wise to share responsibility across the project group so that each member takes on the task of keeping their discipline in touch. Wherever possible existing communications systems should be used - to avoid the need to create new meetings and paper work. Clarity about the message - what are you trying to say? - and the role of the messenger is essential.

For most people involvement in work to change clinical behaviour is a learning experience. Manage project meetings so that the collective learning of the group is captured. Allow time in the meetings for reflection so that those activities that have been a success and those that have not can be discussed. An honest approach where successes (and failures) can be openly discussed is essential: asking a team member to take on a facilitation role can be helpful. Taking steps to ensure that the learning is used to influence other local initiatives will ensure that there is a better return on costs of initial project. It will also represent an important contribution to the development of local clinical governance systems.

Delivering Better Health Care: How can you make it happen?

♦ Find a suitable leader
♦ Recruit the right team
♦ Secure adequate resources
♦ Take communications seriously
♦ Learn as you go!

Where to find help?

There is growing number of people across the NHS who have experience of creating and leading projects to implement improvements in clinical practice. Most are keen to share their experiences with colleagues across the NHS. This

sharing used to be difficult and had to rely on personal networks - such as people you met at professional conferences.

The creation of the NHS Learning Network in 1999 has changed this and stimulated a range of activities designed to help people share experience and good practice across the NHS. ImpAct is one element of that activity; another is the network of NHS Beacons (Box).

Similarly there are a growing number of website that offer details of local initiatives (again look at the Bandolier links and management section). All of these offer a useful way to start and can help you avoid re-inventing the wheel. It will help identify colleagues in other organisations who might be able to help make progress more quickly and who might be able to learn from your experiences - be honest with successes and failures.

Delivering Better Health Care: Where can you find help?

♦ Don't try to re-invent the wheel
♦ Share successes and failures
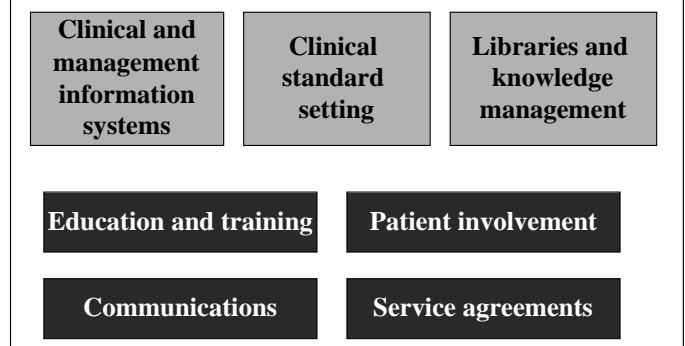
An approach to clinical governance - creating links

The introduction of clinical governance has the potential to streamline the process for implementing change in clinical practice. The experience from managing implementation projects suggests that the key task for organisations is to put in place linked systems covering the monitoring, improving and maintaining the quality of health care. Failure to make the right connections between different strands of work means that people have to spend countless hours working against the systems.

And, in conclusion

Experience has shown advantages from a systematic approach to the management of programmes to improve the quality of health care. Not least, because it ensures that scarce resources to be used to the best effect. But don't adopt a rigid approach where adherence to the plan and timetable is all-important.

Expect the unexpected and learn to coax and cajole the different aspects along together. A good analogy is trying to juggle several balls at once - difficult but not impossible. Keep trying!

Figure 2 Delivering Better Health Care
An approach to clinical governance – creating links

Clinical and management information systems	Clinical standard setting	Libraries and knowledge management

Education and training	Patient involvement
Communications	Service agreements

Seven linked systems could form the basis for managing clinical governance (Figure 2):

1. Providing information to enable clinical staff to review, routinely, the quality of their current practice and identify areas where improvement is needed.

2. Providing access to the breadth of knowledge required to establish local standards of care.

3. Reviewing current practice and setting local clinical standards.

4. Ensuring that patients are at the centre of work to develop and monitor local clinical standards.

5. Providing education and training to support the development of individuals and clinical teams.

6. Ensuring that implementation is managed within service agreements.

7. Ensuring that information is communicated promptly and accurately within the organisation.

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Further reading

Cochrane Effective Practice and the Organisation of Care Review Group (EPOC). Closing the gap between research and practice. Bero L and colleagues. BMJ 15 August 1998; 317: 465-268.

EPOC module in the Cochrane Library Bero L, Grilli R, Grimshaw JM, Mowatt G, Oxman AD (Eds) (1998). Cochrane Effective Professional and Organisation of Care Group. In: The Cochrane Library.

Getting evidence into practice. Effective Health Care. Vol 5, number 1. NHS Centre for reviews and Dissemination, The University of York 1999.

Lessons from the PACE programme. Dunning M and colleagues Turning Evidence into Everyday Practice. London: King's Fund, 1997. Experience, evidence and everyday Practice. London, King's Fund, 1999

Lessons from the FACTS project. Eve, R. and colleagues Learning from FACTS, ScHARR, University of Sheffield, Occasional paper 97/3 May 1997

Management of change in health care: E. Ferlie E and colleagues. 'The New Public Management in Action'. Oxford (1996): Oxford University Press.

Managing change. Garside P. Organisational context for quality: lessons from the fields of organisational development and change management. Quality in Health Care 1998; 7 (Suppl) :S1-S2

Organisational change: the key to quality improvement. Quality in Health Care 1998; 7 (Suppl) :S1-S2 [This supplement provides a series of nine important papers about aspects of organisational development]

Organisational change: the key to quality improvement. Quality in Health Care 1998; 7 (Suppl) :S1-S2 [This supplement provides a series of important papers about aspects of organisational development]

Time for organisational development in health care organisations. Koeck C. BMJ 1998:317: 1267 - 1268 (7 November 1998)