Bandolier Extra

Evidence-based health care December 2001

DELIVERING BETTER HEALTHCARE 3

Getting to grips with the detail. Learning to implementing change in clinical practice

Michael Dunning, Editor, ImpAct

This third paper in our series offers a detailed description of the challenge of implementing change in clinical practice. It is structured around a series of overheads that were prepared for a programme of training workshop we designed in the West Midlands region. The overheads cover the introductory presentation and two group exercises to explore ways to apply the knowledge to a local issue.

The material could be used in a workshop setting or as a tutorial individually. Please feel free to use it. We'd welcome comments on its usefulness.

The first paper in this series described some traps that people fall into as they look for ways to improve clinical practice.

The second paper offered a broad description of that task: an overall view of what's involved.

'Delivering Better Health Care' - a programme of workshops was developed in the West Midlands region in 1999 and 2000. The West Midlands Partnership for Developing Quality funded the programme.

What were we trying to do?

All NHS Trusts are developing their capability to introduce clinical governance with the Government looking for a systematic approach to quality improvement. As they look to the future, Trusts need to ensure that they have suitable local systems in place and staff with the appropriate knowledge and experience to assure quality. The design of these systems is able to draw on the growing knowledge about the issues involved in implementing improvements in clinical practice. An ability to facilitate change will be a key measure of success.

Our aim was to offer each NHS Trust in the West Midlands region a short two-hour workshop for a multi-disciplinary group of about fifteen people including clinicians and managers. We talked about a diagonal slice to embrace different disciplines and different levels in the organisation. We wanted to create a group of people in each Trust that might be able to work together with the same understanding of the tasks involved. We wanted to get away from the problem that arises when someone goes away on a training course and returns full of enthusiasm about a particular approach - but cannot then find colleagues who share their enthusiasm for a particular model of working.

Delivering Better Health Care: a picture

In designing the workshop we were keen to present a picture that would offer a framework of understanding for participants: to leave an image in their minds. We knew that we had a lot of ground to cover in the presentation and with the best will in the world it was unlikely that everyone would take it all in! We came up with a flag and quadrant design (Slide 1). The design was intended to help participants see the separate parts of the presentation in context and show where each part fitted into the overall picture. The design would be used as a logo on each overhead.

The plan was for a workshop in two parts: an opening presentation followed by small group discussions on a local implementation issue. The aim was to be practical and offer ideas for action, not to concentrate on the theory.

Did it work?

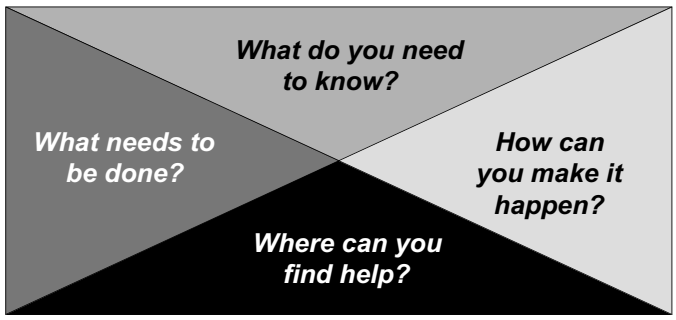
Pilot trials indicated support for idea behind the workshop. But, later, on-going evaluation showed that the session was too busy and too short. We were trying to handle too much detail in the limited time available. One option could have been to extend the time for the session - but conscious of the pressure on peoples' time we decided instead to offer a more concise version. The previous paper Seeing the wood for the trees described the concise version.

While the original workshop model may have too to detailed, essential information is covered in a structured way which may be helpful to people planning implementation projects: hence this paper. It is set out as notes to the overheads used in the original model for the workshop. The paper is in two parts, first linked to 23 overheads used in

the opening presentation and second the two tasks to provide structure to the small group discussions.

A. The Opening Presentation

Slide 1. Learning Objectives



The learning objectives were intended to enable participants to feel confident about answering four basic questions. We worked on the premise that change is a way of life in the NHS and therefore everyone knew something about the process. But as in any sphere of life it's difficult to know what you don't know.

The four questions were:

What do you need to know?

We wanted to offer a way to help people find their way through the growing body of knowledge about managing change in the NHS. The aim was not to provide all the answers but rather offer a series of signposts to help people follow-up on what they did not know.

What needs to be done?

We wanted to create a broad picture of the range of tasks involved so that work could be planned in an integrated way.

How can you make it happen?

We wanted to illustrate the range of skills and scale of resources required so that these issues could be tackled before the work was launched.

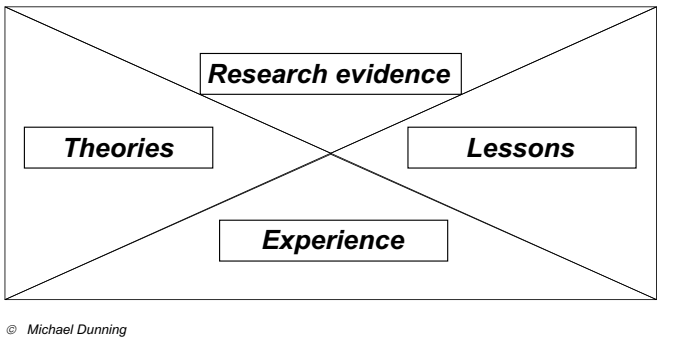
Where can you find help?

It can be a lonely job trying to shake up and change practice and services. We wanted to encourage people to seek help from others at difficult times and later share their experiences with others. What have they learnt that would be of benefit to others?

Key point:

Build a picture in your mind of the range of knowledge and tasks involved.

Slide 2. What do you need to know?



A context-setting slide to frame four types of knowledge.

Research evidence from studies about changing professional behaviour: a growing field since the introduction of evidence-based practice.

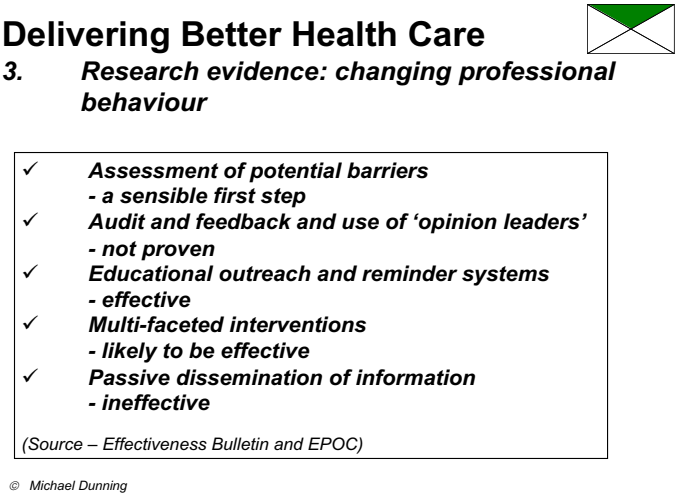
Theories which have been drawn from studies about how people learn and about how behaviour can be changed.

Lessons from initiatives to improve the quality of services, often drawn from non health care settings

Experience learned by others who have been involved in initiatives to change clinical practice and health services.

Slide 3. Research evidence: changing professional behaviour

The growing interest in evidence-based practice prompted many questions about how we could ensure that we



adopted the idea of evidence-based implementation. Andy Oxman prepared a seminal paper in 1994, No Magic Bullets, which argued:

"There are no magic bullets for improving the quality of health care, but there is a wide range of interventions available, that if used appropriately, can lead to substantial improvements in the application research and, ultimately the, the effectiveness and efficiency of health care".

Since the early 1990s the UK Cochrane Centre, the NHS Centre for Reviews and Dissemination and other similar bodies have started to improve access to research evidence about changing professional behaviour. A clearer picture about how to do this is emerging - even though important questions remain. An Effectiveness Bulletin produced by the Centre for Reviews and Dissemination at York University in 1999 provides a useful summary of current knowledge.

Within the Cochrane Collaboration, the Effective Practice and the Organisation of Care (EPOC) collaboration is providing an important means of helping to co-ordinate researchers working in this field. Details about the group are available at: http://www.abdn.ac.uk/public_health/hsru/epoc/index.hti

What is this research telling us?

Understand the context within which you are planning to work.

You need to assess the potential barriers to change. But, be clear about the level of detail you need. Experience from the PACE programme suggests that broad understanding is sufficient. Learn the lessons from the pharmaceutical companies who spend significant resources to assess their markets. Much of the intelligence they use is readily available in the NHS if you ask the right people. Who are good networkers who have their finger on the local pulse?

Build on what works

Evidence points very strongly to the need to use a multifaceted approach, which brings together a range of techniques targeted to the local context. For example, research has shown that well constructed educational programmes that take the message to clinicians can be successful: called educational out-reach. But be wary of the comment 'not proven' (in research terms) it does not mean 'not effective'. For example, experience has shown the merit of respected clinical leadership for implementation projects - even if the jury is still out on opinion leaders from a research point of view. While there is no firm research evidence that clinical audit works it has been shown to make an important contribution in some settings. Carefully presented it can prompt action. Similarly while there is no research evidence to suggest that the simple dissemination of information has an impact on clinical behaviour it may play an important part in raising awareness about the initiative.

Key points:

You need a good broad understanding of what is known - balancing the four types of knowledge.

Make sure that you keep in touch with new material.

Key source:

Effectiveness Bulletin: Getting evidence into practice: available at: http://www.york.ac.uk/inst/crd/ehc51.htm

Slide 4. Theory: models of behaviour change

Delivering Better Health Care

4. Theory: models of behaviour change

- ✓ ***Learning theory***
- ✓ ***Social models***
- ✓ ***Social marketing***

(Source – Effectiveness Bulletin)

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This is an extensive field that has a long history of study, much of the work is drawn from outside the NHS but has relevance as change initiatives are being planned. Three areas offer some helpful tips when planning implementation initiatives.

Learning theory offers an explanation of how behaviour is maintained and changed. It points to the importance of motivation of individuals - what is in it for them? Changes are more likely to be adopted and sustained if there is a process for following up and reinforcing the benefit and need for change.

Social models offer ideas about how beliefs, attitudes and relationships affect people's willingness to adopt new behaviours. Perhaps the best known is Roger (1983) who developed a model based on the receptivity to change. He suggested classifications running from innovators keen to take up new ideas, to laggards likely to resist new ideas.

Social marketing offers a framework for identifying factors that drive change. It suggests that success requires the use of change methods suitable to the needs of the target group. It defines a staged process from planning and choice of strategy to testing the proposed process. Evaluation and feedback should follow all of this.

Key points:

The first step should be to understand the context within which you are planning to work.

Working with willing volunteers is more likely to lead to early success. Be clear what the benefits are for those involved.

Slide 5. Lessons: about quality and change management

There is a long history in the NHS of developmental approaches to quality improvement and organisational development. There is an equally extensive literature. Work on the steps in the continuous quality improvement cycle will be familiar to many. It has many advocates.

The lessons from work under the quality banner point to the need for clarity of purpose (about what is desired) linked to a process for implementing change. Important features are the need to manage the process effectively with resources, a project team of able people with adequate time and resources. The momentum of the process can be maintained if demonstrations of successes are promoted to all those affected by the work.

Another useful approach is the EFQM Excellence Model developed by European Foundation for Quality Management. It offers a way of looking at the whole of an organisation's activities: not only about performance and outputs. The model's assessment process ensures that an organisation can see where it is performing well and where it is performing poorly and thus spot the important areas for improvement. Once the focus for effort has been agreed the most effective approaches can be designed. More details are available at the British Quality Foundation's website www.efqm.org.

Examples of work using the EFQM approach are [Include urls for the South Tees and Salford projects (plus the piece about A Proven approach to Quality Management) in the November 1999 issue of ImpAct]

Key points:

A systematic approach to project management is essential.

Explore how suitable quality models can provide a framework for local initiatives.

Key source:

Organisational Change: The Key to Quality Improvement. Quality in Health Care 1998; 7 (Suppl): this supplement provides a series of important papers about aspects of quality and organisational development.

Slide 6. Experience from implementation projects

The concept of evidence based practice was originally intended to influence the way individual clinicians went about their business. It sought to instil a new way of thinking by encouraging clinicians to make a more concerted effort to keep up to date with emerging research findings. Important papers had spotlighted the time lag between interventions being proven and their general adoption.

The interest in evidence-based practice raised questions about how to improve the quality of clinical care: could ways be found to speed up the process? Was there a practical way to manage the process of implementing change? These discussions prompted the creation of several major programmes across the NHS over recent years. Examples are:

- Getting Research into Practice (GRiP) in Oxford in 1993 that explored implementation from a health authority perspective. Could health authorities commission effective practice?

- Framework for appropriate care throughout Sheffield (FACTS) in 1995 sought to influence the clinical behaviour of GPs in Sheffield.

- Work within an R&D initiative in the North West NHS Region in 1995 to explore the creation of Research Liaison Groups. One element of the work was how to manage implementation.

- Work in the North Thames NHS Region to explore questions about methods of implementing research findings. This built on the preparatory work for a national R&D initiative on behaviour change.

- Promoting Action on Clinical Effectiveness (PACE) programme based at the King's Fund between 1995 and 1998. PACE was set up to show that implementation of evidence based practice could be achieved using (then) current knowledge about managing change in the NHS and about changing clinical behaviour.

All of these initiatives took as the starting point, particular

pieces of research evidence and sought to explore how change could be achieved. Most were designed as demonstration projects to show what was possible.

The slide suggests four main points that have emerged from the experience of managing implementation:

1 Implementing change is a complex, non-linear process. It is unlikely that the work will move forward in a logical sequence.

2 Time and resources are required to support the project activity.

3 Need for flexibility because of the unexpected.

4 Good communications are essential to ensure that those affected by the work understand how the work is being handled and progressing.

Key points:

Change is possible but it is a complex, expensive business.

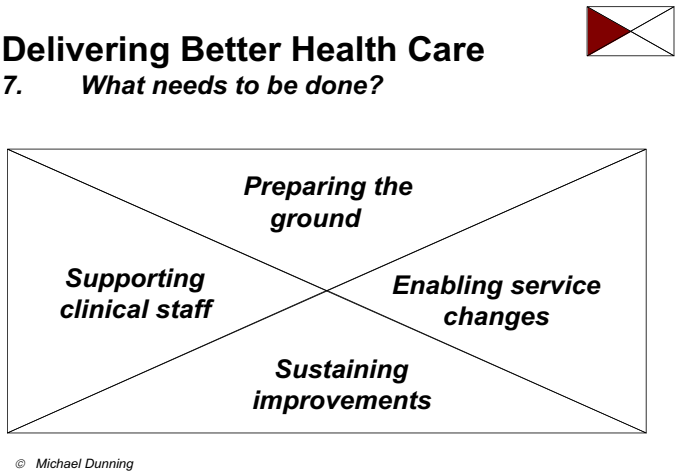
Stamina and resources are essential.

Key sources:

Lessons from the PACE programme. Experience, evidence and everyday Practice. London, King's Fund, 1999 (ISBN 1-85717-239-6). This final report provides brief descriptions of the sixteen local projects with many examples of lessons learned through the work.

Learning from FACTS, ScHARR, University of Sheffield, Occasional Paper 97/3. May 1997

Slide 7. What needs to be done?



A context setting slide to identify four areas where work is required.

- Preparing the ground, to understand the context within which the work is planned.
- Supporting clinical staff, to make the change process practical for busy clinicians.
- Enabling service changes so that local services reflect can support the delivery of evidence-based practice.
- Sustaining improvements to make sure that the changes achieved through the initiative survive in the medium and longer term.

Key points:

Don't expect to manage the four streams of the work sequentially.

Learn to coax and cajole the project along on a broad front.

Slide 8. Preparing the ground

Careful preparation is important and a pre-cursor to project work. Think carefully about how the initiative will be presented. Put the emphasis on quality and development and avoid talking about the work in ways that might be taken by some as criticism. It should be a support process, to enable clinicians to improve the quality of their practice not a threat to tell them what to do.

Preparatory work can be handled in five stages:

Evidence: will be one of the starting points so it is important to ensure that it is rock solid. Reliance on a research review undertaken by a reputable source will help to avoid countless potentially lengthy debates about what is the evidence. Favoured papers by a colleague from medical school may not be the same as evidence. The use of critical appraisal training can help to build a consensus.

Current practice: information will be needed to illustrate the nature of current practice so that the scale of change can be assessed. Clinical audit might be helpful. The aim should be to assemble a reasonable picture of current practice. It doesn't necessarily need to be too detailed.

Local views: information will be needed about the likely attitude of those who might be affected by the work: identify your allies and opponents. Where are the barriers to change? It will help you plan where best to start. Experi-

ence shows it is unwise to label people: those you think might be opponents might turn out to be strong supporters of your efforts.

Taken together these activities will create a sound understanding of the scale of change required and the likely problems that might be encountered. Detailed objectives and a timetable can then be constructed. This information will provide a reliable basis for the assessment of resources required to deliver the project.

The next step is to secure senior **commitment** to the work and agreement to the scale of resources required. It is about funding and time. This will help make involvement 'legitimate' - as an acceptable way to spend time. It can avoid the question: why are you spending time doing X.

The benefits for patients and the organisation need to be clear. Explore ways to link the proposed initiative to current priorities within the organisation. For example if questions about resources are dominant find ways to present the initiative as a way of using resources more effectively. If the concern is for service quality place the emphasis there.

Finally, be sensitive when deciding how to present **local standards**. Some clinicians are hostile to the concept of guidelines and may find care pathways or protocols a more acceptable term. Whatever approach is adopted avoid a glossy presentation: guidelines however good have a limited shelf life. And, they are the (relatively) easy part of the process: it easy to write down what others should do! There is an extensive literature about the presentation of guidelines and standards.

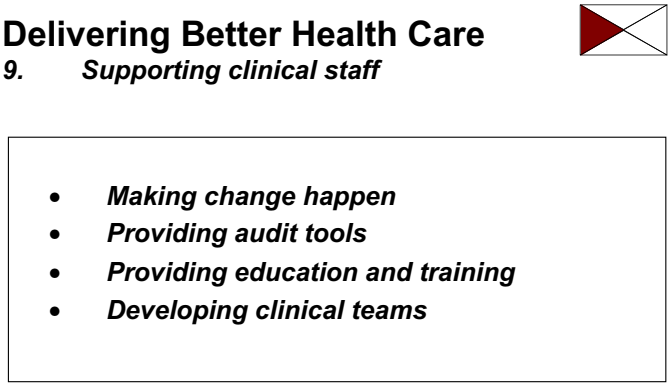
Key points:

Be practical, understand what and who needs to change.

Secure senior commitment to for the use of time and resources.

Slide 9. Supporting clinical staff

Evidence shows that providing information does not necessarily change the way people behave. Opportunities need to be provided to help make change a practical and painless process. Clinicians need time and space to understand the evidence and how they need to change. Find ways to answer the question I've been treating my patients with X for years with no complaints so why should I do anything different?



Change doesn't just happen. You have to work at **making change happen**. Careful preparation ought to have helped you decide how best to achieve change - what barriers need to be overcome and how? For example if the proposed change should influence the treatment for existing patients how will those patients be identified and how will their treatment be changed? **Providing clinical audit tools** can enable teams to review their own practice. Research has shown that the feedback of the findings from audit studies is more likely to influence clinical practice if it is part of work with those who have already acknowledged that change might be necessary.

Experience has shown that it is wise to pilot (test) how to take the work forward: what is likely to work here? But remember a short pilot will give you all the answers. Testing a process with a group of primary care practices does not guarantee a sound understanding of all local practices - but it will help you learn how to work with primary care.

Education and training will be an important component of any change programme. Clarity about the training needs of those involved will allow you to design the most suitable approach, with clearly defined learning objectives. Research suggests that interactive training sessions are more likely to change clinical practice than lectures. Experience has shown that taking training to people rather than expecting people to come to the training is more likely to be successful. Offering individual tutorials to busy clinicians, at time that suit them is more attractive than an invitation to a seminar! (see Warwick case study, November 1999). Seminars might however have a place as a means of promoting interest in the work.

Support from colleagues can be an important factor as clinicians engage in discussions about evidence and how it might affect the roles of team members. Effective teams have been shown to provide a means to harness the different contributions of individual clinical disciplines to the best effect for patients. But be patient, teams do not develop without help. Support for **developing clinical teams** can help support the change process. Effective teams require a common purpose and clarity about the contributions made by each discipline. A shared understanding of research and evidence is important. Teams only thrive with open communications between team members.

Key points:

Be incremental, patient and work systematically to help clinicians adopt evidence-based practice.

Provide support as well as information.

Key source:

Celebrating teamwork Firth Couzens, in The Key to Quality Improvement. Quality in Health Care 1998; 7 (Suppl)

Slide 10. Enabling service changes

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10. Enabling service changes

- ***Assessing resource consequences***
- ***Linking to budget timetables***
- ***Involving patients***

Changes in clinical practice will have an impact on resources and the level of service provided: such as:

Pharmaceutical budgets, perhaps to increase the use of some drugs and reduce the use of others.

Diagnostic services, where greater use of specific investigations may be required

Particular services, for example additional nursing time to lead clinic sessions.

Experience has shown that it is unwise to assume that the resources will be there. Time will be required to negotiate new service levels. Achieving this match will require two parallel actions.

Assessing resource consequences so that the scale and nature of changes is clear. The preparations for the initiative should have provided firm reliable information for this assessment. Costed plans will be essential. A realistic timetable will also be required: the aim should be to keep the development in practice in step with changes in resources.

Linking to budget timetables so that resources can come on stream as changes to practice are achieved. Strict timetables dictate the development and agreement of service budgets. Make sure that there is a strong link between the project work and these timetables. A practical means to this end is to ensure that the right people are involved. Managers may have key role from the outset, not only when service consequences are becoming an issue. Don't leave them out until you need them and expect their willing co-operation. They may resent last minute involvement.

Finding ways of **involving patients** in the work is essential: patients increasingly want to be involved in decisions about their care and treatment. Notwithstanding a need to involve them, experience has shown that patients can be powerful agents for change. Patients can offer practical contributions to project teams to help the team find ways to present information and get it into the hands of patients. Information about the nature of effective care in the hands of patients has been shown to lead them to seek this from the clinicians providing their treatment. Patient held records are a useful way of reinforcing information provided in clinical guidelines.

There is an extensive literature about questions about why patients should be involved and how that process can be achieved.

Key points:

Give questions about resources consequences priority - it can take a long time to change service funding levels.

Find ways to involve patients in project work - they can be influential allies.

Slide 11. Sustaining improvements

Delivering Better Health Care

11. Sustaining improvements

- ***Providing reminders***
- ***Influencing induction training***
- ***Supplying records/material***
- ***Learning from the experience***

All projects go through three main phases. First, the early days when the work is particularly exciting with new challenges almost every day. Second, the main bulk of the work when stamina to make the change happen is important. Finally, when people can see the end of the project and the work is coming to an end. The intensity of the work starts to slow down. It's not surprising that during this last phase people start to look for new challenges. But at the same time, no one wants to be associated with a failed (dead) project with the short-term improvements fading away.

Making sure that changes endure should therefore be a priority for all those involved. The challenge is to make sure that the changes become part of routine clinical practice. Who will coax and cajole when the project focus has ended? Three specific areas merit attention:

Providing reminders and changing the content of patient records. Research has shown that such reminders can be effective ways of prompting action by clinicians when clinical decisions are made. For example, to use stickers as a short-term measure to provide a place to record prescriptions. Parallel action should ensure the redesign of material before any major reprint.

Influencing induction training for newly appointed staff. All organisations should have some form of formal training to ensure that newly appointed staff, in all disciplines, understand the policies of the organisation and department they have joined. These staff induction programmes offer a practical way of reinforcing local practice standards and getting over This is how we do (it) here.

Supplying records and material to support the changes to practice. Virtually all implementation activities will create some new documentation - guidelines, referral forms, protocols, leaflets for patients etc. Arrangements need to be put in place to ensure that supplies are maintained. Who will order the reprints of the leaflets? And, how do clinical staff order supplies?

Managing and working on implementation is likely to be a new experience for many. Steps to capture the **learning from the experience** will ensure that other similar, subsequent activities are able to build on the successes and failures of the work. Make sure that the work is managed as a learning process. A project diary may be a useful means of maintaining a record of successes and failures. Honesty is important. The involvement of someone in the project team with facilitation skills can ensure that time set aside for reflection is used to the optimum effect. Positive action to build an effective team should create a willingness to join in open discussions, and for example review where things have gone wrong as well as gone well.

Key points:

It's never too early to start thinking about the end of a project and how the improvements achieved will be carried on in the longer term.

Regularly step back from the work and acknowledge what has been learnt and think about how to use those new skills in other settings.

Slide 12. Delivering results

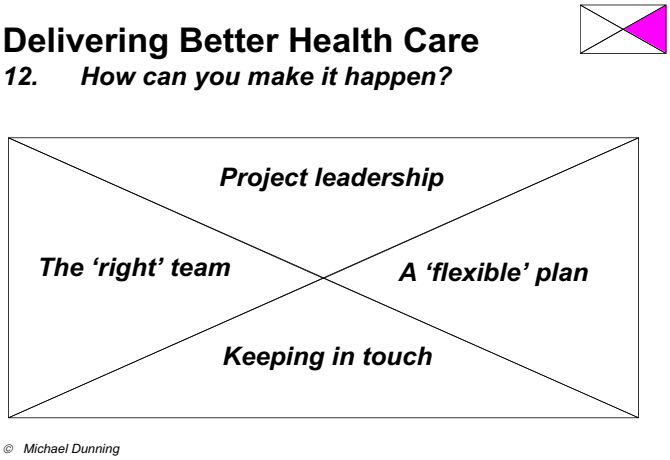
A context setting slide to identify four areas where work is required ie

Project leadership - who will lead the work?

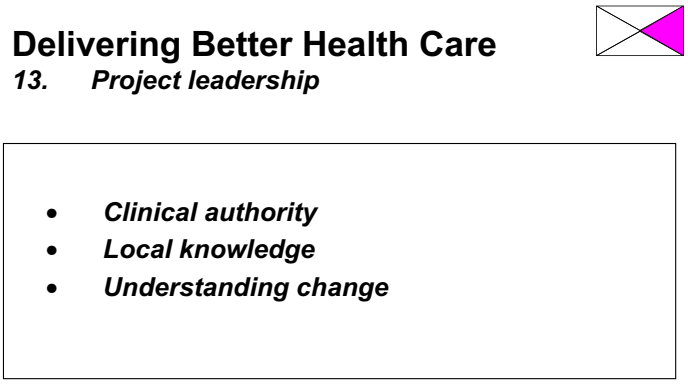
The right team - are the right skills available?

A flexible plan - suitable to the context within which the work is being done.

Keeping in touch - making sure that all those affected by the work are kept in touch with progress.



Slide 13. Project leadership



The complexity of the task emphasises the need to ensure that the right person is invited to provide overall leadership for the work. There are three broad factors to consider.

Clinical authority. In most situations, but not necessarily all, it may be wise to enlist a local (senior) clinicians to lead the work. Be guided by professional status locally, can they influence, and are they respected by, their peers? This may be more important than position in the organisational hierarchy.

Local knowledge. The importance of establishing a sound understanding of the context for the work puts particular importance on choosing someone who is alert to local policies and politics and who has or can make connections to cross departmental and organisational boundaries.

Understanding change. Managing change in the NHS is a complex business. The person chosen to lead the work needs, at least, a broad understanding of the task and its components.

Support to make the task do-able may be important. There may be real problems finding space in a busy (clinical) schedule. Appointment of someone, a project manager, to support the project leader and who has more time may help to keep the show on the road may be helpful. Make sure that both of these people are in place before key decisions about the project are made.

Key point:

Choice of the right person is important: it may be better to defer the work that start with the wrong person.

Slide 14. The right team

Successful implementation will require a detailed assessment of the resources needed in terms of people, time and materials. The different aspects of the work will require a range of **skills and experiences**, so care is needed to pick the right people. Building on an existing group may help speed up the process of creating an effective team but be systematic about the skills required. There may be benefits in involving someone with facilitation skills to ensure that

Delivering Better Health Care
14. The'right' team

- ***Skills and experiences***
- ***Team working***
- ***Clinicians and managers***

the learning from the work is recorded and diffused to future projects.

Good **team working** has been shown to be an important element in many implementation projects. Experience has also shown that it is important to ensure that the roles and objectives for individual members are clear.

There may be a natural inclination to concentrate on clinical staff to lead and undertake the work. Experience has however shown that effective teams and groups need to bring together **clinicians and managers**. Managers carry responsibilities about local priorities, about resources and about monitoring the effectiveness of the services. They will be important as questions about resource consequence arise. Managers may also bring along skills in managing change.

Key point:

Be serious about finding and recruiting the right people to make sure the objectives can be delivered. Don't rely only on close professional colleagues and friends.

Slide 15. Recruiting the right team: finding the skills

Delivering Better Health Care
15. Recruiting the 'right' team: finding the skills

Auditing
Budgeting
Communications
Critical appraisal
Education and Training
Facilitation
Information and IT
Public relations
Project management

This slide is an illustration of the range of skills that may be required. All are important. It offers a useful checklist.

Slide 16. A flexible plan

The broad contextual analysis, undertaken as part of the preparatory work should provide a firm base on which to plan the project. However, experience shows that an ability

Delivering Better Health Care
16. A 'flexible' plan

- ***Being clear about resources***
- ***Objectives and timetable***
- ***Tools and techniques***
- ***Keeping the work in balance***
- ***Monitoring progress***

to react flexibly as issues arise is important: it is very unlikely that the work will go to plan! As a project plan is being formulated five areas merit attention.

Being clear about resources. Organisational commitment to the work should ensure that resources are set aside to support the work and 'buy' the skills required. Be clear what resources are available and act accordingly. Do not expect people to give up their free time for you.

Make sure that realistic **objectives and timetable** are agreed for the work. A period for testing how the changes can be achieved before they are rolled out will provide valuable intelligence. But it may not provide all the answers. Experience shows that implementation of changes in clinical practice usually takes a significant amount of time and effort. It often takes longer than expected.

Adopting proven **tools and techniques**. Reflecting the complexity of the work effective project management will be essential. Research and experience has shown that a multifaceted approach - using a range of intervention techniques (such as local guidelines, educational programmes and audit and feedback) is the more likely to be effective. The choice should take into account the growing body of knowledge.

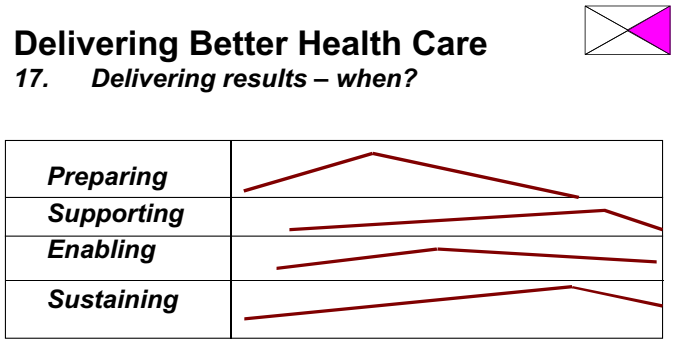
Keeping the work in balance. Because of the complexity of the work care need to be taken to keep the separate activities in balance. Don't spend too much time doing the familiar. For example avoid focusing too narrowly on preparatory tasks, such as agreeing local standards (creating guidelines) when more time may be required to secure change (with work to develop education and training opportunities).

Monitoring progress and keeping the project plan under review. Flexibility will be important as well as the means to adjust time scales when aspects of the project move ahead more slowly - or quicker - than planned. Listening to the reaction of those you seek to influence may be as important as working to keep the messages about the project consistent. Hear what they say.

Key point:

Don't believe that writing one plan will be enough - be ready to change and adapt as the work evolves.

Slide 17. Delivering results when?

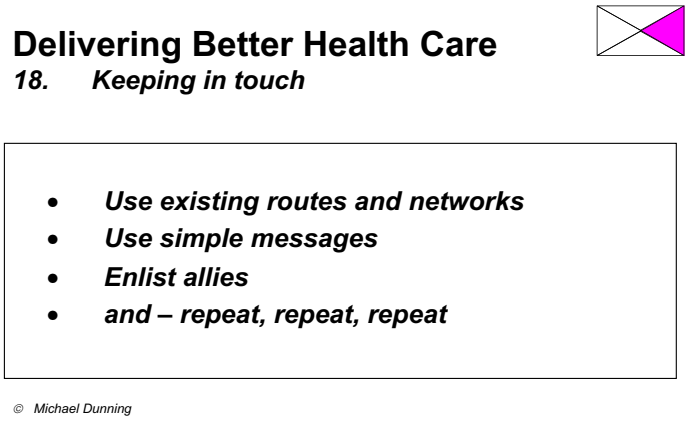


This slide is an illustration of the different pace of the separate aspects of the work. The aim is to encourage people leading projects to try to keep in mind four parallel paths of activity.

Key point:

Don't expect the work to be a smooth, sequential series of activities. The challenge is to learn to juggle these four streams.

Slide 18. Keeping in touch



Many clinicians and managers will need to know about progress with the work. The baseline assessment should have provided a map of those who will be affected. Communications is very important. People need to understand the impact of the work and how it affects them and how the work is progressing. Setting aside time to agree a communications strategy and how it will be implemented will be time well spent. It should be an early task for the project team. Three particular aspects merit attention.

Using existing routes and networks will save time and avoid adding to busy meeting schedules and documentation. Remember busy clinicians have little spare time for additional reading or meetings. For example, find ways to include the initiative on the agenda of relevant meetings, such as uni-disciplinary meetings, professional fora and professional and organisational development meetings. Similarly negotiate a column in relevant current local newsletters rather than creating a new one.

Using simple messages to build a common understanding of the work. Focus on clear, simple and consistent messages which evolve as work on the project progresses. Judge with care who will be entrusted with carrying the messages, who will listen to who? Share these tasks between members of the team and make communications a regular item for discussion at team meetings.

Enlisting allies to reinforce your efforts. Pick people who have contact with clinicians and whose practice you are seeking to influence. For example, prescribing advisers could reinforce your messages in their discussions with GPs. Similarly, think about how to engage others that may have direct contact with clinicians, such as community pharmacists, GP tutors and those charged with supporting professional development. Make sure that your allies carry the same consistent messages about the project and the standards of practice being sought.

Key point:

If you treat seriously the process of keeping people in touch with your work those on the receiving end are more likely to listen.

Slide 19. Where can you find help?

A context-setting slide identifying four sources of help.

This part of the presentation is intended to encourage people to be systematic in looking for support and help from others. The supporting slides are only illustrative of the possible sources. There are four broad headings.

- Local contacts
- Research groups
- Literature
- National and regional contacts

Key points:

A lot of people across the NHS have been involved in implementing evidence-based practice. Many are keen to share their experiences with those about to embark on similar initiatives. Learn from them.

There are no brownie points for re-inventing the wheel.

Slide 20. Local contacts

In large organisations it is often difficult to find the right people who might be able to offer advice and support. Many people may have the experience you seek but finding the needles in haystacks is a dauntless task. People can rely on personal networks do you know someone who can X ? But over and above this three groups or teams might also offer a good starting point.

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20. Local Contacts

- **Clinical Governance Team**
- **Quality Teams**
- **Training Groups**

All organisations will have a created a **clinical governance team** charged with the development of clinical governance in the organisation. It should be a local priority so resources may be available.

Many organisations that have sought to take a serious approach to the improvement of practice and services will have a **quality team**. Members may have experience in project management as well as other helpful skills such as the use of the Continuous Quality Improvement (CQI) methodology (and the Plan-Do-Study-Act cycle).

Finally education and training is an important component of all implementation initiatives, so local training groups should be an early port of call. They should be able to offer advice about setting up and running sessions to promote the project's aims.

Key point:

Don't rely only on who you know. Seek out local teams within your organisation who could support your efforts.

Slide 21. Research groups

Interest in the implementation has prompted significant investment in research about behavioural change and other aspects of the work. The work is evolving. Three areas offer potential support.

Within the **Cochrane Collaboration**, the Effective Practice and the Organisation of Care (EPOC) group is providing an important means of helping to co-ordinate researchers working in this field. Details about the group are available at: http://www.abdn.ac.uk/public_health/hsru/epoc/index.hti

Delivering Better Health Care
21. Research Groups

- **Cochrane Collaboration (EPOC)**
- **Academic Centres**
- **Quality Groups**

Many **academic centres**, universities and medical schools, have developed teams to tackle questions about improving the quality of health care. Check with your local academic organisations.

Check out also quality groups such as **British Quality Foundation's** website www.efqm.org who can support work using the EFQM Excellence Model developed by European Foundation for Quality Management.

Key point:

Substantial energy is being deployed to find answers about implementing change. Make sure you benefit from that effort.

Slide 22. Literature

Increasing interest in helping people in the NHS learn from the experiences of others has led to a rapid growth in publications in paper and electronic form.

Local **NHS libraries** should be on the top of anyone's checklist. The development of the National electronic Library for Health (NeLH) is slowly building up the infrastructure to facilitate access to knowledge.

ImpAct and **Bandolier** are reliable and trusted sources of evidence and experience of people in implementing change.

The **NHS Beacon programme** was launched in 1999 to identify good local services. It aims to help people in other organisations learn how to mirror good experiences. Information about Beacons is available from www.nhsbeacons.org.uk.

Delivering Better Health Care
22. Literature

- **NHS libraries**
- ***ImpAct* and *Bandolier***
- **NHS Beacons**
- **Databases and Web-sites**

The plans for the **NHS Modernisation Agency** should also offer practical ways to learn from nationally led development programmes as it is taken forward. Keep in touch.

Key points:

Don't be afraid to ask. Real effort is being made to support personal development and learning in the NHS.

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23. National and regional contacts

- **Regional Offices**
- **Quality and Practice Development Groups**
- **NHS Learning Zone**

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B. Small Group Sessions

To provide an opportunity for workshop participants to reflect on the material discussed in the presentation the programme concluded with small group sessions. People learn by getting involved, not listening to talking heads. Before the workshop, the organisation had been asked to suggest clinical topics where change in clinical practice might be required.

Two questions were used to structure the small group discussions. The groups were given copies of the slides to facilitate recording and feedback of the discussions.

Group Task 1: Discuss the skills and experiences required for the project and to identify who could provide that expertise.

The groups were asked to consider systematically the skills and experiences they would need to deliver their local project. And, importantly who would provide those skills.

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Task 1: Discuss the skills and experiences required for the project and identify who could provide that expertise.

Skills and experience	*Who - or where from?*

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Task 2: Assume 150 days are available to deliver the project - and review how those resources might be best deployed during the life of the project

	Months 1-6	Months 6-12	Months 12-18
Preparation			
Support			
Enabling			
Sustaining			

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The groups were encouraged to use Slide 15 as a starting checklist.

Group Task 2: Assume 150 days are available to deliver the project and review how those resources might be best deployed during the life of the project

The group was asked to think through questions about the deployment of resources across the four broad areas of activity. Could they see a practical way to keep momentum on all aspects? The groups were encouraged to think about the pattern given in Slide 17.

At the end of the workshop, we set aside some time to allow the separate small group to exchange views. It proved helpful material that those charged with setting up the local initiative could use as their plans took shape.

Conclusion

Making the most of local training sessions is fraught with problems. Everyone is so busy. The main problems we found were getting the right people there on the day, making sure that the session was not a one-off event detached from other programmes and getting the timing right, so that it could help stimulate action. In short it was about timing, links and relevance. Despite all this, on the day evaluation suggested that those involved found the sessions helpful. All of the information offered was and is relevant. It's a model that is worth trying either for a group session or as in individual tutorial.

Good luck.

Michael Dunning
April 2001