Continuous quality improvement: educating towards a culture of clinical governance

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Abstract

The National Health Service in England and Wales has recently adopted a policy aimed at embedding continuous quality improvement (CQI) at all levels and across all services. The key goal is to achieve changes in practice which improve patient outcomes. This paper describes the use of a training course for multiprofessional groups of participants tailored to offer them relevant knowledge, management and team working skills, and approaches to personal and career development. These were intended to assist them in changing their practice for the benefit of patients. The participants rated the course highly in fulfilling its objectives. One cohort followed up for 6 months named changes in practice which related specifically to learning from the course. This paper shows the important contribution of multiprofessional learning to CQI and presents a useful method of evaluating links between learning and performance.

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Traditionally, most healthcare education from undergraduate through to postgraduate training is offered within specific professional groups. Most training is focused on the care of individual patients with specific conditions and little attention and time goes to educating healthcare professionals on wider professional issues such as how patient care depends on contributions of colleagues from other disciplines; working in teams; organisational behaviour and change; and clinical audit or continuous quality improvement (CQI). Nurses and doctors will therefore learn separately about the care of patients with, for example, diabetes from their own professional viewpoints, but often do not learn about the organisational aspects of care of people with diabetes. Although these aspects of care are not about individual people and individual treatments, getting them right impacts on both the quality and the safety of the care patients receive. Some health professionals believe that they learn better when only with their peers and are not attracted to multiprofessional learning opportunities.¹

Encouraging healthcare professionals to understand and learn about the importance of these wider aspects of care is crucial if care is to become more patient centred and if quality improvement initiatives are to have any real impact. New policies within the NHS acknowledge the need for multiprofessional

Key messages

- Evidence shows that professional barriers are broken down when training across professions is undertaken.
- Almost all participants in the "Managing Life" education programme on CQI and multiprofessional team working recognised the learning they had achieved, rated it as highly important, and related it to improvements in clinical practice.
- Health professionals participating in the programme appeared to alter their practice as a result of this educational intervention.
- Creating a widespread culture of CQI will require explicit support and commitment, with investment in time and funding if substantial change is to occur.
- It is possible and rewarding for professionals involved in commissioning education for quality improvement in health care to work together to share resources and create educational programmes which promote a potentially sustainable culture of CQI to the benefit of patient care.

team working and decision taking based on expertise pooled between all those concerned in the care of a patient—a substantial change in the prevailing culture in health care. In the 1998 Government White Paper on quality² the term "clinical governance" is used to describe the links between clinical and organisational responsibility for the quality of care. No longer are chief executives of health and healthcare organisations responsible only for the financial "bottom line"; they also bear responsibility for the quality of clinical service. Importantly, there is an imperative for clinicians to see quality improvement as an organisational as well as a professional and clinical issue. The aim is to establish a culture in which quality improvement is central to the work of all so that the "10 Cs" of clinical governance can become embedded in that culture (box 1).³

"10 Cs" of clinical governance

- Clinical performance
- Clinical leadership
- Clinical audit
- Clinical risk management
- Complaints
- Continuing health needs assessments
- Changing practice through evidence
- Continuing education
- Culture of excellence
- Clear accountability

Box 1 The "10 Cs" of clinical governance.

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Much of this thinking is not new. For example, the professional guidance to doctors through the UK's General Medical Council (GMC) emphasises the necessity to develop and maintain good team working skills in the interest of patient care.⁴ However, there is little encouragement or promotion of multiprofessional working from within the NHS, nor has there been a firm lead on developing these important skills from the educational institutions.

Intuitively, developing postgraduate work based training programmes that enable professionals to learn to develop common values, skills, and goals with respect to health and health care may be one way of increasing effective multiprofessional working. Pre-qualification courses do not emphasise these aspects of professional roles. It is thus necessary, if initiatives such as clinical governance are to make any real difference to patient care, that healthcare professionals are given the opportunity to acquire the necessary skills in their post-qualification years. To this end, in 1998 one of the two London PostGraduate Deaneries (the organisations responsible for commissioning and implementing postgraduate medical training) and the local health education commissioning bodies for all other healthcare clinical workers (nurses, midwives, therapy staff, laboratory technical staff) known as educational consortia (box 2) developed a hospital based interprofessional curriculum aimed at providing recently qualified healthcare staff (3–5 years post-qualification) with an educational programme upon which to better understand the principles and practice of CQI and the need to work more effectively in multiprofessional teams. The main objectives of this programme—known locally as “*Managing Life in the NHS*” (“Managing Life”) were:

- to explore the potential for starting a range of healthcare workers from different professional groups to learn together the attitudes, skills, and knowledge needed to enable them to support CQI in the workplace to the benefit of patient care;
- to encourage young healthcare workers to consider their own personal and professional development in the context of CQI and team working; and
- to assess whether such an educational intervention would impact on patient care.

This paper describes the development and implementation of the “Managing Life” programme. The first stage is an overview of all those who completed the programme in whole or in part (approximately 200 participants) by the time of this analysis. The second is an in depth evaluation of one course cohort followed longitudinally from the start of the course, throughout its time, and then for a further 6 months to determine the impact of this educational intervention on their clinical practice and on patient care.

The programme

TRAINING ALREADY AVAILABLE

In 1998, before setting up the programme, a regional survey was undertaken to ascertain the

Educational consortia were established in the mid 1990s in England and given the financial and managerial responsibility for commissioning pre-registration education for nurses and midwives, and post-registration education for nurses, midwives, and therapy staff. The constituent members comprised all those employing healthcare staff in these groups, including hospitals (both NHS and non-NHS), local government organisations, and voluntary agencies. At the time of this project there were eight in the North Thames health district. The educational consortia have evolved into more complex and sophisticated groups called Workforce Development Confederations which are responsible for commissioning education for all healthcare staff, including medical staff. There are now five of these in London.

Box 2 Educational consortia.

range of management and other generic training and educational programmes that were available locally for healthcare workers. A questionnaire survey was sent to the human resource (HR) directors of 61 hospitals in the North Thames geographical region. Information was requested on the details of management and generic skills training provided at each local hospital; who was eligible to participate in the training; and who, in practice, took advantage of these educational opportunities. The purpose of this scoping survey was to identify the range of generic training opportunities on offer in hospitals since this would reflect the areas that healthcare employers and employees thought important for further professional development.

Thirty different areas of training were offered by the hospital training departments, ranging from presentation skills (the most commonly offered educational programme) to equal opportunities. Most of the hospitals indicated that training was open to all staff groups, but that only in a very few instances did medical staff take advantage of training that was not specifically doctor focused (such as presentation skills).

DEVELOPMENT OF PROGRAMME

A Steering Group representing those organisations responsible for commissioning postgraduate education for all professional healthcare groups drew up a curriculum together over a period of some 4 months (fig 1). The representatives from the consortia were senior doctors and senior nurses, educationalists, and HR and training leads from hospital services. The information from the scoping survey provided a “needs analysis” from which the Steering Group developed the elements of the draft curriculum. It agreed that the educational programme should consist of three modules—one each on the knowledge, skills, and attitudes thought relevant to learning about CQI or clinical governance. Each module offered five educational days and was structured to identify

Figure 1 Programme development.

the learning aims, objectives, and outcomes for each of the training days. Small working teams of 2–3 people met outside the Steering Group to consider and draft these. The members of the Steering Group received the drafts and then met in plenary session to debate, revise, and agree them.

The Steering Group did not wish to impose a curriculum but rather to develop a programme that met the needs of relevant stakeholders. The draft curriculum was therefore circulated for consultation to hospitals (chief executives and HR directors) as the employers of the healthcare workers at whom the curriculum was aimed, medical consultants responsible for both managing specialty training and for advising training doctors (clinical tutors), public health directors in health authorities, and to the chief executives of the educational consortia.

The consultation revealed widespread support for the principle of interprofessional training on generic issues, for such a programme to be delivered within the workplace, and for this education to be delivered to agreed standards across all organisations participating in health improvement programmes. It was noted that such educational activity could also be used to foster partnerships and encourage agencies to work across traditional barriers. Most respondents thought additional financial resources would be needed to implement such a

programme. As anticipated, there was widespread (although not universal) agreement with the content of the proposed curriculum, with some respondents suggesting that additional areas such as ethics and legal issues be included. The agreed curriculum is shown in table 1.

The consultation identified potential constraints to the implementation of the programme. These chiefly involved issues around multiprofessional learning and resources and are further explored below.

LOCAL OWNERSHIP

Given the broad mandate from the consultation, the Steering Group agreed that each of the educational consortia should have local ownership of the programme and implement it to suit local needs and local employment issues within hospitals, especially concerning arrangements for enabling staff to participate in professional development activities. Programmes had to be delivered to the agreed curriculum and evaluated to a standard format (appendix). Participants were asked to score aspects of the sessions on a scale from 1 (very poor) to 5 (excellent). Quality assurance was achieved through the development of a subgroup of the Steering Group that reviewed the proposals presented by each educational consortium and monitored the outcome of the evaluations. A programme was accredited under the banner of “Managing Life” if it followed the curriculum and if its evaluations continued to be satisfactory. This novel approach to the genesis and the implementation of a single educational curriculum delivered over a wide geographical area by a number of provider organisations enabled the Steering Group to investigate the causes of training evaluated as unsatisfactory, to quality control its delivery, and to ensure that the educational standards of the programme were being met. The Steering Group also agreed that local programmes had to reflect, as far as possible, a multiprofessional mix of approximately one third medical staff, one third nursing and midwifery staff, and one third from the therapy services and other professional groups.

The Steering Group continued to meet on a regular basis over the subsequent 2.5 years to share the learning from the development and implementation of the local programmes.

IMPLEMENTATION

Each of the representatives from the educational consortia who was on the Steering Group consulted with local educationalists and training departments within hospitals to implement the curriculum. A range of models was used. In some areas external facilitators were used to design and deliver each individual training day to meet the curriculum specification while, in others, local hospital training departments enlisted NHS and other speakers and facilitators to provide training through lectures, workshops, role play sessions, tutorials, and project work. The local programmes all subscribed to the curriculum learning objectives, to delivering the programme in a

Table 1 "Managing Life": course curriculum

Module 1: Knowledge	Module 2: Skills	Module 3: Attitudes and personal development
Clinical governance and the modern NHS (including values, ethics and accountability)	Presentation skills and managing meetings	Communicating with patients and colleagues
Quality and complaints in the NHS	Clinical audit skills	Assertiveness and influence
Critical analysis of data and evidence	Managing life during change, leadership, and working in teams	Time management and prioritising
Diversity and equal opportunities for staff and patients	Negotiation and conflict	Career development
Managing financial resources	Appraisal and performance management	Mentoring, supervising, and supporting colleagues

multiprofessional setting, and to regularly returning the completed standard evaluations.

PROBLEMS AND BARRIERS

The implementation process moved at a different pace within each of the consortia localities, depending on local issues, so the Steering Group was able to regularly review progress with implementation and to consider problems brought by the representatives from the consortia. Three major areas of difficulties, all of which had been raised during the consultation process, were reported by local groups.

Firstly, there were some important professional issues that had to be addressed. Cultural barriers over perceived differences in learning approaches, especially articulated by doctors and nurses, and pace of learning were identified. Several training departments raised this before implementation of educational programmes, observing that different professional groups have different levels of background knowledge and experience in such areas as the analysis and use of critical evidence. Furthermore, some senior healthcare professionals, especially doctors, believed that learning about values and other generic topics interfered with the technical and specialty skills of practice which they were anxious for doctors in training to acquire.

Secondly, there was concern about the funding needed to support these programmes. The consultation process had highlighted a lack of dedicated funding for implementation. More broadly, the need to invest in the educational and professional development of healthcare staff to achieve fundamental and CQI in patient care was noted.

Thirdly, senior nurses and other therapy staff raised concerns over the impact of releasing ward nursing staff for sufficient time to attend the programme offered. Both funding and availability of replacement staff were very limited. This was not an issue for doctors in training since dedicated time and funding are available for them to undertake such training.

These organisational and professional barriers were real. Those developing programmes were aware and sensitive to the potential learning differences of the professional groups. The evaluations that were received highlighted areas where these differences impacted on learning—for example, critical appraisal skills. Local programmes modified the curriculum and its presentation to try to address this. Professional reluctance to engage in either managing, teaching, or participating in local programmes was not dealt with confrontationally but was marginalised by seeking active

champions to implement and encourage participation. The postgraduate deans advised those with responsibilities for training doctors and the doctors in training that learning about the context of quality improvement in the NHS was a vital part of their progress to senior positions. The postgraduate deans gave £10 000 to each of the consortia to be used as locally required to implement the curriculum. The consortia gave at least matched funding; in some localities more was allocated at the discretion of the consortium.

EVALUATION OF THE PROGRAMME

Each participant completed a standard questionnaire at the end of each day of the course with an additional set of four summary questions at the end of the five day module. These were entered into a database and SPSS was used to analyse the data. The overall evaluation of the programme centred on the additional four key questions, three of which relate directly to the objectives set:

- Did the programme enhance participants' understanding of CQI?
- In the participants' view, did the programme enhance multiprofessional working in the future/current team?
- Was the programme likely to impact on the participants' future clinical practice to the benefit of patient care?

The fourth asked if the participant would recommend this educational programme to a colleague.

The in depth evaluation of the longer term effects of the programme was carried out through a series of three semi-structured interviews with each of the 16 participants of the first programme. These interviews took place before the programme commenced, within 3 weeks of completion of the programme, and 6 months later. All the interviews were conducted by the same interviewer (GS) who is a doctor involved in health service research. The participants had already submitted the standard evaluation for each day of training. They also scored the training for each day when subsequently asked directly by the researcher. These were then cross referenced to the mean scores obtained by the standard evaluations. The interviews also covered a wider and greater depth of issues around clinical governance.

EXTENT OF THE PROGRAMME

Thirty four modules, each of 5 days duration, were offered in the 14 months between October 1999 and December 2000. Within each local area represented by an educational consortium each of the three modules was

Figure 2 Participants in "Managing Life" programme by profession.

offered at least once. This meant that individual healthcare workers could access the full programme comprising the knowledge, skills, and attitude modules. The evaluations received covered 1197 participant days. In addition to the daily evaluations for each element of a module, at the end of each 5 day module participants were asked to complete the four summary questions covering their views about the educational programme in which they had participated; 208 responses were received to these summary questions from 28 of the 34 programmes. Early operational issues initially prevented the remaining six programmes from sending in evaluation results. The professional groups to which the 170 participants belonged are shown in fig 2.

Results

SUMMARY EVALUATIONS

The responses to these questions by 208 respondents are shown in table 2; 191 (92%) indicated that participation in the programme had enhanced their understanding of CQI; 200 (96%) said it was likely to enhance multiprofessional working; 201 (97%) said participation in the programme would be likely to improve their clinical practice in the future to the benefit of patient care; and 206 (99%) said they would recommend the programme to a colleague.

For several reasons there is some uncertainty about the response rate to the four key questions. Firstly, some participants were unable to attend each day of training in each module. Secondly, initial registration for a module was not necessarily indicative of attendance since course organisers reported that occasionally, due to clinical or other unexpected commitments, registrants could either not attend at all or could only attend part of a programme.

The evaluation return methodology was set up so that individuals attending the final day of a module were highly likely to complete the

four questions: the evaluations were distributed within the time allocated for training; time was given for participants to complete them; and they were collected in before participants left. In two consortia where nine modules were delivered the response rate to the four questions is known since these course organisers were clear about the numbers of registrants who attended all or part of the programme. Analysis of the figures from these courses alongside those of participants who returned a response to the four final questions on day 5 of that module gave a response rate to the four final questions of between 82% and 100%. This is likely to be very similar to the overall response rate.

Results from the first programme, which was subject to in depth evaluation, mirrored the findings of the summary evaluations. The mean evaluation scores of the standard evaluations from each individual day of the programme are displayed with those of the in depth evaluations in table 3. The overall evaluation gave scores ranging between 3.8 and 4.4 (1 = poor; 5 = excellent), rating especially highly sessions on quality and complaints and on negotiation and conflict (4.4 out of a possible 5.0).

IN DEPTH EVALUATIONS

First interview

Sixteen healthcare workers (10 doctors in training, three nurses/midwives, and three therapists) participated in this programme and were included in the in depth evaluation. Before the programme all participants said that they expected to gain knowledge of the local health structures and policies. Fourteen of the 16 participants expected to learn management skills, including presentation skills, leadership, conflict resolution, team working, and delegation. Five perceived the programme as an opportunity for personal development and the assessment of future career options. All were unclear as to precisely how their clinical practice would alter as a result of undertaking this educational programme: six could not offer any view on whether this might happen at all.

Fifteen believed that CQI would enhance health care. Two participants were concerned that there might be insufficient time and money to change practice successfully, and two others were anxious that it might encourage defensive medicine and destroy the autonomy of clinicians.

Second interview (within 3 weeks of completing the programme)

Following the same interview schedule, all participants at this stage believed that CQI should enhance health care and change the culture of the NHS for the better, but 13 qualified this by voicing concerns over the time and money that it would need for successful implementation across the board. Four alluded to poor staff morale and two worried that innovation might be stifled if all areas of practice were subject to protocols and guidelines that allowed little clinical autonomy. Six said that the following would be needed:

Table 2 Response to key questions (n=208)

Question	Yes	No
Has this programme enhanced your understanding of clinical governance?	191	17
Is "Managing Life" likely to enhance multidisciplinary working in your future/current team?	200	8
Is it likely to impact on your clinical practice in the future to the benefit of patient care?	201	7
Would you recommend this educational programme to a colleague?	206	2

Table 3 "Managing Life" course: comparison of scores between in depth study evaluation and wider evaluation

Course session	Wider evaluation mean	In depth study evaluation mean
Clinical governance and the modern NHS	4.1	4.1
Quality and complaints	4.4	3.7
Data analysis/decision making	3.8	3.7
Diversity and equal opportunities	3.9	2.8
Finance	4.2	3.0
Presentation skills	4.2	3.8
Clinical audit	4.0	3.9
Change, leadership and teams	4.2	3.7
Negotiation and conflict	4.4	3.9
Appraisal, performance management	4.0	3.4
Communications	4.0	3.5
Assertiveness and influence	4.0	2.3
Time management, prioritising	4.1	3.7
Career development	4.2	3.0
Mentoring etc	3.9	3.1
Mean of means	4.1	3.4

Note that the in depth scores were out of 10 and the wider evaluation scores were out of 5. To allow direct comparison the in depth study mean scores have been halved.

- resources—both time and money;
- education—a wider understanding by healthcare staff of CQI;
- skills such as those learned on this programme.

The 16 participants wanted all their colleagues to benefit from the experience of the programme, with all but one believing that it was most suitable for those with several years of health work experience.

Third interview (6 months after the programme)

At this interview participants were asked to say if their performance had changed following the programme and, if so, to offer specific examples where this had happened. Thirteen of the 16 named a discrete activity, ranging from reviewing clinical treatment regimens to reconsidering the use of agency staff, to career development, and using reflective practice (table 4).

Twelve participants thought they themselves had changed as a result of attending the programme. They cited qualities such as greater confidence and better use of evidence in decision taking:

"Now I am much more thoughtful about why I do things and whether my actions are appropriate—I try to look things up more."

"I manage myself and my workload differently and reflect on my role on a day to day basis".

Table 4 Changes in practice identified by course participants 6 months after completing the course

New activity	Course element(s) used by participants
A new approach to the treatment of corneal abrasions	Clinical audit and the use of evidence
Reviewing and altering the system for late reporting of x rays in the A & E	Clinical governance basics, project, personal development
Collecting evidence for using warming blankets for patients undergoing certain procedures	Clinical audit, presentation skills
Reviewing and altering the use of agency nurses	Time management, project planning
More consistent and careful documentation of unexpected incidents	Clinical governance basics, quality and complaints
Career planning for personal development	Career planning, other personal development
Closer adherence to procedures for proper consent in theatres	Clinical governance basics, quality and complaints
Review and alteration to the treatment of acute urinary retention (there was an audit for this in train, but it has been changed in the light of "Managing Life" knowledge to a more focused study)	Clinical audit
Checking more closely that there is evidence for pharmaceutical advice given, and being clearer with people when it is absent	Library work on finding evidence, clinical governance basics, personal development
Reviewing the logistics of a walk in GUM/HIV clinic	Project planning, clinical audit
Reviewing the clinical management of pulmonary emboli	Clinical audit, personal development
Beginning a journal club at which the clinical team meet at regular intervals to analyse and discuss newly published work in their area of expertise	Use of evidence, personal development and reflections on practice
Spending time each day reflecting on practice and being more assertive over imperfections	Clinical governance basics, remembering course evaluation time, personal development

Nine of the 16 participants spoke unprompted of the importance of the multiprofessional nature of the programme, naming it as an extremely important part of the learning:

"The interaction with the multidisciplinary group was the most important aspect of the course."

"It eliminated some prejudices I didn't know I had. I look differently at other colleagues now."

All participants believed that CQI would enhance health care, though all but one had reservations similar to those expressed in the interviews immediately after the course. All 16 participants again stated their view that clinical staff with several years' experience of working in health care should undertake the programme, with seven suggesting that attendance should be made compulsory:

"Not just a slogan. The delivering of greater effectiveness, which contains standards of health and safety, and involvement together of all members of a clinical team. It means caring for patients and team working to achieve one objective—the best for the patient."

"The quality of service and the professional development of staff will best be done by making sure that evidence based medicine is practised, and that the standards of poorly performing hospitals are brought up to the standards of the best performing hospitals."

Discussion

How well did this educational programme meet its objectives?

SUPPORTING LEARNING ABOUT CQI

The first objective was to explore the potential for starting a range of healthcare workers from different professional groups to learn together the attitudes, skills, and knowledge needed to enable them to support CQI in the workplace to the benefit of patient care. The overall evaluation strongly supported the success of the programme in this area since 92% of respondents indicated that participation in the programme had enhanced their understanding of CQI, 96% said it was likely to enhance multiprofessional working, and 97% of respondents said participation in the programme would be likely to improve their clinical practice in the future to the benefit of patient care. The in depth evaluation comments provided further evidence for this.

Local programme organisers were aware that health professionals harbour negative stereotype prejudices about one another which can be diminished by multiprofessional learning.⁵ Favourable traits are difficult to acquire but, once acquired, are not easily lost.⁶ This is important: misunderstandings can be caused by a lack of a common interprofessional vocabulary, by the differing value systems leading to the setting of different goals by different professional groups, and by the need for each discipline to protect its own agenda. Despite all these potential pitfalls, the weight of evidence favours collaborative training and working for health and social care.¹

Shaw⁷ found that positive changes in perception between professional groups frequently waned following multiprofessional courses. Participants in the in depth evaluation appeared to demonstrate that they had sustained their interest in CQI since they undertook activities to support clinical governance activities. Managers and colleagues need to offer encouragement and create opportunities for participants of courses such as this one. The organisations involved with this programme were alive to the need to pursue multiprofessional team working back in the workplace and encouraged the constituent bodies to search for suitable projects.

CQI AND TEAM WORKING

The second objective was to encourage recently qualified healthcare workers to consider their own personal and professional development in the context of CQI and team working. Concerns within the NHS over money spent on education programmes without evidence of their effectiveness in realising their goals—especially in improving patient care—are well recognised.^{8–10} There is a particular dearth of evidence on the value of multiprofessional programmes, especially at the postgraduate level. Indeed, the Standing Committee on Postgraduate Medical and Dental Education (SCOPME)¹¹ published a report in 1999 in which it was observed that *“a skills training approach in team working is neither necessary nor appropriate. If individuals are provided with autonomy and a climate of equity and mutual respect between different professional is created, then a multiprofessional group will develop its own way of working and learning effectively together.”* Bligh and Parsell¹² have queried this view and argue that *“planned education, undertaken with sensitivity at the right time, will help to generate the mutual trust and respect that is so essential for multiprofessional working and learning to achieve its goals.”*

Pirrie *et al*¹³ believe that the changing structures of the NHS have indeed increased the importance of teamwork. They articulated the tension in multiprofessional training between retaining unique areas of skills and knowledge, and sharing overlapping aspects to mutual benefit. Hardern¹⁴ has suggested that topics such as palliative care and the ethics of medicine are the most suitable for multiprofessional learning since they cut across boundaries and focus on teamwork. An increasing number

of courses are being offered in other countries on a multiprofessional basis—for example, Cloonan *et al*¹⁵ in the USA offer a course on medicine, law, and ethics.

This educational programme was established for a range of health professionals to follow together. Those who completed it cited the multiprofessional nature of the group as the heart of the most important learning they gained. In the wider evaluation there was overwhelming support for increasing multiprofessional team working. Greater team working will need investment of money, time, and persuading others of its benefits. Those responsible for postgraduate medical and dental education in London have encouraged local healthcare bodies to support complementary multiprofessional programmes for more senior healthcare professionals and, to date, 25 such programmes have been developed and are being implemented and evaluated.

Multiprofessional programmes need proper resources, clear objectives agreed by all parties, strong commitment by all staff to overcome logistical difficulties, and time for people to reflect on both the positive and negative outcomes of a multiprofessional programme. It can be difficult to pitch the teaching to suit all participants. There is a danger that one discipline outnumbers others to dominate and perhaps reinforce stereotypes. Our programme appears to have successfully addressed this issue by encouraging proportional representation, where possible, from different professional groups.

There are other problems, such as recognising that professional value systems and standards feel under threat and that participants may take time to become receptive. Operational issues such as the disparity between funding and educational cycles can also stymie efforts at multiprofessional programmes.¹³

IMPACT ON PATIENT CARE

The third and perhaps most important objective was to assess whether such an educational intervention would impact on patient care. Evaluations of multiprofessional training generally report on alterations in attitudes and perception, but few on their impact on practice. It is difficult to link directly and causally any changes in performance to one particular factor. By including an in depth evaluation of some of the participants we were able to get closer to assessing the ultimate goal of such educational programmes—namely, the impact on patient care.

Thirteen of the 16 participants interviewed named a change in practice that they linked directly to the education programme (table 4). These included more awareness of risk management, using evidence based practice, clinical audit, and improved efforts at personal development—all key elements in the continuous improvement of quality care so necessary for the culture change being pursued by the NHS. Clearly this study could go no further than participants' statements about their own practice, but their reflections are encouraging. It would be interesting to investigate whether

such a programme has effects on attitudes and practice that are sustained over the long term and what additional “refresher” learning or support mechanisms are needed to continue and enhance these changes.

Finally, the authors believe that the study presents good evidence of programme effectiveness through the use of the in depth longer term follow up complementing the broader evaluation of all participants. The combination of a quantitative and a qualitative analysis seems to provide a robust method of evaluation which could be refined and universalised with significant benefit.

Conclusions

This programme appears to have been effective in enabling participants to reflect on and change their practice in a way that is likely to contribute to CQI. Furthermore, 99% of participants would recommend that colleagues undertake the programme suggesting that it had addressed educational needs that, when met, may enable participants to give better patient care. Such multiprofessional programmes that address gaps in education not provided by standard professional courses may help to achieve both the culture change sought and the necessary understanding by health professionals of the importance of being part of the changing health landscape in which quality of patient care and the need to engage in improving practice is central.

The programme is one strand in the seismic culture change necessary if the NHS is to change, focusing on CQI in a rigorous fashion¹⁶ and delivering its potential. The objectives were set to reflect the realisation that CQI will be a touchstone for the success of the health and healthcare systems in the future. The programme evaluations showed that the participants gained greater understanding of working

in multiprofessional teams, and also gained knowledge, skills, and tools for personal and professional development. Participants were robust in their belief that CQI would enhance health care, but retained concerns about the resource investment this would need, the time it would take, and the clear need for strong, overt and continuing support from senior NHS players and Government.

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Standard Evaluation Document
Managing Life in the NHS: Educating Towards Clinical Governance

Title of today's educational programme: _____

Module Number: _____ Section: _____

Today's Date: _____ Tutor/facilitator: _____

Venue: _____

		Please circle one				
		Poor				Good
1	How well did the educational programme for the day meet the stated aims?	1	2	3	4	5
2	How well did it match your own learning needs?	1	2	3	4	5
3	How interesting did you find it?	1	2	3	4	5
4	How relevant did you find it?	1	2	3	4	5
5	How would you rate the design of today's programme?	1	2	3	4	5
6	How would you rate the style of the tutors/facilitators?	1	2	3	4	5
7	How would you rate the knowledge of the tutors/facilitators?	1	2	3	4	5
8	How would you rate the pace of the day?	1	2	3	4	5
9	How would you rate the different learning approaches used during the day (e.g. small groups, videos, etc)	1	2	3	4	5
10	How valuable was learning with colleagues from other disciplines?	1	2	3	4	5
11	How would you rate your overall level of satisfaction with the educational programme you took part in today?	1	2	3	4	5
12	How useful did you find the opportunity to reflect on the day?	1	2	3	4	5

- 13 Do you think that asking patients/carers to be involved in the delivery of this educational programme would be valuable? Yes No
- 14 Do you believe that today's educational programme is likely to have an impact on your future practice? Yes No
- 15 What could we do to improve today's programme? _____

- 16 Please identify your professional group (tick one) ☐ Nurse/midwife ☐ Doctor ☐ PAM ☐ Manager
☐ Primary Care ☐ Other
- 17 Please indicate your specialty: _____
- 18 When did you qualify? _____
- 19 What grade are you? _____
- 20 Do you work in an acute or community setting? _____

Please only respond to these questions on the last day you complete the full module (tick one): ☐ Knowledge
☐ Skills
☐ Attitudes/personal development

- 21 Looking back over the last several days, do you think that the educational programme you have participated in:
- (a) has enhanced your understanding of clinical governance? Yes No
- (b) is likely to enhance multidisciplinary working in your current/future team? Yes No
- (c) is likely to impact on your clinical practice in the future to the benefit of patient care? Yes No
- 22 Would you recommend this programme to a colleague? Yes No
- 23 Are there any other comments you would like to make? _____