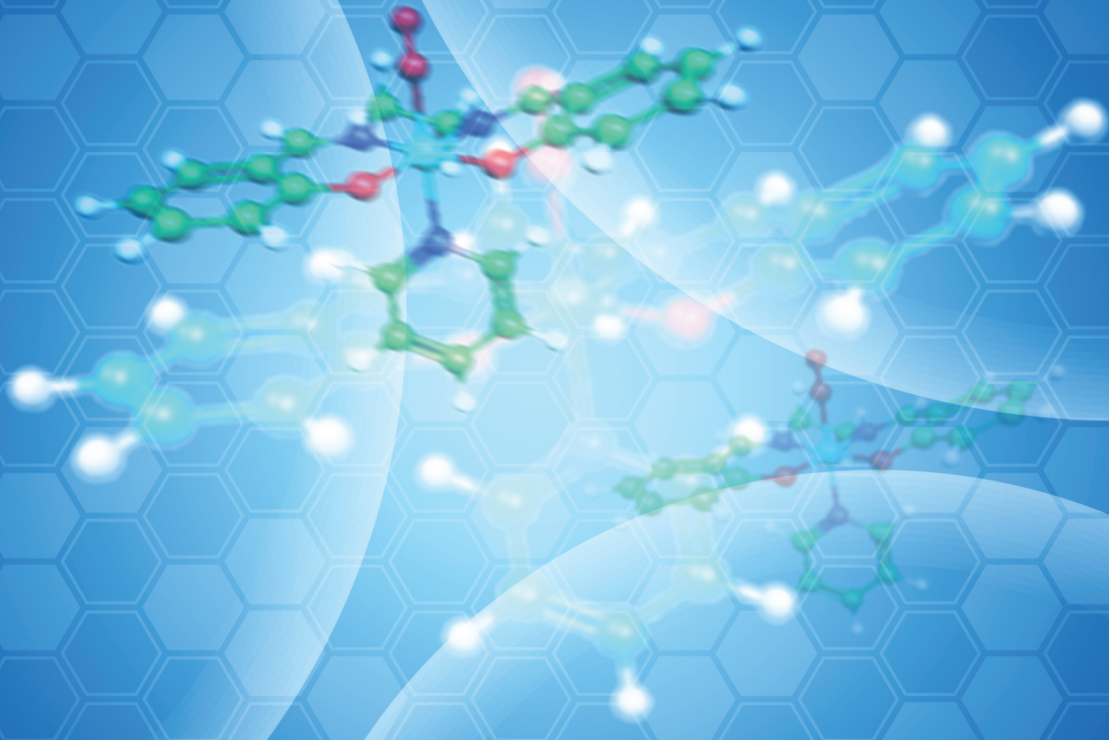


Engaging clinicians in a quality agenda



National Leadership
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Engaging clinicians in a quality agenda



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Cover Reference:

Engaging Clinicians in a quality agenda

Control:

Practical resource/paper that suggests the important elements necessary for successful and sustained strategic clinical engagement. Includes two simple 'self assessed' tools which can aid assessment and implementation of a strategic plan for clinical engagement across diverse health communities.

Date:

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Description:

This resource is the final of the current 'Clinical Engagement' series from the National Leadership and Innovation Agency for Healthcare forming part of the Clinical Support to Local Health Boards programme. (Also produced "Referral Management Centre in Wales – Final Report" Dec 07 and "Clinical Engagement – Primary Care leading by design" March 08). It builds on work originally produced in the USA and interprets it in the context of the NHS in Wales (and possibly the UK). It includes some practical examples from leading clinicians in Wales and the USA in primary care and acute care settings.

Consequence:

The purpose of this document is to share international knowledge across NHS Wales on how it may engage/develop engagement of clinicians in healthcare improvement work. It aims to aid the future development of quality improvement by outlining what effective strategic clinical engagement needs to involve and achieve across health communities, organisations, departments or practices.

Target Audience:

Healthcare organisations and professional bodies/groups in Wales dependant on clinical engagement to effectively manage the care of patients within/across primary and secondary care.

Intended Circulation:

WAG Policy Leads; Local Health Boards; NHS Trusts; LMCs; Clinical Professional Groups; Regional Commissioning Units.

Originator:

Institute for Health Improvement (IHI) white paper, "Engaging Physicians in Shared Quality Agenda" (Reinertsen JL, Gosfield AG, Rupp W, Whittington JW) with adaptations by Susan Baboolal of the Welsh Medicines Resource Centre and Breeda Worthington, National Leadership and Innovation Agency for Healthcare.

Authorisation:

Chief Executive, National Leadership & Innovation Agency for Healthcare

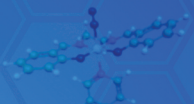
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Context and Background

As a large complex organisation under constant pressure to meet demand and drive innovation, the duty of the National Health Service (NHS) to providing high quality patient care has never been more challenging.¹ Organisations and individual clinicians are coming under intense pressure to produce measurable quality and safety improvements. At the same time, local and national strategic priorities are being keenly debated, service reconfigurations for the NHS are being undertaken, and health policy is being scrutinised by both politicians and the media.¹

Healthcare organisations often have trouble generating enthusiasm in clinicians for quality initiatives. Healthcare professionals' desire to deliver quality services doesn't always translate into support for change, and responses to quality initiatives can range from apathy to direct opposition. NHS Wales is not alone in this regard – poor engagement is a “long-standing, multifactorial, and international problem.”² However, while some organisations struggle to implement evidence-based protocols and rigorous safety practice, others are making dramatic improvements in quality. Yet even in the most advanced, one of the most common questions raised is, “How can we do an even better job of engaging our clinicians in the quality and safety agenda?” This question arises because of several overlapping realities:

- ▶ Clinicians' primary professional focus is their own practice – the quality of care they personally deliver, and the economics of their own professional microsystem (for example, their clinical environment may comprise a large general practice or a specialist hospital department). In many instances, these priorities seem out of alignment with the quality issues faced by the larger organisations with which they work.

"Quality has been used as a weapon in the fight against limits to healthcare funding. In one corner of the ring stands the clinician, outraged that a paper pushing manager concerned with throughputs and efficiency does not understand or care that quality of care is adversely affected by cost cutting. In the other corner stands the manager, convinced that quality is the last refuge of the medical scoundrel – a convenient, vague, and all embracing term used to block any attempts to question or change clinical behaviour."

Buchan, 1998²

- ▶ At best, clinicians have little time to spare for the quality agendas of these organisations, whether they are that of the local health board (LHB), hospital trust, or broader NHS. At worst, relationships are strained because the clinicians' quality agendas appear to be in conflict with those of the organisation.

For example, in one hospital the manager wished to standardise hip prostheses, both to obtain better pricing and to reduce costly and hazardous variation in the process of hip replacement. An orthopaedic surgeon responded, "What? I've just become really comfortable with the prosthesis I'm using. I'm getting great results, and it's efficient for me. Now you want me to take the time to learn a whole new prosthesis? That's risky for my patients. How is that an improvement?"

- ▶ A critical fact about healthcare systems is that very little happens without a clinician's order: almost all actions in health care are derived from their decisions and recommendations. Therefore, any changes in the way care is designed and delivered require clinician acceptance, either as individuals or as professional groups.
- ▶ A belief in personal responsibility for quality is powerfully engrained in the clinician professional culture – and is largely responsible for clinicians' fierce attachment to individual autonomy. This cultural element puts clinicians in conflict with a core principle of improvement theory: a systems view of quality and safety. It also leads naturally to a blaming culture. Clinicians are taught that "If we work and study hard enough, we won't make a mistake." This leads them to believe that if a mistake does happen, then someone (a clinician, in this instance) didn't work or study hard enough. Both of these effects – lack of a systems perspective, and a tendency to blame individuals when things go wrong – arise from the same basic belief in personal responsibility.

Given the deep-seated nature of these realities and the importance of clinician engagement to achieving quality results, it is surprising that so few organisations have actually articulated a plan to improve the engagement of their clinicians.

The main findings of a report recently commissioned by the National Leadership and Innovation Agency for Healthcare (NLIAH)³ demonstrate a lack of clarity surrounding clinical engagement within Wales – somewhat unexpectedly given that it is a central tenet of the Designed for Life agenda. This lack of clarity is evident particularly in relation to what engagement is, what it is supposed to achieve, and how best to proceed in developing it.

Importantly it is clear from the research that there are different perceptions of what clinical engagement should be – that of the policy maker, the commissioners, and the clinicians – leading to confusion and, in some case barriers, to developing services further. It is essential that common ground is actively explored and sought in order to continue to promote service improvements across Wales. However, this must be taken a stage further – developing clinical engagement should form a strategic part of service development within Wales in order to achieve the changes and developments required to produce a modernised NHS. Some commentators propose that rather than being a particular activity, clinical engagement should be more of a “philosophy” that underpins a partnership approach.⁴

The primary purpose of this document is to present a framework which leaders might use to consider clinician engagement in quality and safety.

The Framework for Engaging Clinicians in Quality and Safety comprises six primary elements, as shown in Figure 1 (page 7). Each framework element and its components are described in detail in this document.

The original paper on this framework produced by the Institute for Healthcare Improvement (IHI) focuses on hospital systems in the United States: it has been adapted by NLIAH for the purposes of sharing the ideas and findings with the NHS in Wales. To this end, examples of practice have been included that have been identified through the Welsh Assembly Government Healthcare Improvement Plan, in work commissioned by NLIAH that has been produced by Cardiff University and the Clinical Research Group, and in projects undertaken by participants in the University’s Department of General Practice’s Organisational Effectiveness Programme.

It is important to note that the available evidence (international and national) to share is limited. Many of the published reports of service improvements do not specifically detail the processes or mechanisms related to clinical engagement.³ Literature reviews that have assessed clinicians’ current understanding, attitudes, and engagement in quality initiatives are primarily based on “grey literature” or published studies of self-reported attitudes or experience.

“Best-in-the-world laboratories” for learning about clinician engagement

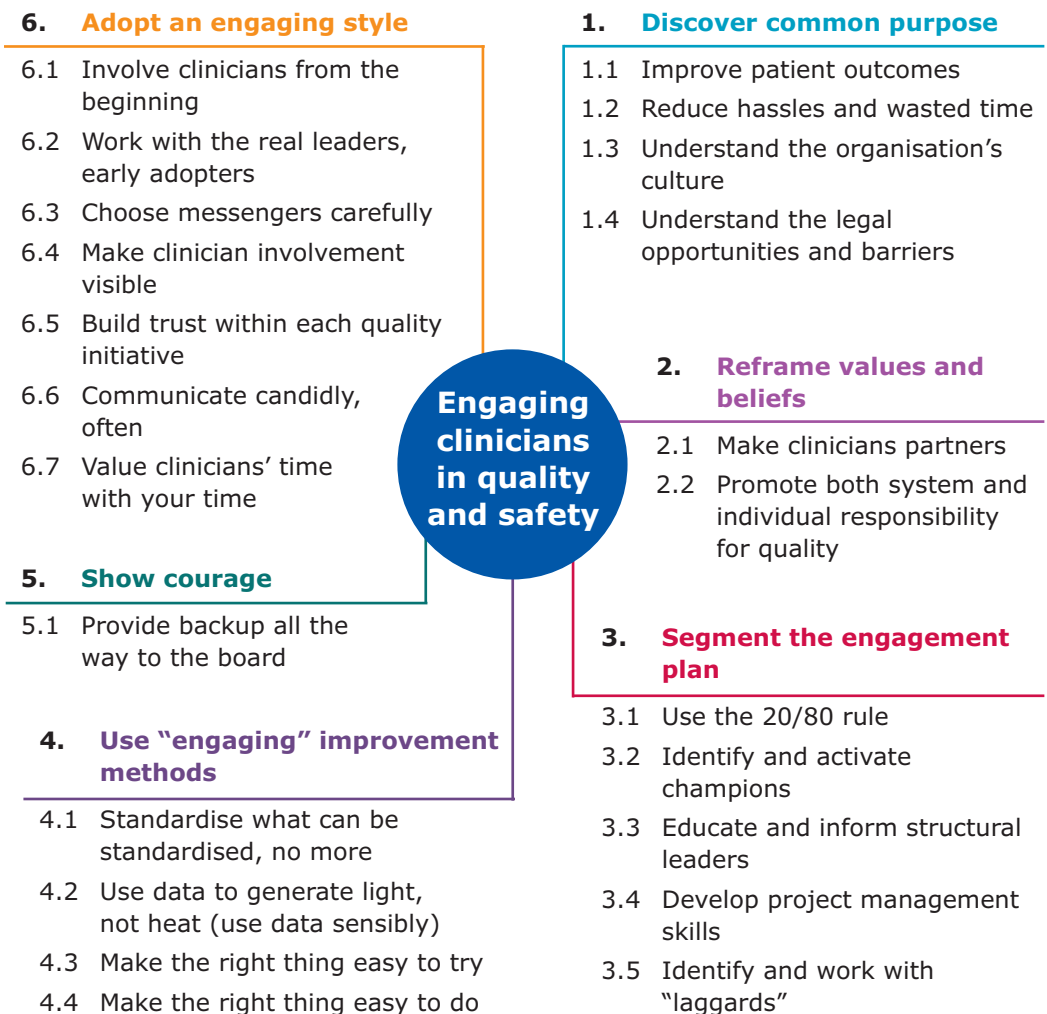
The measure of effective leadership is results. The core elements of the Framework for Engaging Clinicians in Quality and Safety are drawn from the lessons and ideas of several organisations that have effectively engaged clinicians to get results in quality and safety.

These ideas come from organisations in the US such as Virginia Mason Medical Centre, McLeod Regional Medical Centre, Hackensack University Medical Centre, Immanuel St. Joseph’s – Mayo Health System, and Tallahassee Memorial Hospital, along with many others in a variety of settings ranging from multi-specialty group practices to independent medical staffs to the NHS in the UK. None of them claims to have the answer to clinician engagement in quality. But many of them have achieved stunning results. For example, Tallahassee Memorial Hospital⁵ and Immanuel St. Joseph’s – Mayo Health System have reduced mortality rates 30 to 40 per cent. Hackensack and McLeod are now capable of delivering “perfect care scores” on evidence-based care at levels of only 1 or 2 defects per 100, for all Centres for Medicare & Medicaid Services (CMS) Core Measure sets.⁶ McLeod has gone seven straight months without a single adverse drug event,⁷ as measured with the IHI Trigger Tool methodology⁸ (an objective count of medication-caused harm which does not depend on incident reports or other self-reporting systems). These results could not have been achieved without significant engagement on the part of the clinicians.

Because we learn as much or more from failure as from success, notice has also been made of what doesn’t work. The path to more and better clinician collaboration is not always smooth. So in addition to extracting lessons about what leaders should do to improve clinician engagement in quality, some things that leaders should not do are also addressed. The hope is that the Framework for Engaging Clinicians in Quality and Safety, built from elements learned from “best-in-the-world laboratories,” will encourage leaders to develop and execute a written plan to improve clinician engagement in these sorts of quality and safety initiatives.

Framework for Engaging Clinicians in Quality and Safety

Figure 1. Framework for Engaging Clinicians in Quality and Safety



Framework element 1

Discover common purpose

Link the organisation's quality agenda to the clinician quality agenda

The first element of the framework requires a mind shift on the part of directors, managers, and clinical leads. It suggests that the question "How can we engage clinicians in the organisation's quality agenda?" could be rephrased as "How can we engage in the clinicians' quality agenda?" This question forces organisations to recognise that clinicians are interested in quality – in particular, two attributes of quality: patient outcomes and personal *muda* (waste), especially issues around wasted time. Interestingly, these two quality concerns – outcomes and time – are not independent variables. They are strongly linked.

1.1 Improve patient outcomes

Improving patient outcomes remains the essence of the clinical role. However, the evidence to suggest how this should or could be achieved is at times conflicting and at worst arbitrary. The diversity of humans and the variability of interactions between them make providing a simple or even understandable method for improving patient outcomes the holy grail of healthcare.

Wales and England have been working hard at improving processes of care through selective implementation and development of "care pathways" and "care bundles" across primary, secondary, community, voluntary, and social care settings – these processes standardise what happens, when, and to whom based on reliable evidence, thereby ensuring a standard level of care even in the absence of key members of a clinical care team. Improving care processes aims, not only to directly improve patient outcomes, but to support and improve the capacity and capability of clinicians to deliver services.

1.2 Reduce hassles and wasted time

Giving clinicians more time in their day is neither simply an issue of personal satisfaction with the quality of their professional lives, nor merely an opportunity for them to generate more income. Rather, the issue of time is one which itself has a significant impact on quality and outcomes. "The transfer of knowledge is care."⁹ That transfer may occur through dialogue, the writing of a prescription, the interpretation of a study, or the performance of a procedure. To optimise that knowledge transfer, the clinician must apply the best evidence available to the specific patient taking into account, not only the patient's allergies to medicines, laboratory test results, social, family, and medical history, but also the patient's fears, beliefs, and socioeconomic status – in essence, everything that makes the

patient unique. To do this effectively requires time: time to listen, time to examine, time to think, time to explain, time to operate, time to interpret, time to comfort.

The lack of time to do a good job is a particularly strong driver of unhappiness in primary care,¹⁰ but all clinicians feel these pressures to some degree. Trusts and LHBs can help by changing the way work gets done, providing resources and support, and improving work flow processes and efficiency, so as to remove “time stealers” and improve patient outcomes. In essence, this reframes the quality agenda so that the clinicians’ needs for fewer hassles in their daily work and better outcomes for their patients, are harnessed to the health service’s need for things like reduced waiting times and improved Quality and Outcome Framework (QOF) measures.

NHS work includes many activities that are time stealers for clinicians: documenting care, waiting for delays and backups in patient flow, locating patient records and referral letters, serving on committees. These are in addition to the demands clinicians face: responding to the demands of other service providers for certificates of medical necessity for equipment and ambulances; managing patients’ pharmaceutical needs with repeat prescriptions; interacting with social services, and more. All of these activities can potentially steal time from the valued aspects of their relationships with their patients.^{11,12}

“ . . . team meetings are an ideal forum for discussing quality issues as there’s representation from the different professional groups . . . but it’s hard enough to find the time to meet to discuss the clinical issues let alone add extra time on for quality.”

UK hospital consultant.¹³

Clinician engagement in the hard work of quality improvement is much more likely to occur if health service leaders remember John Gardner’s teaching that one of the key tasks of leadership is to explain “why,” in personally meaningful terms.¹⁴ What could be more meaningful for clinicians than “Our aim in quality is to eliminate those things that waste everyone’s time, so that you and the entire healthcare team can have more time to do the important things that really determine patient outcomes”?

1.3 Understand the organisation's culture

An essential first step to finding common purpose is to be abundantly clear about the place from which you are starting your clinician engagement endeavours. Here, the point is to be brutally realistic and not unduly rosy-eyed about the real work at hand. If clinicians hold grudges from past tensions and battles, they will carry the scars of those skirmishes into the context of any new initiative, including one concerning quality. The clinician memory of difficult interactions is often very long. And whatever the problems might have been, the fact that they have nothing to do with the current proposal, or even current personnel, is often irrelevant. More to the point, different clinician groups within an organisation will view the same issues quite differently.

In today's environment, within one geographical region, clinicians might practice in single-handed or multi-partner practices, or other primary care entities affiliated with an LHB. Some of those clinicians will be employed full-time, others part-time or on a locum basis. Some have academic affiliations and career goals, others do not. Some will refer patients principally to one location while others will have varied referral patterns. Still other clinicians may work within the private healthcare sector. Clinicians in secondary care might be employed directly by an NHS trust, delivering services in one or several hospitals or healthcare settings or, in the case of specialist commissioned or tertiary services, across different trusts. The perceptions of each of these types of clinicians regarding their positions in the organisations and their roles in quality and safety initiatives are likely to be quite different.

A complex mix of factors influences the difficulty an organisation will have in moving from a defined starting point toward higher levels of clinician engagement in quality and safety. Some factors are structural, such as the various employment arrangements described above. Others are historical – the memory and residual effects of relationships and events in the organisation's past. But the most powerful factor of all is culture – the beliefs, norms, and values (spoken or unspoken) that form the basis for patterns of behaviours of the clinicians. Understanding the existing culture is critical to changing to a new one.

Patterns of behaviour provide the primary window into the culture of any given organisation. It's important to note that an organisation does not have a single culture; rather, it contains multiple "micro-cultures," corresponding to clinical groups, departments, subspecialties, and so forth. To illustrate: what pattern of behaviour might you expect if an improvement team recommends the adoption of a standardised method for all clinicians' insulin orders? Is the pattern of behaviour the same across all units, practices, departments? What underlying beliefs support these various patterns of behaviour? If quality leads have a good understanding of the beliefs, norms, and values that are driving these behaviours, they are more likely to bring about successful engagement at a higher level.

The issue of culture becomes particularly difficult when two organisations merge, or enter shared arrangements, requiring clinicians in different cultures to work together; for example, several independent practices working on a common LHB directive, or a small community-based centre merging with a large teaching institution. The patterns of behaviour and the underlying beliefs around topics such as clinician autonomy, partnership with managers, and relationship to executive and board members are likely to be substantially different – and will constitute a significant challenge to clinician engagement in quality.

The Clinician Engagement Difficulty Assessment

For the purposes of developing a strong plan for improving clinician engagement in quality and safety, it is not necessary to define every aspect of the organisation’s culture and micro-cultures. But it is important to assess those aspects of the various cultures that will predictably thwart (or enhance) clinician engagement. The Clinician Engagement Difficulty Assessment (see Appendix A) is intended to provide a rough assessment of the cultural and historical factors that need to be taken into account when building a clinician engagement plan.

(Note: the suggested scoring system is not intended to be used rigidly; there are undoubtedly many nuances to an organisation’s answers to the items in the assessment. For example, clinicians directly employed by a NHS trust may be just as resistant to change as an independent practice contracted by an LHB. Or, a clinical team may be highly functional even though its policies are obsolete and essentially irrelevant.)

The historic cultural factors (see Assessment item 9 in Appendix A) deserve additional explanation, since these sorts of issues play such a prominent role in the culture of many organisations. Some examples include:

- ▶ Recent battles over policy changes or service arrangements might have been “flash points”.
- ▶ A recent quality initiative might have started badly, and left a sour taste in everyone’s mouth. Further efforts will be tainted by this experience.
- ▶ Failed contracting strategies can haunt an organisation long after the contracts are terminated.
- ▶ Successful clinician-administration joint ventures can provide part of a foundation on which to build quality engagement.

Repeated re-organisation and dramatic shifts in policy in the NHS are likely to have resulted in a degree of cynicism and if this view is widespread amongst clinicians in Wales, the approach to engagement must take it into account. It should be recognised as an “actual” stumbling block that needs addressing sooner rather than later by the quality of communication and the effort put into developing positive and productive working relationships, together with an open agenda.³

Identifying obstacles to clinician-led engagement is an important part of leading change.

With large scale reconfiguration of hospital services planned, the Caerphilly County Borough Primary, Community and Social Care Commissioning Strategy has identified the need to involve clinicians in the LHB commissioning process. One aim of the LHB is to develop “locality cluster groups” of general practitioners (GPs) to address gaps in local service provision. Barriers to establishing these groups include:

- ▶ time – both GP and LHB managerial time
- ▶ money, i.e., reimbursement of locum fees
- ▶ demographics – arranging GP attendance from several small and single-handed practices
- ▶ perceptions – overcoming suspicion of clinician involvement in managerial work, and the experience of past initiatives that have had little impact.

Alun Edwards, LHB Medical Advisor.
Organisational Effectiveness Programme, Cardiff University

From these examples and the self-assessment in Appendix A, an important point emerges regarding plans to engage clinicians in quality and safety: sometimes, in some stages of an organisation’s history, you might have to re-engage the clinicians much more broadly on a variety of administrative and strategic issues, before taking on the quality and safety agenda. On the other hand, when relationships between clinicians and the organisation are rocky because of issues such as those noted above, the quality and safety agenda can function extraordinarily well as a bridge-builder because it appeals to the deep professional aspirations of clinicians and managers alike.

The Clinician Engagement Difficulty Assessment is designed to prompt leaders to think carefully about the structural and historical factors present as these will inform the degree of difficulty that they might have in moving together with the clinicians to a higher level of partnership for quality and safety.

The “best” total score on the Clinician Engagement Difficulty Assessment is 9. At this level, clinician engagement is not necessarily assured, but it is a lot easier to get to an integrated, collaborative, sustainable, quality-driven culture than at the “most difficult” score of 31. That is a difficult job, and might require a very different approach.

The total score is not determinative of what might happen, but in essence is a taking of the organisation's temperature. Completing the self-assessment and discussing its implications among leaders and the clinical team, is an important early step in understanding, prioritising, and sequencing the work that needs to be done in order to develop and execute a plan for clinician engagement in quality and safety (see Appendices B and C).

This assessment is a relatively crude tool for thinking about and asking for clinicians' views of their circumstances. Whatever the responses, the process of going through an honest self-examination of where your organisation is starting from (1) can be useful to custom tailor your efforts toward any engagement moving forward, and (2) will point, in some measure, to the attention that will have to be paid to certain overarching principles of engagement that are useful in winning the support of the clinicians for quality improvement (see Framework Element 6).

The key to changing a culture is to first write down a non-judgmental, specific description of the current culture, and to develop a shared picture of the patterns of behaviour driven by that culture. Only when everything about the starting point is on the table can a group have useful discussions about what changes in culture will be necessary to accomplish the organisation's aims in the future. Two successful methods to accomplish such a change have been advocated by Dr. Jack Silversin and his work with "compacts,"¹⁵ and by Dr. Marc Bard and his development of a tool called "simple rules."¹⁶ Both methods involve defining the current state of the culture, and then the desired culture needed to support the achievement of specific organisational aims.

1.4 Understand the legal and financial opportunities and barriers

Clinicians are the lifeblood of a healthcare system. They admit patients, order services, and decide when to discharge patients. They personally perform many of the most critical and intimate procedures in the care of patients. In the course of all these activities, they generate "income" for the organisation (as well as the great majority of the operating costs).

There are many regulations surrounding the handling of finances and contracting of services by NHS bodies but in many instances financial incentives are available for clinicians providing services that improve quality; for example, the QOF measures agreed in the General Medical Services (GMS) contract for GPs. The new GP contract emphasises quality measures that are designed to improve services for patients, at the same time as it has brought fundamental changes that allow greater flexibility in GPs' workload.

Does this mean clinicians will not engage in quality work without pay? No. In fact, many organisations are finding that clinicians have a deep need to contribute to improving quality in the health service – to be part of what’s right, rather than what’s wrong.

One clinician articulates this below. His organisation has worked with its physicians to achieve 99 per cent “perfect care” scores for virtually all quality measures, dramatic reductions in mortality rates for acute myocardial infarction, and extraordinary improvement in medication safety (two orders of magnitude reduction in harm events).

“If we have a secret, it is that we have become a ‘learning organisation’ and that appeals to life-long learners, which physicians are. We like to say that our improvement work is ‘Physician-Led, Evidence-Based, Data-Driven,’ but what we’re really saying is that we believe that physicians have a deep-seated need to learn together, with evidence and data at the foundation of the learning. Moreover, we’ve found that it’s important to broaden the group doing the work beyond physicians. This team learning, done across disciplines, increases respect and communication. We showcase the physicians and staff, implement their efforts, and give ownership of success to them. This gives them the relatedness necessary for personal growth, and it gives them real self-esteem.”

Alva Whitehead, MD, Vice President of Medical Services at McLeod Health (South Carolina). Personal communication, 2006.

Money isn’t mentioned.

Nevertheless, there are creative ways in which an organisation can help clinicians meet their needs with direct financial benefit to them, while furthering quality. For example, many clinicians would like to delegate appropriate tasks to other professionals. Highly trained individuals do not come cheap, and clinicians are often fearful that they will not be able to afford full-time salary and benefits for them. Organisations can fund technicians, clinical assistants, staff grade physicians, allied-health professionals, nurse practitioners, and managers to support clinician activity for the purposes of quality improvement. Thus, different professional groups are working and contributing at their highest level. These practitioners can support the development of integrated care pathways and partnership working and help deliver initiatives in areas such as chronic disease management, unscheduled care, referrals, and prescribing. Benefits of restructuring care teams can include improved relationships between primary and secondary care, and extended primary care services with integrated health and social care arrangements in place.³

In Wales, projects supported by the Inequalities in Health Fund¹⁷ required partnership working and indicated that GP practices are interested in engaging in service development when both the practice and patients benefit. Examples of successful applications to the Fund resulted in increased resources such as a branch surgery in a deprived area, more practice nurse and dietician time, and computer-based registers that made the call and re-call of patients at risk of coronary heart disease much easier. This in turn resulted in the effective implementation of National Service Framework Standards, increased clinic throughput, and a reported significant increase in the achievement of GMS quality standards, which enhanced practice income. One project involved every practice in Carmarthen.³

While a health service has no “business” without the patients or “customers” who are treated by clinicians, clinicians within the service often operate competitive businesses. As more technologies and processes, once only deliverable as part of inpatient care, can safely be provided in other settings, more clinicians do exactly that.

Competition between primary and secondary care for resources associated with service delivery is seen as a possible obstacle to engagement as it potentially inhibits co-operation. The resulting entanglements and competitive battles constitute a significant barrier to the “common purpose” agenda. These sorts of problems are often the elephant in the room in conversations about engaging clinicians in quality and they strain relationships between clinicians. A significant part of the task of uncovering common purpose requires that leaders first rebuild damaged relationships. Finding ways to support each other’s business success by improving quality and safety is a primary route to rebuilding those relationships and therefore has a prominent place in this framework.

Framework element 2

Reframe values and beliefs

Two major cultural changes – re-framing of deep-seated values and beliefs – need to occur in order for clinicians to engage fully in an organisation’s quality agenda. First, managers need to stop regarding clinicians as customers and start treating them as partners in the delivery of care. Second, clinicians need to stop seeing their care responsibilities as narrowly focused on the patient in front of them, and start seeing their responsibility for the performance of the organisation as a system. Neither of these changes is easy.

2.1 Make clinicians partners

“Evidence shows that working across boundaries and within networks is more effective in delivering the changes needed in the NHS (Goodwin et al, 2004). Clinical leadership and engagement when working in this way, however, is crucial if these changes are to be achieved and sustained.”¹⁸

Clinicians, particularly doctors, working within the NHS have historically had a large degree of autonomy. This is powerfully demonstrated in the actions taken (or not taken) when organisations face the choice between enforcing a policy on the one hand, and offending physicians/surgeons/GPs, on the other. Leading-edge healthcare organisations have recast the relationship with their clinicians, and consider each other partners in the delivery of services to the only customer – the patient. This “remaking of the physician compact” requires a dramatic shift in viewpoint from both the clinicians’ and the organisation’s perspectives, and seems to be a marker of many organisations that have achieved dramatic new levels of clinician engagement in quality and safety. Characteristics of this new relationship include:

- ▶ Clinicians are asked to lead and work in partnership with managers to improve the system.
- ▶ Information, resources, and responsibility are shared openly with clinicians.
- ▶ New recruits are clearly advised as to the nature of the relationship before joining the organisation.

Perhaps the most powerful example of this idea at work is the statement found at the top of virtually every quality agenda and performance report at Park Nicollet Health Services (Minnesota):

“The patient is the only customer.”

2.2 Promote both system and individual responsibility for quality

The other major cultural shift needs to be brought about within the professions themselves. Clinicians are imbued with a deep sense of personal responsibility for the outcomes of their patients – their own patients – and for that portion of the patient’s care that involves their own decisions and actions. This professional value, which is the primary driver of the clinicians’ fierce attachment to individual autonomy (“If I’m personally responsible, then I must have complete control and autonomy in the decisions about care”), stands in direct contrast to the central idea of quality improvement – the nature of a system, and the recognition that most quality outcomes are system attributes, rather than independent, individual attributes. In many ways changing values and beliefs on this issue begins with clinicians giving up their personal autonomy to a broader view of professional control,¹⁹ and with their understanding that an entire field of science – systems science – exists.

Hackensack University Medical Centre (HUMC) in New Jersey set out to improve cardiac care, and in particular, their scores on evidence-based care measures for acute myocardial infarction and congestive heart failure. In their “old” method, physician autonomy held sway, which meant that whenever issues regarding heart disease patients arose, physicians were contacted directly. So the physicians worked with the unit nurses to develop protocols to handle common problems immediately,²⁰ and authorised nurses in the cardiology unit to take on functions that had previously remained within the purview of physicians. By sharing autonomy with each other (designing a common system for all clinicians to use) and sharing some responsibility with the clinical nurse specialists, HUMC was able to achieve spectacular improvements in virtually all measures of care, while simultaneously freeing physicians from many disruptive calls. Care improved and physicians gained precious time. In the process, clinicians began to see these outputs (e.g., improved patient outcomes, CMS Core Measure scores) as a product of their new cardiology “system” rather than as attributes of their individual contributions.

Here in the UK, the development of care pathways, such as those used in palliative care, are being developed for use in acute settings. In Swansea NHS Trust, a cystic fibrosis inpatient care pathway that is easy to use has been developed by a multidisciplinary team. It is used by all staff to ensure that any child admitted for intravenous antibiotics has all investigations and measurements (e.g., lung function, weight) done and recorded on the appropriate day, standardising the level of care regardless of which members of the cystic fibrosis team are available.²¹

To get clinicians to see the system in which they work as part of their professional responsibility, leaders must use approaches that encourage a systems view, and allow clinicians to make a profound shift in mindset, framed as follows: "As a leader in this system of care, I share responsibility for the outcomes of all the patients in the system, regardless of whether I was personally involved in their care."

Quality leads might consider any of the following specific suggestions for encouraging clinicians to adopt a systems view:

- ▶ Start every professional executive committee meeting with a specific story about a serious, recent adverse event, along with an analysis of the systems issues (e.g., handovers, teamwork, system design) that contributed to the event.
- ▶ Gather the leadership groups annually and provide a detailed, candid assessment of the performance of the system, and the interactions among the parts of the system (e.g., discuss in detail the relationship between something that concerns clinicians, such as emergency department closures, and something they don't want to change, like the elective surgical schedule).
- ▶ Use "morbidity and mortality" reviews to broaden the discussion from "Was there an error of judgment or an error of technique by an individual clinician?" to "How did the system of care fail this patient and what could we do to reduce that risk in the future?"
- ▶ Provide opportunities for leaders to track an individual patient for a day or two through all the various interactions, waits, and other experiences that typify a contact, visit, or stay with the organisation, and report their observations.
- ▶ Have a clinician track medication orders from the moment they are written until they are executed, and report back.

- ▶ Use staff meetings to expose interesting variation in common practices and the effects it has on the system of care. For example, ask the clinicians present at a meeting to respond on a question such as “I wish to be called for a post-op temperature of...” and then display and discuss the variation among staff. (Clinicians tend to be curious, and nothing provokes curiosity like unexplained variation.)
- ▶ Show the system’s results on quality and safety measures at each staff meeting, and also send these results to the entire staff, regardless of whether that particular group or individual has a logical relationship to any particular quality measure (e.g., send surgical site infection rates to cardiologists, not just to surgeons, and send “door-to-PTCA” times to surgeons, not just to cardiologists).

Framework element 3

Segment the engagement plan

There is *"no such thing as improvement in general."*

Joseph Juran²²

Similarly, there is no such thing as "clinician engagement in general." Both improvement and engagement take place at detailed levels, with specific changes in processes and designs, in the case of improvement, and within individual clinicians, in the case of engagement. One of the most practical ideas for developing a plan to engage clinicians in quality and safety is to segment the plan: identify specific roles that need to be played by clinicians, and develop a detailed plan to prepare individual clinicians to play these specific roles.

Prioritising and sequencing

The first task in segmenting the engagement plan is to review what your organisation is trying to accomplish. Trusts and LHBs are complex organisations that are usually working on dozens of initiatives at any one time. Clinician engagement at the highest levels is critical to some of those initiatives; for other initiatives, clinicians do not really need to be engaged at all. For example:

- ▶ Clinician engagement is imperative for activities involving clinician credentials, privileges, accountability, and disciplinary action. It is also required for choosing and applying clinical practice guidelines, planning for clinician recruitment, and for many quality-of-care and patient-safety initiatives.
- ▶ Clinician involvement is important for activities such as strategic planning, workforce planning and allocation decisions, risk management, and clinical governance, especially if the plans touch on clinician services or attributes, directly or indirectly.
- ▶ Clinician involvement is typically not a priority in setting up a finance management plan, or tendering for a maintenance contract.

So the first task in developing a segmented plan for clinician engagement in quality is for the executive committee or leadership team to be clear about what they need to engage clinicians in.

Sequencing is also important. For some organisations, at certain stages of their organisational life cycle, the path to clinician engagement in key quality or safety work might be indirect – coming as a result of other activity. For example, an LHB that has had a bad contracting experience that did not work out well for their GPs might choose as a first step to build bridges with these clinicians – for instance, by funding nurse practitioners to support practices, thereby giving them an immediate opportunity to improve their quality indicators. Later, when the relationships are better, the LHB might start to work with the clinicians and the nurse practitioners to implement chronic disease management initiatives – a proposal that may have fallen on deaf ears if it had been the initial effort.

3.1 - 3.5 Identify and activate champions, educate and inform structural leaders, develop project management skills, identify and work with “laggards”, and use the 20/80 rule.

The second task in developing a segmented plan is to examine the quality and safety work plan itself, and ask the more focused questions that follow.

For which projects and initiatives do we most need clinician engagement?

Within the broad quality and safety arena, projects differ in the level of requirement for clinician leadership and engagement. As a general rule, efforts to improve the reliability of evidence-based care delivery, reduce the risk of adverse events in patients, and other projects aimed directly at clinical outcomes need a great deal of leadership, input, and support from clinicians. On the other hand, initiatives focused on improving the quality of front-line supervision of technical personnel or improving emergency response times, might require clinician awareness but far less direct engagement than for clinical projects. As a general rule, if a project is going to require clinicians to change the orders they write, to adopt new clinical policies and “rules,” or to alter their daily workflow, their engagement at a high level is necessary for success.

What specific roles are we looking for clinicians to play in each initiative?

For many projects, it is important for at least one clinician to play the role of a champion. Within the same project, it might be critical for key leaders such as executive committee members and directors to play other important roles. For some projects, a clinician is needed as the project leader, a role distinct from champion or structural leader. Almost all clinical projects ask some clinicians to implement the project's recommendations in their practices – the role of adopters, if you will. And finally, in many clinical projects, the engagement plan needs to identify and work with the "cautious laggards," that is, those clinicians who require extremely strong evidence before making any changes in their practices, and who are adept at finding flaws in proposed designs for improvement. To build a segmented plan for clinician engagement, it is important to understand each of these roles a bit further.

- ▶ **Champion:** A strong champion can make a critical difference in many clinical projects. The key test of a champion comes at any point when the project faces a challenge – usually from another clinician – for example, "The proposed change doesn't rest on strong enough evidence. We should continue with our current methods. Change is too risky. I'm not going to go along with this." There are many ways in which a champion might respond to such a challenge in order to keep the project moving forward. But there are two ways that an effective champion will not respond: either with silence, or with an offensive attack on the individual objecting to the initiative. This leads to the identification of the two key attributes of an effective champion: courage and social skills.

Certainly, other attributes are also highly desirable in a champion. Effective champions are often highly respected clinicians and, ideally, have experience in a specialty relevant to the initiative under consideration. A good champion has "professional gravitas," not necessarily "organisational gravitas" (i.e., a champion need not be a structural leader, and in some instances, participation as a structural leader might actually diminish the credibility of a champion). But no personal characteristics are more important than both the courage to speak up when the project is about to be paralysed by one clinician's objections, and the social skill to be able to use one's voice effectively. For example, a courageous, useful response to the objection cited above might be: "I understand you feel that way; the evidence isn't perfect. But it never is, is it? The consensus of expert opinion in the specialty society itself, have all recommended that we make this change. I don't think we're going to reinvent the science here in our practice, and I think we should adopt these changes. There might be risk in making the change. But we've seen the evidence of the harm that's occurring to our patients with our current approach. What is the risk to our patients of not making the change?"

That's a champion at work.

Here is a specific example of one champion's effectiveness:

OSF Healthcare System, a seven-hospital, 2000-clinician care system in Illinois, was experiencing difficulty getting full support from all clinicians in reducing central line infections. Because it was following the full set of the Centre for Disease Control's (CDC) recommendations, one of OSF's intensive care units (ICUs) had dramatically decreased its line infection rates while the other ICUs in the system were reporting much higher rates of infections. A champion with courage and social skills stepped forward and shared the data on all ICUs with a group of surgeons who had been resisting some of the recommendations. When confronted with evidence on the effectiveness of the changes, the surgeons agreed to follow the recommendations. At the same time, the champion encouraged the Clinical Governance Committee to pass a "red rule" that required anyone placing a central line in a non-emergent situation to follow the CDC guidelines for using maximal sterile barrier precautions. (A "red rule" must be followed. If it is not, a clinician will be called before members of the Committee and the Chief Executive Officer. This was another idea that the safety champion had encouraged.) This action led to a 37 per cent reduction in central line infection rates for the OSF system.

- Project Leader:** It is not necessary in every instance for an improvement project – even a clinical project – to have a clinician as project leader. This role – to bring together the project team, to organise and execute the project plan, to lead the various meetings and other activities – is often extremely time-consuming, and requires specific project management and other skills that are not commonly present among practicing clinicians.

For this reason, when it is important symbolically to have a clinician identified as the leader of the initiative, many organisations also identify a key administrative co-leader who can do much of the time-consuming background work to allow the clinician project leader's time to be used most effectively. Even with this sort of administrative support, clinician project leaders should, at a minimum, be effective communicators who understand good meeting management skills, and who can articulate the rationale for the project ("explain why") in terms that are credible and engaging to clinicians.

- Structural Leaders:** In most instances, structural leaders are already in place and the issue isn't "Who should be the structural leaders for this initiative?" but rather "How should we best use the structural leaders that are in place in order to achieve the needed improvements?" Within the organised staff, structural leaders such as committee or department chairs, executive committee members, and directors might be particularly important when quality initiatives require adoption of new policies. After all, these are the individuals who will be

responsible for these changes to formal organisational policies, and therefore, leaders need to make a specific plan to work through the organisational “politics” of such decisions. This is a very different plan from that required to support champions, or to train and equip project leaders.

- ▶ **Adopters:** Every initiative needs adopters – those clinicians who can take the initial work of others, see the evidence that it might benefit patients and their own practices, and apply the new method in their work. A thoughtful clinician engagement plan will stratify the clinicians into “early adopters,” “early majority,” “late majority,” “late adopters,” and so forth, and will map out a strategy to allow the early adopters to pave the way for more widespread, full-scale application of the changes. The plan will also take into account more than just the characteristics of the individual clinicians. A good plan will reflect the nature of each proposed change (e.g., how easy it is to try the change, how risky the change appears to be, etc.), as well as numerous other factors that will influence any individual clinician’s attraction to the innovation.²³ Gaining support of well recognised clinicians and making appropriate use of teaching practices or departments can make a difference to wider clinician involvement and participation.³
- ▶ **Cautious Laggards:** Clinicians’ primary mode of thinking is “logical negative.” Every day, for patient after patient, their job is to think through “What is wrong with this picture?” They are good at it (for which all of us as patients should be grateful), and they fall naturally into this mode of thinking when confronted with new ideas (which causes anyone who is advocating change some challenges). Some clinicians are particularly good at noting the flaws in proposed changes, and it is important for the clinician engagement plan to have a method for listening carefully to these “cautious laggards.” Yes, they are often overly cautious or excessively negative; but sometimes, they are right.

One interesting method for listening to these clinicians is employed by McLeod Regional Medical Centre in the US, where a committee is convened on an ad hoc basis when initiatives have had some early testing and are ready for wider deployment. This committee has been intentionally populated with the clinicians who have historically been the most vocally critical and negative about new programmes and changes. The job of this committee is clear. They are told: “You are good at seeing what’s wrong with things. So tell us – what’s wrong with what we’re planning to do?” Then the leaders of the initiative listen. A large proportion of what they hear comes under the category of “We’ve never seen a change we like and this is no exception.” But they almost always hear something else as well – observations about real flaws in the proposed change. The committee is thanked for their input and, if indicated, the proposed changes are modified accordingly. The results, when the change is finally implemented on a broad scale, are noteworthy: the members of the committee don’t necessarily embrace the change, but generally they go along with it and don’t undermine the process.

Which clinicians are candidates for which roles?

An effective plan to engage clinicians will examine all potential candidates and will first separate out those clinicians that actually have any direct involvement in the care of patients affected by the initiative. The “20/80 rule” generally applies here; that is, only 20 per cent of clinicians usually deliver the vast majority (80 per cent) of the clinical services.

From this short list, leaders of an initiative should identify the best initial candidates for roles such as champion, early adopter, and so forth. In order to “screen” the list for the final candidates, the best strategy is simply to have a brief face-to-face conversation with each clinician in which you describe the initiative, what it might do for patients and for the daily work of clinicians, and the clinician’s potential role in the initiative. While describing the project, watch their body language. If the clinician’s eyes light up, you have identified a champion or a project leader. If the clinician starts working his or her BlackBerry®, you should move on to another candidate on the list. This isn’t a perfect method for identifying which clinicians are candidates for which roles, but it is practical, quick, and reasonably effective. It should be noted that clinicians whose eyes don’t light up aren’t necessarily bad candidates for future projects; it may well be that other factors are interfering with their ability to get excited about this particular project at this particular time.

Maslow’s Hierarchy of Needs (see Figure 2, overleaf) provides a useful framework for thinking about how to approach individual clinicians (or clinician groups) in these conversations about potential leadership roles in quality and safety.

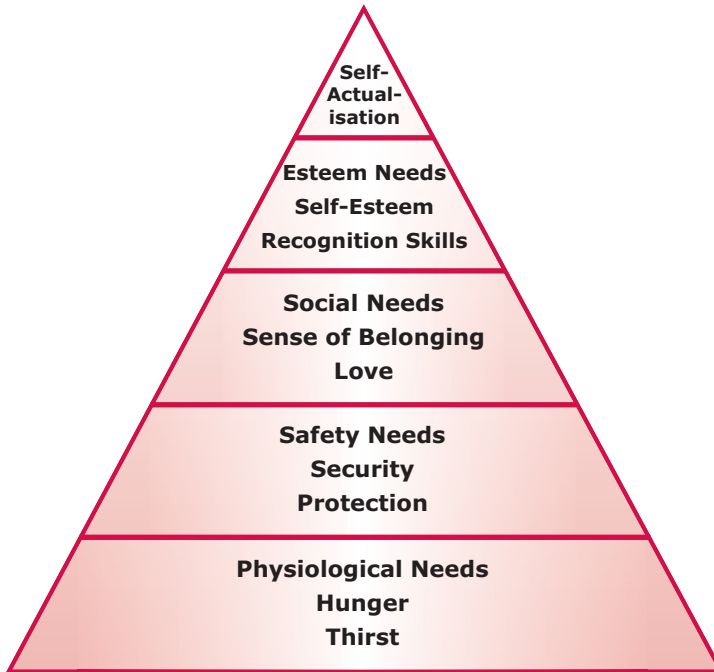


Figure 2. Maslow's Hierarchy of Needs

(Abraham Maslow, *Motivation and Personality*, 2nd ed., Harper & Row, 1970.)

The idea is that clinicians are unlikely to work at the highest levels of this pyramid (e.g., using creativity and innovation to improve safety and care for patients and to contribute to the design and development of a better healthcare system) if their most basic needs are not being met. For example, real-life barriers to physiological needs (air, food, sleep, sex) are evident in healthcare work (frequent out-of-hours calls, absence of specialist services, backups in flow that cause late admissions). Examples of barriers to safety needs include risks of medical claims, distrust of managers, burden of debt, and unavailable information on laboratory results. Barriers to belonging and love are legion: working in professional isolation (even in group practices), lack of relationships with managers or directors, lack of family time. So those who wish to engage clinicians in common purpose around quality, at the top of the pyramid, must often first deal with some of the more basic problems that clinicians face.²⁴ The ultimate aim, however, is to engage clinicians at the highest levels of self-actualisation.

"This is the true joy in life, the being used for a purpose recognised by yourself as a mighty one... the being a force of nature instead of a feverish selfish clod of ailments and grievances complaining that the world will not devote itself to making you happy."

George Bernard Shaw

What is our plan to equip and support those clinicians in each role?

Finally, once the leadership team has identified the specific initiatives needing clinician engagement, the roles to be filled, and the individuals to fill those roles, the team must also put together a specific plan to support them effectively. While this support plan will necessarily be highly specific to any individual organisation, initiative, and set of clinicians, some common questions will need to be addressed in any effective support plan:

- ▶ How can we maximise the effective use of this clinician's time and avoid wasting it?
- ▶ How will we provide the clinicians with timely, credible data?
- ▶ What training and development is needed if this clinician is to be effective in this specific role?

Training is an important aspect to consider when engaging clinicians. Developing skills through targeted continuing professional development (CPD) to address specific needs of clinicians in relation to managing change and in line with overall policy may be one way of gaining support from clinicians, allowing them to take ownership of the process of change.³

- ▶ What communication system will be necessary in order to keep all stakeholders informed and build trust throughout the initiative?

The planning steps in Appendix B and the template "checklist" in Appendix C further lay out an approach to segmenting a plan for engaging clinicians. What is clear, is that it is absolutely essential to think through this challenge carefully at a very detailed level. Juran was right; there is no such thing as "clinician engagement in general."

Framework element 4

Use “engaging” improvement methods

4.1 Standardise what can be standardised, no more

Healthcare leaders often complain that “our clinicians won’t accept any standardisation of practices.” But when you look at what the organisation is trying to get clinicians to do, you find that it is asking them to follow detailed protocols with multiple branching logic trees covering every aspect of care for stroke patients, or other complex, extended standardised “pathways.” These pathways attempt to standardise too much, are too complicated, and are legitimately resisted by clinicians as “cookbook medicine” in many instances.

It is much more engaging to clinicians to begin at the other end of the spectrum – with creation of standard work around common practices and procedures such as “monitor blood pressure” and “prescribe oral corticosteroids.” It is much more difficult, and perhaps not worth the effort at this stage of improvement, to standardise the decision as to whether to start a patient on corticosteroids. Some best practices in deciding what to standardise include the following:

- ▶ The evidence-based “goal posts” are often quite wide. It is useful to pick a specific goal within the parameters and to standardise to that goal; being inside the parameters isn’t enough.

A recent lesson in control of blood glucose levels in cardiac surgery provides an example. Each surgeon in an academic programme in the US was using a protocol that fit within the evidence-based parameters (ranging from “start insulin for any blood sugar over 110 [mg/dl]” to “start insulin for any blood sugar over 160, but only for diabetic patients”). Hypoglycaemia was common, and deep sternal wound infection rates were 1.4 per cent. When the surgeons all agreed to use one method within the parameters, and then conducted successive improvement cycles, becoming more and more aggressive. Eventually they were all starting insulin at a blood sugar of 110, using an identical protocol, with stunning results: no deep sternal wound infections for 19 months, and very low hypoglycaemia rates.²⁵

- ▶ Start with something a few key clinicians can agree to standardise, and move onward from there. For example, start with something simple and local like “a standard protocol for prescribing oral corticosteroids in our practice.”
- ▶ Measure and communicate the benefits of standardisation in clinician-relevant terms (better patient outcomes and less wasted time for clinicians) rather than “reduced prescribing costs”.

But it’s not enough to decide the “what” of standardisation. Successful organisations have learned to standardise many other aspects of care processes such as who, when, where, and how. Standardising the “what” requires understanding of the evidence. Standardising who, when, where, and how requires understanding of how the organisation’s system of care operates on a daily basis.

The “old way” and the “new way” of standardisation can be contrasted as follows.

Old Way:

- ▶ Experts design a comprehensive protocol using evidence-based medicine over months of meetings, focusing on the “what” of standardisation.
- ▶ The result of the expert meetings is a protocol considered by the team as a finished product.
- ▶ Subsequent changes to the protocol are discouraged.
- ▶ The compliance strategy is to educate, expect vigilance and hard work, then report miscreants.
- ▶ No expectations are expressed by leadership regarding reliability of the standardisation process.

New Way:

- ▶ Standardise how, what, where, who, and when.
- ▶ The “what” is based on clinical evidence.
- ▶ The “how” does not need clinical evidence, but rather knowledge of how your system works.
- ▶ Very little expert time is invested in the initial protocol.
- ▶ Initial protocols are tested on a small scale.
- ▶ Changes to the protocol in the initial stages are required and encouraged.
- ▶ Defects are studied and used to redesign the protocol.

The new way of standardisation is far more engaging to clinicians, and should be part of any written engagement plan.

One very powerful effect of the new way of standardisation results from the use of rapid tests of change. When clinicians realise that the process is going to test many ideas, they tend to become less vested in their own ideas and more receptive to others. They know that their idea is going to get a chance to be tested, and that only the ideas that work, in real-life applications in their own setting, are going to be adopted.

4.2 Use data to generate light, not heat (use data sensibly)

"While most people are in favour of measurement, few are comfortable being measured."

Loeb, 2004²

There is a paradox embedded in clinicians' attachment to individual responsibility, on the one hand, and their sensitivity to individually attributed data on quality and safety, on the other. Far too much heat is generated by clinicians (and quality leaders) on arguments about "the data aren't right, aren't properly adjusted, aren't relevant to my patients' outcomes," etc. Much of this wasted energy is caused by clinicians' intuitive recognition that many quality and safety data elements are not attributes of individual performance, but rather are attributes of the system.

We create even more heat when we generate data for purposes of comparison to others, as opposed to generating data for improvement. And we approach explosive levels of heat when we use these sorts of comparative, clinician-specific quality data for profiling and credentialing individual clinicians. Two general categories of best practices fall under this element of the framework:

- ▶ Revise reports on quality so that they report system attributes as system attributes, not as individual clinician attributes. For example, show clinic waiting lists for departments as a whole, or national prescribing indicators for practices as a whole, not for individual practitioners. Once the whole system is performing at 95 per cent or better, then deal with the few clinicians who seem to be performing as individual statistical outliers. (Note: If your cultural assessment indicates that clinicians and managers are capable of using individual clinician data for learning rather than for judgment, then it is possible to use individual clinician performance reports to accelerate improvement before the overall performance of the system reaches 95 per cent reliability. But the ability to learn, rather than to judge, from individual data is not a common cultural attribute of most healthcare systems.)
- ▶ Revise reports on quality so that they are framed in reference to the theoretical ideal, rather than in reference to comparative benchmarks. (To the extent possible, remove the denominators.) For example, instead of reporting only

“Central line infections per 1000 line days,” simply show a run chart of “Number of central line infections per month,” or “Number of days since the last central line infection.” Your data will appear more timely, less “abstract,” and much more engaging to clinicians. Most importantly, you won’t be lulled into complacency because you’re “better than the 50th per centile of the benchmark.”

A good example of a practice that uses data in a “light-generating” way, while simultaneously encouraging clinicians to take a systems view (Framework Element 2), is the mortality analysis process at OSF Healthcare System. OSF hospitals review all deaths, using a team of clinicians whose specific task is to look for and make recommendations on patterns of process and system issues possibly underlying in-hospital mortality. These mortality review committees at OSF have uncovered a number of important system factors in mortality rates for the hospitals: end-of-life planning, getting patients to the right unit on admission, a high rate of diabetes in some populations, etc. Typically, the discussions about the systemic improvement opportunities surrounding each death are so rich that the teams have a difficult time moving from case to case. During the time since this process has been implemented, risk adjusted mortality at OSF has fallen by 30 per cent. (Note: this committee of clinicians (in some instances, multidisciplinary) occasionally does uncover an individual clinician “peer review” issue, in which case the matter is referred to a different committee. This is a good example of separating the use of data for learning, as opposed to using data for judgment.)

4.3 Make the right thing easy to try

Clinicians often see a proposed change as risky. The logic goes something like this: “What’s being done now can’t be bad, or else we wouldn’t be doing it? Any change has the potential to make things worse. So we should be absolutely certain that the change is the right thing to do before we make the change.” Clinicians will debate endlessly about the merits of this paper or that article, rather than getting on with trying things that might make the system better. The result is paralysis by analysis. Or better said, “paralysis by needing to determine what the best idea is, before you’ll try any idea.”

The best antidote to this stalemate is to make sure that when clinicians are considering ideas that might improve performance, they understand that trying out an idea is not the same thing as full-bore, everybody-will-do-it-this-way-forever implementation. It is simply a test of the change. It is time-limited, and on a small scale.

For example, “What if three of us who insert a lot of lines tested this new idea for reducing risk of infection over the next week? We’ll keep a simple log of each procedure and give you all a report on how it goes...whether it slows us down too much, whether the nurses have the right training and equipment to support us, and so forth. We’ll bring back a report to the full department meeting, with some suggestions for any improvements. Then we’ll test out the improvements, and once it seems to be working well, then we’ll bring it back to the department for more general adoption as a policy.”

This approach has proved successful over and over, in almost every type of improvement project. It doesn’t ensure success, but it makes it far more likely that a solid majority of the clinicians will be willing to “have a go,” as than would be the case if the change were debated endlessly, without testing in the real world, and then brought to the full department for “implementation for ever and ever.”

4.4 Make the right thing easy to do

When changes are being tested on a small scale, it isn’t enough to test whether the change is associated with improved outcomes, or reduced harm, or whatever the outcome of interest is. Particularly where clinicians are concerned, it is vitally important that the small-scale tests are also designed to study “implementability,” particularly the question, “Does the new way require more clinician time and effort than the old way?” If the answer to this question is “Yes, it’s more cumbersome to do it this way,” then it’s important to conduct additional small-scale tests to find out ways to make it easier to do the process right (the new way) than to do it wrong (the old way). Far too few tests of change measure the impact of the change on clinicians’ time in the process, for example, and it’s not a surprise that front-line staff react negatively to the change when it’s finally rolled out.

NHS Wales’ Trusts

Many planning and improvement methods have been addressed by clinical teams who have successfully implemented Safer Patient Initiatives in hospitals in Wales. Interventions range from “care bundles” introduced in critical and intensive care units for patients on ventilators, and for those requiring central lines. Other initiatives introduced to reduce adverse events, include measures to improve hand hygiene and reduce MRSA bacteraemia in general wards and peri-operative areas.

Key elements for achieving sustained reliable implementation have been identified (by Cardiff and Vale NHS Trust, North Glamorgan NHS Trust, and North East Wales NHS Trust) as:²¹

- ▶ ensuring reliable design
- ▶ standardising wherever possible
- ▶ identifying champions
- ▶ involving the right people – use multidisciplinary teams, and involving all appropriate staff from support workers to senior managers in the quality agenda
- ▶ using simple straightforward measures that are easily and rapidly implemented with small amendments as required
- ▶ linking changes to organisational strategy, current practice, culture and staff behaviours
- ▶ using rapid-cycle small-step changes or small tests of change
- ▶ measuring outcomes
- ▶ identifying clear structures regarding “who” “what” “where” and “when”
- ▶ communicating as much as possible – from educating and raising awareness to providing feedback
- ▶ providing sufficient and timely information at an early stage
- ▶ developing leadership and negotiating skills, project management, etc.
- ▶ using existing resources - sharing lessons with other areas.

Framework element 5

Show courage

5.1 Provide backup all the way to the board

NHS organisations have historically sent mixed signals to clinicians on quality. Leaders, including clinical governance committee members, have talked about their commitment to quality, but when a prominent member of staff ignores the policies and procedures that are recommended by the leadership, no one takes action.

Medical records are a chronic problem for many organisations. It's a requirement that the records be timely and complete, including having a full history charted when the patient goes into surgery and a discharge summary available to others who might need to care for the patient within a reasonable time after discharge. Many hospitals struggle with this requirement, and the executive committee and board repeatedly forgive or otherwise "bend the policy" for doctors, especially those who are big admitters. The signal that's read by the quality leads, clinician champions, and many of the rank and file members of staff, who are all aware of the situation, is: "They're not really serious about quality. If we can't execute the policies we have in place on something as simple as charted information on history and examination, how can those who are working to adopt policies on vital safety processes, believe that the hospital leadership and board will behave any differently?" This leaves the quality leads and clinician champions feeling very vulnerable, and uncertain, when they anticipate or counter opposition to an important policy.

An essential component of the Framework for Engaging Clinicians in Quality and Safety is to "demonstrate backbone." All who work in a system need to know that the organisation is willing to take action to protect its patients from harm, and to drive forward significant improvements in quality.

Everyone working on quality "needs to know that they have backup, all the way to the board."

Donna Isgett, McLeod Regional Medical Centre (South Carolina)

The importance of the board's support for demonstrating backbone cannot be overemphasised. (See IHI's "How-to Guide" for the 5 Million Lives Campaign on engaging the board.²⁶) By the same token, though, where an organisation is trying to change its culture to one of real clinician engagement in quality, the courage of the clinician quality leaders within the organisation is also important, especially when they are not the structural leaders. Courage comes up against a core value of the medical profession – collegiality, and a requirement for consensus decision making and universal agreement before change is adopted.

*"Organisational silence"*²⁷ – the reluctance to confront problems that need to be addressed – is toxic to improving quality. Several versions of this kind of silence have been observed. "Cultural censorship" occurs where untoward events or problems are recognised but covered up as "expected medical variation." Similarly, "consensual neglect" occurs where the decision makers tacitly ignore problems that are discovered so as to maintain the superficial appearance of unity of purpose and harmony.

Clinicians do not accept criticism of their own performance easily. Moreover, quality problems are, as noted above, criticisms of some clinicians in their midst. So it takes courage to speak about these problems. The good news, though, is that research suggests that once a single person visibly breaks conformity and offers an alternative point of view, others are far more likely to follow. Clear support within the organisation for the hard work of quality change is also essential. Clinicians typically regard "grand rounds" as their model for intellectual engagement; yet most who participate in these grand rounds know that there is rarely any real criticism or intellectual engagement in these settings where, typically, a renowned expert presents recent information that the assembled doctors may find interesting. To the extent that clinicians in such conversations engage around the matters presented, the debate is often conducted at a fairly intellectual and abstract level. This is not a model for working on real problems at home in their own house, so to speak. So while support all the way to the board will be fundamental to real cultural change, support within the organisation's culture for the clinician champions and others who raise difficult issues – sometimes requiring real courage – is also important.

Framework element 6

Adopt an engaging style²⁸

Clinicians do not engage around business or management methods like business people or even other professionals. Their mechanisms for hearing, processing, and responding to data are driven by how they are trained and what they do in their professional lives. Their training ingrains in them hard-won, immutable values they will bring to bear in their work within the organisation in their departments or practices. This is not merely a cocktail party truism. It is important to understand the clinician mindset in order to engender successful clinician engagement around any endeavour. The following six observations about the clinician mindset are directly relevant to engaging clinicians in quality:

- 1.** Clinicians treat patients, one patient at a time. To help them do that in a way that takes into account a broader context of care within the organisation will depend, in part, on how data regarding a desired quality change is presented to them. Several of the principles in this framework reflect the particular data management issues associated with clinician behaviour.
- 2.** At some point in training or practice, it has entered the consciousness of all clinicians that they bear a searing, daunting, life-changing, personal accountability for the life and death of the human beings whom they treat. They are acutely aware of their vulnerability to making poor decisions, based on imperfect information and human frailties in complex circumstances. Most clinicians, no matter how long they've been practicing, can tell you – by name – every patient whom they believe was harmed or killed by their actions. They must gird themselves against this risk every day in order to do what they do. For this reason, they feel separated from, and superior to, those who do not understand this powerful reality. As a result, they see information provided to them by others in light of whether the source has shared this experience. Importantly, they do not view all clinicians as co-equal on this point and ascribe credibility more to those whose experience is closer to theirs in terms of this risk. Thus, they differentiate the credibility of the source of information based on experience as well as specialty.
- 3.** Clinicians also have concerns about their actions resulting in medical claims,²⁹ so they filter potential action through the lens of how it will impact their risk of clinical negligence. This issue is best confronted directly regardless of the initiative under consideration, but it also raises the issue that they live with a certain level of paranoia that guides their responses to change. They are very concerned about how change will impact their liability, in addition to what demand it will place on their time.

4. Clinicians have a strong sense of collegiality. During training, clinicians learn to share their intellectual capital with each other. Consultant specialists are called in to give their views of how to treat patients. They may participate directly in the care, but at a minimum they share their expertise and opinion with their colleagues. While clinicians are fiercely individualistic in their management of what they do (in part because of their perceived individual accountability for that patient), this tradition of collegiality can be called on to support quality initiatives.
5. Although in practice they are supreme empiricists – clinicians believe what they have seen or experienced themselves before almost any more formally gathered data – they do see themselves as science based. Consequently, evidence they consider credible does influence their thinking.
6. They place very strong faith on “due process,” which they take to be a fairly elaborate series of steps to ensure that clinician “rights” are safeguarded when their competence or professional quality is questioned. This reflects their concern that “there but for the grace of God go I,” which relates to their sense of their own vulnerability. As a result, quality initiatives with potential negative consequences to clinicians must take this value into account.

A hospital administrator, doing a review of serious quality deficiencies of a particular surgeon, privately asked every other clinician, “Would you allow this surgeon to operate on you or a member of your family?” The unanimous answer was a resounding, “NO!” But when the administrator acted on that information and suspended surgical privileges for that surgeon, the staff reacted in an uproar. “Where was the due process?” was the concern.

Understanding these values of clinicians leads to seven simple principles of engagement that comprise Framework Element 6 and can support collaboration between clinicians and healthcare organisations regarding quality. These principles of engagement based on clinician mindset are in the nature of the “quality initiative checklist,” similar to an airline pilot’s checklist. To facilitate the likelihood of a successful project, the list should be reviewed before launch of each project and from time to time throughout its implementation.

6.1 Involve clinicians from the beginning

"There is definitely resistance to change among some consultants which I think is caused by the way they feel let down by how changes have happened in the past. We were asked about the transfer of some services to a different site. Lots of us felt the timescale was too short and the move couldn't be done safely . . . but it happened anyway, our opinions weren't taken into account."

UK hospital consultant.¹³

Clinicians are often suspicious of initiatives that are handed to them partially developed, even when they are asked to participate in bringing them to fruition, and they are far more suspicious of programmes that they are asked to accept when delivered to them full-grown.

Research into engagement in primary care conducted in Wales, reveals that the type, level, and effectiveness of clinical engagement activity varies considerably across LHBs.³ The most effective LHBs are offering an integrated support system that allows two-way dialogue between the GPs and the LHB and forms part of an overall engagement strategy, whereas others approach clinical engagement as a 'bolt-on' to their existing duties. The medical directors recognise the importance of offering a range of options to engage GPs at different levels. Whatever the approach, those LHBs who have strong relationships with GPs appear to have a much clearer definition of what clinical engagement involves and how service improvements could stem from this. Most importantly activities are not just seen to be 'talking shops' and provide both sides with opportunities to actively contribute to service improvements. In comparison, a number of LHBs' clinical engagement activities are opportunistic, such as one-to-one discussions with practices at annual QOF visits, and some CPD opportunities and protected time. While these in themselves enabled LHBs to develop relationships and engage GPs in dialogue, it is acknowledged that more could be done to support these activities.

Maximising opportunities for engagement is critical to its success, and reducing duplication and – in some cases – contradiction across LHBs is important to developing trust and integrating engagement across the LHB. This is illustrated in the case studies (pages 42-3), where the engagement strategy developed to support better prescribing practice has now led to further opportunities to access and engage GPs in LHB priorities more widely.

Fundamentally this approach is to work with GPs – rather than imposing developments on them – and this is achieved by maximising existing opportunities to build up trust and commitment for service development. There are clearly defined linkages between the various elements of the LHB and how these impact one another, for example, building relationships through prescribing support, provides a basis for developments in other areas such as chronic disease management.

6.2 Work with the real leaders, early adopters

Leaders of improvement are not necessarily the titled “leaders” in the organisation. The real leaders have earned respect in their peer culture as magnanimous representatives who can advocate for colleagues concerns and communicate effectively back to their practices or departments, avoiding an emphasis on a personal agenda. But they do have to be given the opportunity to fulfil this function. Stemming from their collegiality, clinicians will expect to be kept informed about the activities that will affect their lives. Depending on the specific organisational culture, this may require formal reports from leaders to constituents. Although these can be inefficient and time-consuming to some, sometimes they are necessary.

In addition to identifying the “real leaders,” it is critical to know and work with the “early adopters.” Everett Rogers has developed the concept of innovators, early adopters, early majority, late majority, and laggards.²³ This stratification can be applied to almost any group of clinicians, whether a practice or department, or the entire staff of an organisation. The early adopter group is most forgiving of the inevitable imperfections in any change concept. They will work with and modify a concept to a working reality and will, in fact, embrace and enjoy the process of change. Focusing on this group is most likely to produce the critical mass for change, “the square root of n.” Trying to institute a change across the organisation at one moment is probably doomed to failure because the initial versions cannot be perfect and the late majority and laggards will not be forgiving of early imperfections.

6.3 Choose messages and messengers carefully

Because clinicians ascribe credibility in part to who delivers the message, it is important to plan how and by whom the engagement is initiated and who is involved from the organisation as the quality initiative unfolds. Who invites participation, who reports ongoing progress, and how the message is conveyed and communicated are especially important early in quality efforts, and become less critical as more trust is built. Similarly, it is important to choose words carefully in communications about the project. Terms such as “accountability” and “performance reports” can be loaded with unintended meaning, and so it is important to regularly audit your communications to make sure that your language is engaging and not inflammatory.

6.4 Make clinician involvement visible

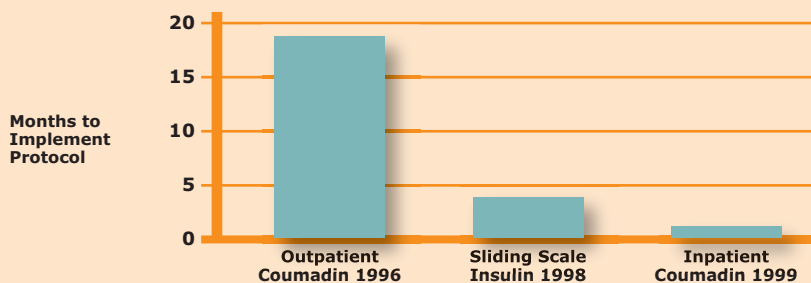
Not all clinicians need be involved at all stages, but if they do not know some clinicians have been part of the process from the beginning, they will not be as accommodating to the proposal presented to them.

6.5 Build trust within each quality initiative

Whether or not past grudges still live in the present, trust is a vital dynamic in the organisation-clinician relationship, and it is earned from both sides of the partnership. But it is earned over time and the same way for both parties: "Do what you say. Say what you do . . . consistently over time."

At Luther Midelfort – Mayo Health System (Wisconsin), one of the early improvement projects was development of a standardised outpatient anticoagulant protocol run by nurses. It took almost 18 months and many one-on-one conversations to get all clinicians engaged and using the protocol. Data was repeatedly shown regarding the decrease in INR variance, in clots and in bleeds – thus documenting improvement in patient care. The key for clinicians was to see data on improved outcomes. Once the clinicians learned that these sorts of protocols were not just "cookbook medicine" and actually could produce better results for patients, each subsequent standardised protocol has taken less time than the last (see Figure 3), as data is shown to prove the improvement in care and the medical staff's trust in standardisation increases. Many standardised protocols can now be widely disseminated in a matter of weeks because of the overall trust level of the clinical staff.

Figure 3. Progressive Reduction in "Time to Implement" Standardised Protocols at Luther Midelfort – Mayo Health System



This principle relates directly to the next.

6.6 Communicate candidly, often

Engage in open, frequent, candid communication, even when the matters at hand are difficult, sensitive, and strategic. Clinicians are trained not to trust interpreted data. It is always better to provide the raw data supporting the asserted analysis, even though the clinicians might not have time to actually evaluate it. It is the withholding of raw data that they will find troublesome. Giving data to clinicians helps them believe in the value of the undertaking.

When IHI's 100 000 Lives Campaign was announced in December 2004, a presentation was made to Immanuel St. Joseph's Medical Centre (ISJ) medical staff indicating that hospital leaders had signed up for the Campaign and, based upon their size and number of discharges, leadership estimated that ISJ could expect a saving of 40 to 80 lives by implementing all of the Campaign interventions. Initial reaction from the medical staff was outrage and insult: "You cannot tell us that we are needlessly allowing 40 to 80 patients a year to die at ISJ." But two years later, after persistent candid communication, including widespread display of credible, unedited data on deaths, hospital-acquired infections, and other measures, an estimated 100 lives per year have been saved, and the medical staff is proud of its accomplishment and publicly touts the results.

6.7 Value clinicians' time with your time

Show clinicians that you value the process enough to spend your time on it. When clinicians are engaged in collaboration with the organisation, and they take time from their professional lives to assist the organisation with what it needs, organisational leaders must consistently attend quality initiative meetings and respond to requests made of them in a timely manner. Doing otherwise can undermine the potential for the programme by seeming to devalue clinician input. Similarly, if you ask for clinicians' engagement, expect to support those efforts administratively with clerical help (e.g., typing, photocopying, taking meeting minutes) so that you draw the most efficient level of effort from clinicians at their highest and best use in the engagement itself.

These principles, as well as concomitant expectations of the clinicians who are participating, are worth articulating. Developing a written document of principles, a new manifesto to which the parties can refer, is in some settings a useful way of reframing the new approach. Such a document also serves as a statement to others in the community about the expected changes.

Case Studies

Integrating clinical engagement across an LHB³

Conwy LHB

Conwy LHB supports 19 GP practices and 75 GPs by providing a range of activities within the area to improve clinical engagement and influence the services provided. Although many of the activities described relate to prescribing, these are not seen in isolation and there is significant overlap across disciplines.

Activities throughout the year include bi-monthly CPD opportunities for GPs through the Local Enhanced Prescribing Service Forum. GPs are encouraged to participate in the Forum through protected time payments and there is a good attendance rate with approximately three quarters of all GPs in the area attending a meeting at any one time. The Forum is also open to local pharmacists, and practice nurses. Practice managers and others attend when the content is relevant.

Over time, this Forum has developed a wider agenda. The items chosen for discussion are designed to allow GPs to engage in dialogue surrounding a range of clinical topics, such as glomerular filtration rates and antibiotic resistance, and are actively supported by the two hospital trusts who perceive it as a valuable opportunity for secondary care clinicians to access 'front-line' services and discuss the best options for improving services between primary and secondary care. Moreover, the processes used to support the prescribing sub-group are now recognised within the LHB as an opportunity to "sound-out" – often sensitive – new ideas such as changes to the out-of-hours services, hospital reconfigurations, and tendering opportunities. Indeed, the prescribing meetings sometimes risk getting hijacked by these wider areas of engagement. These discussions are actively fed back into other areas of the LHB, both informally (e.g., via GP board members) and more formally where required.

In addition to the above, prescribing support is further reinforced via a medicine management newsletter, which is developed by a pharmacy prescribing advisor. There is also a process for summarising and disseminating guidelines and other policies. To ensure that these are recognised and implemented, annual clinical governance reviews assess how these are incorporated in practice.

Rhondda Cynon Taff teaching LHB

Rhondda Cynon Taff teaching LHB has built strong relationships with its Local Medical Committee (LMC) and based its clinical engagement activities on pre-existing mechanisms within the LHB. These include:

- ▶ supporting a practice development manager for each of the three valleys it covers
- ▶ developing an integrated approach with the LHB Primary Care Support Unit
- ▶ developing a learning culture in support of practices to improve their performance through a range of measures
- ▶ ensuring a fair and equitable approach to dealing with performance issues in line with all Wales guidance
- ▶ consulting GPs directly in service redesign at the earliest possible point in time
- ▶ providing opportunities for primary and secondary care clinicians to meet to discuss service developments
- ▶ having clear and explicit approaches to CPD, including what costs will be covered and how frequently GPs should attend
- ▶ providing ongoing support for practices through the use of salaried GPs
- ▶ developing the role of the LHB as the 'honest-broker' between trusts, politicians and the public as well as being seen to 'champion' the GP voice with support from the LMC
- ▶ working with GPs wishing to retire to pro-actively take over the management of their practices with a view to returning them to GMS services when appropriate – demonstrating a managed rather than a reactive crisis approach.

A commentary on responsible engagement

Most of the discussion in this framework has been about ideas for how quality leads might engage clinicians in the organisation's quality agenda. But creation of a new relationship – a real partnership – raises serious expectations and responsibilities for the clinician partners as well. To engage effectively, clinicians must overcome the challenges that lurk in some common clinician behaviours and take on their new responsibilities responsibly.

Some useful principles that can help to guide clinicians (whether leaders or followers) in responsible engagement are described below.

Engage responsibly, or support those who do

Consistent clinician involvement is often difficult to achieve. Patient demands hold trump and make it difficult for clinicians to attend meetings consistently or on time. When clinicians agree to participate in defining the environment in which their patients will receive safer, better quality care, they and their practice colleagues should recognise the value to all from clinician engagement. When clinicians are not seen as active participants in the projects that affect them, one of their first complaints is, "Why weren't we involved in designing this?" Yet they will also argue that their partners or colleagues won't let them participate. This issue is directly related to how much they see the initiative as benefiting them. To engage responsibly, when practising clinicians agree to participate in organisation-wide initiatives, their colleagues should recognise and provide coverage for them so that patient demands do not call them away from the quality initiative commitments they have made.

Maintain confidentiality

In significant quality improvement (and other governance-related) projects, clinicians may gain access to sensitive and strategic information. There is a need to maintain confidentiality, both of data and of the process itself, until it is ready to be shared or publicised. Adopting a communication strategy that will enhance the project can help. Mutually determined principles of communication and confidentiality are an essential part of all quality initiatives.

Trust your leaders

Stemming from their issues with respect to control of the processes that affect them, and their tradition of collegiality, clinicians tend to have a town meeting culture (i.e., all should participate at all times). Often, the introduction of a new idea will be met with a response such as, "Let's get all the cardiologists involved." This is inefficient, but those who are excluded from the work may be resentful. In addition, if the champion of the project is not the titular leader, steps will have to be taken to make sure that the nominal leader does not feel disenfranchised and therefore entitled to undermine the process. Drawing on the involved few to inform the affected many is a significant path to success, but it can be laden with barriers. For the followers to trust them, the leaders must "do what they say, say what they do... consistently over time," and they must keep the followers informed without breaching confidentiality. This is a challenge, but it can be accomplished.

"Leaders must do what they say, say what they do . . . consistently over time."

Support the process you've agreed to

Failure to honour this principle is usually manifested in two ways:

1. A clinician who is participating in developing the project will revisit his particular concern about the process design over and over. Because clinicians tend to be consensus decision makers, reflecting their collegiality, they are often willing to listen to one loud negative voice until that clinician is satisfied. Here, "majority rules" may solve the problem. Although it is not necessary to be unduly formalistic in the meetings or mechanisms by which quality improvement projects are designed and implemented, sometimes taking votes and keeping minutes that document that decisions have been made and will not be revisited are important techniques for continuing to move the work forward.
2. When the decisions have been made, some participating clinicians may publicly, or "behind the back" of the project, air their grievances and attempt to get the decisions undone. If clinicians understand, at least initially, that new ideas will be tried and tested before any mandates or policies are created, the likelihood of this problem occurring can be reduced.

Value process more than structure, but . . .

Clinicians often focus on the formal structure of the mechanism creating an improvement project: "How many clinicians were on the committee? What are their interests? Who else is involved? Are we outnumbered?" These questions reflect both clinicians' need for control and their anxiety that others cannot share their perspectives or speak for them. Clinician quality leaders, whether titular or champions, should be prepared to address these concerns with a communication plan that speaks to the extent of clinician participation. Assuring ongoing communication to garner and sustain the credibility of the work is also important. Although the process of engagement and its substantive output is always more important than the structure that created it, when the culture has in fact changed, it is a good idea to formalise the changes in writing.

If structure is an impediment, change it

For the NHS, the contracts with the various professional services (e.g., GPs, consultant and junior doctors', pharmacists, etc.) define the environment within which collaboration between the health service and clinicians occurs. Guidelines and standards issued from NHS organisations such as the National Institute for Health and Clinical Excellence and Health Inspectorate Wales, and regulatory and government agencies, further define the way in which clinicians work in a common cause for quality, pursuant to clinicians' delegated authority within an organisation's governance structures. As a new environment unfolds, it is useful to revisit the policies and procedures that define the organisational culture.

When real cultural change has been accomplished, standard off-the-shelf policies may no longer be reflective of the reality of the environment. Some organisations, for example, are moving to avoid the rigidity of a strict practice or departmental model in favour of a clinical service model, which can permit clinicians from multiple practices or departments to coalesce on an ad hoc basis to address specific issues. These less formal aggregations can be allowed to remain in effect to manage specific quality problems more effectively or to sunset when they are no longer needed.

For example, to confront the typical endovascular disagreements arising between clinicians in radiology, cardiology, vascular surgery, and general surgery, all of whom are struggling over common clinical turf, quality issues may be best handled outside of any one department.

While legal requirements do define some boundaries for compliance with standards, the health service has evolved and defines an environment in which far greater flexibility is available than has often been perceived. Policies are an ideal place to document change when it has permeated an organisation's culture.

Conclusion

Today's confluence of demands for both demonstrably safe, high-quality health care and clinician performance offers an unprecedented opportunity for healthcare organisations to redesign the essential partnership between quality leads and clinicians. Many healthcare organisations are making improvements without significant clinician engagement. However, optimal quality will only be achieved when clinicians are fully committed and engaged in a common cause for quality within the NHS. The Framework for Engaging Clinicians in Quality and Safety sets forth our current view of ideas, principles, and techniques by which this engagement may be more widely achieved. We look forward to opportunities to test and improve these concepts as all of us continue the work to enhance the health care of the patients we serve.

Appendix A

Clinician Engagement Difficulty Assessment

The Clinician Engagement Difficulty Assessment is designed to prompt leaders to think carefully about the current structural and historical factors in their community or organisation. These factors will inform the degree of difficulty that may be encountered in furthering the partnership with clinicians for quality and safety.

Score your organisation on each of the nine dimensions. Lower scores may indicate an easier environment in which to engage clinicians; higher scores may indicate a more difficult environment in which to engage clinicians. The lowest possible total score is 9; the highest possible total score is 31.

1. Clinician alignment/affiliation

The majority of clinicians' responsibility/accountability is:

- Solely to the health community/organisation – clinicians are employees: *score 1*
- Principally to the health community/organisation – part-time or associated staff: *score 2*
- Only partly to the health community/organisation – staff work within many organisations and/or are independent contractors or temporary or locum staff: *score 3*

Score:

2. Stability of community/organisational structures, mergers, and relationships

- The community/organisational culture has been stable for years: *score 1*
- The staff was merged from more than one community/organisation some years ago and most of the disagreements are over, although there are still some bruised feelings: *score 2*
- The staff underwent a recent merger, and the wounds are still raw: *score 3*

Score:

3. The community's/organisation's vision for quality

- Clinicians are clear about the quality vision and mission: *score 1*
- Staff understand the community's/organisation's interest in improving quality, but do not understand their role in achieving it: *score 2*
- Staff have no idea what the organisation's vision is: *score 3*

Score: **4. Clinician involvement**

- Very good; high attendance at meetings, intense interest in work, information widely shared: *score 1*
- Staff interested in immediate practice/department/group activity only, not so interested in broader community/organisational initiatives: *score 2*
- Difficult to get a quorum of staff, activities fall to the same small groups or individuals: *score 3*

Score: **5. Cross-community/organisational issues**

- There are very few issues with cross-community/organisational working: *score 1*
- There are some groups and specialties where community/organisational boundaries are being crossed and there are struggles: *score 2*
- There is open hostility among/between specialities/organisations regarding turf battles: *score 3*

Score:

6. **Currency of community/organisational policies**

The organisation's policies reflect current reality:

- The policies are dynamic, up-to-date, and reflect the current reality: *score 1*
- The policies were revised in some substantial measure within the last few years to reflect current reality: *score 2*
- The policies have not been amended or revised in years: *score 3*

Score:

7. **Clinical governance committee authority**

- Balanced:** The clinical governance (CG) committee functions effectively for the organisation, and resolves interdepartmental/group/practice feuds. There is a procedural assumption by clinicians that the committee acts fairly and wisely: *score 1*
- The CG committee "represents" the clinicians. The board(s) of directors and administration are wary of ceding too much power to the committee, so they have the power (occasionally used) to approve or disapprove committee appointments/actions: *score 2*
- Civil libertarian:** The emphasis of the CG committee is on protecting individual clinician rights and ensuring procedures are strictly followed even for minor disciplinary actions. Reactive and formalistic, the committee rarely initiates any actions that would impinge on the autonomy of individual clinicians: *score 3*

Score:

8. **Board engagement with clinicians in quality initiatives**

- The board engages directly with clinicians, actively seeks their input, and involves them in all quality initiatives at the earliest stages: *score 1*
- The board watches quality from a distance and depends on administration's reports for monitoring and surveillance of the clinicians: *score 2*
- The board thinks quality of care is purely clinicians' responsibility. There is no real will, no real engagement on the part of the board: *score 3*

Score:

9. Historic cultural engagement

The culture of engagement for clinicians is best described as:

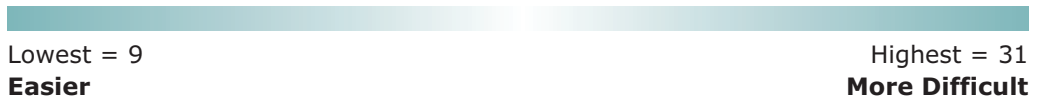
- Full engagement:** Most of the clinicians participate in initiating, implementing, and improving quality initiatives. The organisational leaders and administration assist in responding to clinician programmes. Interdisciplinary team projects are the norm; the board supports clinician engagement with resources and education: *score 1*
- Good engagement:** Many clinicians participate in design and implementation of quality initiatives. The CG committee is convener, arbiter, and communication conduit throughout the clinical staff, with and to managers and the board. There is a clear recognition of “highest and best use” of clinical personnel, with healthcare professions other than doctors having more clinical authority, responsibility, and perception of teamwork than in traditional settings: *score 2*
- OK engagement:** clinicians participate in cross-departmental/group/practice quality projects and work across boundaries on them with other groups such as administration, and/or finance. The board has expressed an interest in quality, but relies on managers to design processes and report results: *score 3*
- Some engagement:** Some clinician leaders/members identify and champion small departmental/group/practice-based projects; some interdisciplinary team efforts have been initiated within isolated units; the board does not make quality a priority: *score 4*
- Minimal engagement:** Clinician leaders respond to some initiatives through traditional structures only, sometimes more in response to practice/unit/departmental projects. There is little cross-departmental/group/practice interaction on quality: *score 5*
- Mutual détente:** Separate spheres of influence; clinicians focus only on credentials, some privileging, rare corrective action; privileges reside in practices/units/departments with little overlap or interaction with other departments or groups; no cross-departmental/group/practice resolutions of problems; there are struggles between different clinical groups over a range of issues: *score 6*
- Openly hostile:** Mutual suspicion; loss of trust; past grievances won't die; big emphasis on clinician competitive challenges. The board and managers focus entirely on the bottom line and financial results; current strategies of the organisation are suspect and challenged (e.g., recent mergers or acquisitions): *score 7*

Score:

Add up scores for all nine questions

Total score:

Clinician Engagement Difficulty Assessment – placement



Appendix B

Using the Framework for Engaging Clinicians in Quality and Safety to build a written Clinician Engagement Plan

The following sequential steps are suggested for quality leads who wish to design and execute a plan for improved engagement of clinicians in quality and safety initiatives.

- 1.** Assess your starting point, using the Clinician Engagement Difficulty Assessment (see Appendix A). This will give you a good sense of how high your aims for clinician engagement might be, and the kinds of approaches you might need to consider in your engagement plan.
- 2.** Prioritise your needs for clinician engagement based on your strategic plan and your understanding of the critical initiatives in which clinicians must be engaged. This will give a good sense of which initiatives your engagement plan must address, and which initiatives have the most dependence on clinician engagement.
- 3.** With your self-assessment in hand, and your priorities clear, state the aims for a few (no more than three) key initiatives during the next year for which you are going to build a detailed plan for improved clinician engagement. Write these aims down as “how good, by when” statements using specific measures of performance. (Example: reduce the total number of nosocomial infections by 50 per cent within 12 months as measured by . . .).
- 4.** For each of the three key initiatives, work through the Framework for Engaging Clinicians in Quality and Safety and address the questions that arise from each element of the framework. Use the checklist in Appendix C to create your plan for each initiative. Your answers to these questions will form your first draft of a written plan to improve clinician engagement in your organisation and can then be more broadly shared for revision and improvement by your leadership team.
- 5.** Execute the plan, and steer any modifications to the plan using data based on two types of questions:
 - ▶ Are your measured quality and safety aims being achieved? (Is the plan working, as indicated by results?)
 - ▶ Is clinician engagement improving? (The answer to this question will depend on a variety of inputs, but the best indicators are what you hear in ongoing informal conversations with clinicians, and asking other staff and quality initiative leaders for feedback on the level of clinician engagement.)

Appendix C

Checklist for building a written Clinician Engagement Plan using the Framework for Engaging Clinicians in Quality and Safety

Figure 1. IHI Framework for Engaging Clinicians in Quality and Safety

6. Adopt an engaging style

- 6.1 Involve clinicians from the beginning
- 6.2 Work with the real leaders, early adopters
- 6.3 Choose messengers carefully
- 6.4 Make clinician involvement visible
- 6.5 Build trust within each quality initiative
- 6.6 Communicate candidly, often
- 6.7 Value clinicians' time with your time

5. Show courage

- 5.1 Provide backup all the way to the board

4. Use "engaging" improvement methods

- 4.1 Standardise what can be standardised, no more
- 4.2 Use data to generate light, not heat (use data sensibly)
- 4.3 Make the right thing easy to try
- 4.4 Make the right thing easy to do

Engaging clinicians in quality and safety

1. Discover common purpose

- 1.1 Improve patient outcomes
- 1.2 Reduce hassles and wasted time
- 1.3 Understand the organisation's culture
- 1.4 Understand the legal opportunities and barriers

2. Reframe values and beliefs

- 2.1 Make clinicians partners
- 2.2 Promote both system and individual responsibility for quality

3. Segment the engagement plan

- 3.1 Use the 20/80 rule
- 3.2 Identify and activate champions
- 3.3 Educate and inform structural leaders
- 3.4 Develop project management skills
- 3.5 Identify and work with "laggards"

- ▶ Do the “temperature check” on your organisation’s starting point by completing the Clinician Engagement Difficulty Assessment (see Appendix A).
- ▶ Prioritise initiatives needing clinician engagement.
- ▶ Establish aims for three important initiatives requiring clinician engagement.
- ▶ Then complete the checklist that follows . . .

Framework element

1.1 Improve patient outcomes

Specific questions to assess current status of element

Is this initiative’s aim framed and communicated to clinicians so that it’s clear we’re aiming to improve patient outcomes?

Specific action plan to use this element (who, what, where, when, how)

Framework element

1.2 Reduce hassles and wasted time

Specific questions to assess current status of element

How will specific aspects of this initiative reduce hassles and wasted time for clinicians?
How will we measure that improvement in ways that are credible to them?

Specific action plan to use this element (who, what, where, when, how)

Framework element

1.3 Understand the organisation's culture

Specific questions to assess current status of element

What cultural attributes will this initiative come up against? What "simple rules" do we need to establish in order to succeed in this initiative?

Specific action plan to use this element (who, what, where, when, how)

Framework element

1.4 Understand the financial opportunities

Specific questions to assess current status of element

Are there any legal and "shared business" opportunities to reinforce the common agenda in this initiative?

Specific action plan to use this element (who, what, where, when, how)

Framework element

2.1 Make clinicians partners, not customers

Specific questions to assess current status of element

Are we ready to share information, power, and resources with clinicians leading this initiative? Are clinician leaders ready to be responsible partners? How will treating clinicians as customers inhibit this initiative?

Specific action plan to use this element (who, what, where, when, how)**Framework element**

2.2 Promote both system and individual responsibility for quality

Specific questions to assess current status of element

How will we get clinicians to see the “balcony view” of this initiative?

Specific action plan to use this element (who, what, where, when, how)

Framework element

3.1 Use the 20/80 rule

Specific questions to assess current status of element

Which clinicians must ultimately be engaged in this initiative if it is to succeed (and which clinicians are not relevant to this initiative)?

Specific action plan to use this element (who, what, where, when, how)

Framework element

3.2 Identify and activate champions

Specific questions to assess current status of element

Which clinicians are on our short list of potential champions for this initiative? How will we select one or two champions? What is our plan to support them?

Specific action plan to use this element (who, what, where, when, how)

Framework element

3.3 Educate and inform structural leaders

Specific questions to assess current status of element

What will be the role of the executive committee, department heads/medical directors in this initiative? What data will be presented, and when, to the boards and other structural leaders?

Specific action plan to use this element (who, what, where, when, how)

Framework element

3.4 Develop project management skills

Specific questions to assess current status of element

Does a clinician need to be the project leader for this initiative? If so, how will we train and support that clinician so that the project will be led effectively?

Specific action plan to use this element (who, what, where, when, how)

Framework element

3.5 Identify and work with "laggards"

Specific questions to assess current status of element

Which clinicians are likely to vocally oppose and potentially derail this initiative?
How could we mitigate that risk?

Specific action plan to use this element (who, what, where, when, how)

Framework element

4.1 Standardise what can be standardised, and no more

Specific questions to assess current status of element

What standard protocols will be necessary to adopt in this initiative? Do we have a plan to use the "new way" of standardisation for these protocols?

Specific action plan to use this element (who, what, where, when, how)

Framework element

4.2 Generate light, not heat with data (use data sensibly)

Specific questions to assess current status of element

What is our plan for use of individual clinician performance measures in this initiative? Are we ready to use them (i.e., are reliability rates already high / is there a culture capable of learning rather than judging)?

Specific action plan to use this element (who, what, where, when, how)

Framework element

4.3 Make the right thing easy to try

Specific questions to assess current status of element

Is the “project set-up” for this initiative based on lengthy design of a big change to be implemented all at once, or is it a series of multiple small tests of change?

Specific action plan to use this element (who, what, where, when, how)

Framework element

4.4 Make the right thing easy to do

Specific questions to assess current status of element

How could this initiative move to implementation in a way that fits easily into the daily workflow of clinicians?

Specific action plan to use this element (who, what, where, when, how)

Framework element

5.1 Provide backup all the way to the board

Specific questions to assess current status of element

Are there any policies related to this initiative where we can anticipate needing to “take a stand”? How could we send the signal in advance that we will support the clinician leaders who champion that stand?

Specific action plan to use this element (who, what, where, when, how)

Framework element

6.1 Involve clinicians from the beginning

Specific questions to assess current status of element

Were clinicians involved in choosing this initiative? How will we open our process and data to clinicians in this initiative at the outset?

Specific action plan to use this element (who, what, where, when, how)

Framework element

6.2 Work with the real leaders, early adopters

Specific questions to assess current status of element

Who are the critical clinicians most relevant to this initiative? How can we involve them? Who are the clinicians that are already doing most of what is needed for this initiative, and are always receptive to trying new things? How are we going to work with them for maximum effect?

Specific action plan to use this element (who, what, where, when, how)

Framework element

6.3 Choose messages and messengers carefully

Specific questions to assess current status of element

Who is the best person to speak about this initiative? What language should we avoid in communications about this initiative?

Specific action plan to use this element (who, what, where, when, how)

Framework element

6.4 Make clinician involvement visible

Specific questions to assess current status of element

As this initiative progresses, what could we do to highlight individual clinicians' involvement, as an example to their peers?

Specific action plan to use this element (who, what, where, when, how)

Framework element

6.5 Build trust within each quality initiative

Specific questions to assess current status of element

How will we as leaders make sure that we say what we do, and do what we say, consistently throughout this initiative?

Specific action plan to use this element (who, what, where, when, how)

Framework element

6.6 Communicate candidly, often

Specific questions to assess current status of element

What results from this initiative are we planning to measure and communicate; to whom, and how often?

Specific action plan to use this element (who, what, where, when, how)

Framework element

6.7 Value clinicians' time with your time

Specific questions to assess current status of element

How are senior executives/directors planning to channel attention to this initiative?
How are they going to personally engage in the work alongside the clinicians they're hoping to keep engaged?

Specific action plan to use this element (who, what, where, when, how)

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Engaging clinicians in a quality agenda is a resource that has been collaboratively produced in CD and hard copy formats by the National Leadership and Innovation Agency for Healthcare (NLIAH) and the Welsh Medicines Resource Centre as part of the Clinical Support to Local Health Boards programme. This programme is run to help develop and facilitate improvement in clinical engagement activity delivered in primary and community care across Wales.

This resource builds on original work produced at the Institute of Healthcare Improvement in the United States. The original authors have been very supportive of the development of this material, seeing it as an example of the effective spread of improving practice. We are grateful to them for their willingness to share and learn with us.

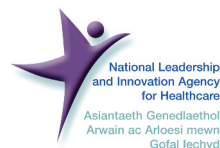
Engaging clinicians in a quality agenda provides a framework for considering clinical engagement and includes some examples of engagement activity set in the context of the National Health Service (NHS) in Wales. The tools presented in the resource have been adapted to try and reflect the NHS today - a time characterised by rapid development and change. It is the hope of NLIAH that the experiences encountered by using this resource will produce further developments and opportunities for shared learning across Wales.

We hope that readers of this resource will find it helpful in deciding, designing and delivering plans for clinical engagement that will improve the care that patients receive, as well as improve the process by which clinicians engage in quality and safety initiatives.

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