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Taking Standards for Better Health Forward in East Kent Coastal Teaching Primary Care Trust

**A staff development project exploring pathways
towards implementation of standards of care**

Final Report

January 2006

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Executive Summary, January 2006

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Introduction

The publication of Standards for Better Health in February 2004 has re-emphasised the importance of the delivery of high quality care. As Primary Care Trusts (PCTs) are now making a major contribution towards the achievement of these standards in the primary care arena, there is an urgent need to assess the local managerial and clinical infrastructure necessary for their implementation. Given that PCT structural and organisational changes are imminent across the UK (DoH 2005), it will be important to capture current information on how standards are understood and applied. This is particularly so in relation to revealing good models of practice, in order to promote knowledge transfer and uniformity of approach within the new structures. This report describes an eight month project funded by East Kent Coastal Teaching PCT that sought the views of primary care workers in relation to standards of care and their implementation. Specifically, the project:

- describes current knowledge, understanding, attitudes and infrastructures surrounding clinical standards
- ascertains what is needed to work towards implementing best practice within the seven standard domains of Standards for Better Health
- makes recommendations for policy and practice

Method

A qualitative approach was adopted using focus group design. Eight focus groups were conducted across one PCT. A total of 220 staff working in the PCT were sent letters of invitation. From this, 39 people took part, giving a response rate of 27.9%. Respondents were from diverse backgrounds and included professional and non-professional staff from acute and community settings, those working in uni- and multi-professional contexts, nurses, therapists, managers and specialists. We were not able to recruit ophthalmologists, dentist, GPs and pharmacists working within the PCT. Group numbers ranged from five to 12 and sessions took place at the University of Kent and community settings. Interviews were recorded via audiotape and data were blended and analysed using a content analysis approach as suggested by Flick (1998).

Summary of Key Findings

- Most respondents regarded standards as acceptable and legitimate solutions to assisting best practice, and there seemed to be a high level of associated professional responsibility connected to their application. Others perceived standards more in terms of an 'insurance policy' or as a means to 'enforce' a particular way of working.

- Recognised and reliable mechanisms were felt to be in place for staff to access information about standards, such as through folders and regular meetings. Many were involved in standard setting or updating, and there seemed to be apparent pathways to inclusion for the disciplines represented in the study. A clear sense of ownership and professional pride was evident among those centrally involved. Reservations about the process included concerns about the slow pace of standard setting, and pressures to implement without sufficient guidance.
- Two aspects emerged as facilitating standards implementation. The training and appraisal systems were seen as useful conduits through which to identify and rectify skills deficits, however this did depend on the adequacy of appraisals. Secondly, some leadership models were identified as being effective, such as the team leader model and 'listening' visits, however experiences were variable.
- With reference to the Standards for Better Health, only senior staff in the sample were fully aware of their existence, most were vague or unaware. When core standards were discussed in individual groups, of the 31 core standards reviewed, 12 were seen as being applied in practice or planned for, 17 were seen as being inconsistently applied and two were seen as not being applied. In general, there was recognition of their importance but an understanding of the impediments to achieving them. These came in the form of competing policies, priorities and targets, organisational cohesiveness and available resources.
- With respect to measuring standards, there was some difficulty in offering precise ways of reflecting achievement with core standards. Respondents were primarily concerned that any measures used would be artificial and not capture the complex realities of practice.
- Suggestions for what the PCT can do to support the application of standards focused on six key areas, namely improving support on the ground; inclusive and clear decision-making; improving communication: investing in resources; a review of training and role development and putting the spotlight on multi-agency and interprofessional working with respect to learning from good models of practice.

Recommendations

- ***Improving support on the ground:*** enhancing managerial contact through possible listening visits and increased face-to-face interaction
- ***Inclusive and clear decision-making:*** greater transparency and inclusion in decision-making that affects practice.
- ***Improving communication:*** improving feedback from audit, incidences or changes, and reviewing and improving information dissemination.
- ***Investing in resources:*** progressing administrative support, developing strategies to help staff deal with time management, improving experiences of work accommodation and tackling the technological support needed by a mobile and geographically dispersed work-force.

- ***A review of training and role development:*** focusing on developing more 'fit for purpose' training through a review of training contracts, and as assessment of requirements connected to 'Agenda for Change' and mandatory training.
- ***Putting the spotlight on multi-agency and interprofessional working:*** developing methods to learn comprehensively from good models of practice.

In addition, three strategies are put forward that thread across the different strands and take into consideration the implications of new organisational changes:

- ***Learning from success – investigating good models of practice***
It is recommended that the PCT capitalises more on existing successes. What is needed is a fuller exposure of the organisational and contextual processes that are the ingredients of success in identified areas
- ***Developing new operational models – front-line ownership***
There is a need for an operational model that moves towards staff on the ground, creating a milieu that allows professionals to act independently from traditional, direct management but within a shared management environment. One way forward could be the establishment of a multi-professional management board. Such a forum could begin to harmonise the current inconsistency within standards implementation and start to develop ways of improving knowledge management.
- ***Managing knowledge***
Any successful organisation needs to manage knowledge in a way that reduces variability, promotes innovation and reduces risk; the PCT is no exception. Running through this study has been a theme of challenges that centre on developing, acquiring and sharing knowledge across distance and between groups of staff. The PCT needs to regard knowledge as the prime currency of its business and manage it accordingly. This means developing a comprehensive knowledge management strategy that underpins the above recommendations and starts to define outcomes for the initiatives they imply.

Taking Standards for Better Health Forward in East Kent Coastal Teaching Primary Care Trust

A staff development project exploring pathways towards implementation of standards of care

Final Report

January 2006

1 Introduction

The publication of Standards for Better Health in February 2004 has re-emphasised the importance of the delivery of high quality care. As Primary Care Trusts (PCTs) are now making a major contribution towards the achievement of these standards in the primary care arena, there is an urgent need to assess the local managerial and clinical infrastructure necessary for their implementation. Given that PCT structural and organisational changes are imminent across the UK (DoH 2005), it will be important to capture current information on how standards are understood and applied. This is particularly so in relation to revealing good models of practice, in order to promote knowledge transfer and uniformity of approach within the new structures.

This report describes an eight month project conducted between April and December 2005 that sought the views of primary care workers, investigating how to achieve best practice in the seven health care standard domains.

1.1 *Aim of the project*

The aim of this project was to explore primary care workers' perceptions of the clinical, professional, managerial, organisational and environmental arrangements necessary to assist Primary Care Trusts (PCTs) in furthering standard implementation pathways.

The project

- describes current knowledge, understanding, attitudes and infrastructures surrounding clinical standards
- ascertains what is needed to work towards implementing best practice within the seven standard domains
- makes recommendations for policy and practice

1.2 *Operational Definitions*

For the purpose of this study, the working definitions of 'clinical governance' and 'clinical standards' put forward in the Department of Health 'National Standards, Local Action' publication will be used (DoH 2004).

Clinical governance: a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish

Clinical standards: evidence-based process and procedural interventions that constitute best practice in a specific area of practice, with the purpose of enhancing quality of care and maximising patient outcomes.

1.3 **Background**

In 1997, the Government introduced a 10 year programme to enhance best practice by improving the overall standard of clinical care, reducing variations in access to services and ensuring that clinical decisions are based on up-to-date evidence (DoH 1998, DoH 2000). A system of clinical governance was developed to measure improvements and detect poor performance based on the establishment of clear national standards and effective monitoring (Donaldson & Halligan 2001). With the disbanding of the inspection agency Commission for Health Improvement and the forming of the new Healthcare Commission, a new way of assessing and monitoring performance is being adopted. Inspection teams will no longer visit Trusts to give recommendations for what should be done and how, but the onus will be on NHS organisations to be responsible for quality improvements, and evidence what they do (Healthcare Commission 2004).

Standards for Better Health

The development of national standards has continued to evolve, and in February 2004, a new framework of standards was launched, re-emphasising that quality should be at the forefront of the agenda for the NHS, and for private and voluntary providers of care (DoH 2004). The standards have been issued to enable Trusts to challenge the past, use innovation and creativity to determine new local solutions, and set new horizons for local services. Separated into seven domains, the framework sets out the level of quality that health care organisations should meet:

- Safety
- Clinical and cost effectiveness
- Governance
- Patient focus
- Accessible and responsive care
- Care environment and amenities
- Public health

In each of these domains there are a series of individual standards that fall into two categories:

- *core standards* which set out the minimum level of service patients and service users have a right to expect

- *development standards* which indicate the way forward for the NHS to plan the delivery of services that continue to improve in line with patient expectations

This framework reduces the amount of targets and signals a shift in focus from previous requirements, moving away from inputs towards health outcomes and the patient experience. While the National Service Frameworks and National Institute for Clinical Excellence guidance will continue to have a key role in supporting improvements in local service quality, these standards form an integral part of the performance assessment conducted by the Healthcare Commission.

As PCTs are taking a leading role and expected to contribute fully towards the achievement of these standards in the primary care arena, there is an urgent need to assess the local managerial and clinical infrastructure necessary for their implementation. In particular, a study of the healthcare staff perspective needs to be carried out to ascertain what is already in place, and to identify the nature of any clinical, professional, managerial and environmental structures needed to assist PCTs in furthering implementation pathways.

1.4 Overview of Literature

A number of studies have been conducted that give insight into the progress with clinical governance and achieving standards, and provide a rationale for the direction of this project. A few key articles are reviewed here.

The National Audit Office review on progress with implementation of clinical governance was conducted in 2003 (NAO 2003). The focus was on secondary and tertiary care, looking at Trusts' progress in putting structures in place and in improving the quality of patient care. The findings indicated that, while most Trusts had the foundations in place, progress was patchy varying not only between Trusts, but within Trust directorates and between the components of clinical governance. The researchers concluded that there was scope for improvement in: putting in place structures and processes; communication between boards and clinical teams; developing a coherent approach to quality; managing risk and poor performance; and putting lessons learned into practice. Key features of Trusts improving the quality of care were leadership, commitment of staff and their willingness to consider doing things differently.

Freeman & Walshe's (2004) national survey of acute health care managers adds to this review. Their sample of nearly 2,000 directorate and board level managers was asked to rate their perceived importance versus perceived achievement in a number of clinical governance domains. The most important and highest rated achievement related to corporate accountability structures such as clinical risk and complaints, possibly due to the relative ease with which these could be set up. Shortfalls in perceived achievement were

reported in joint working across local health communities, feedback of performance data and user involvement.

From a primary care perspective, there is less known about the national picture of clinical governance implementation in PCTs due to their comparatively recent formation and the insufficient organisational time they have had to allow procedures to 'bed in'. However, some studies conducted during the transition from PCG to PCT provide insight into local situations. An evaluation of clinical governance in the public health departments in the West Midlands region for example (Hartley et al 2002) highlighted that a substantial amount of activity was already taking place in relation to accountability, resources and training, policy development and knowledge management. These findings were accumulated through documented evidence and semi-structured interviews with senior public health staff.

In another study, twelve qualitative case studies of PCG/Ts in England were used to investigate approaches to implement clinical governance (Campbell et al 2002). Again, senior staff were interviewed and participants recognised the need for organisational and cultural changes that will support practice. To this end, the PCG/Ts were engaged in taking forward methods that would involve health professionals in quality improvement activities, such as developing and implementing protocols and guidelines, as well as sharing best practice via well attended learning events.

However, there are shortcomings in the studies described here that reinforce the need for this study. The focus of the studies was on evaluation of implementation progress, rather than a more participatory approach to discover how implementation can be achieved. Little is known about how staff measure their own practice in relation to meeting standards. A key PCT requirement will be for Trusts to make public declarations on the extent to which their organisation meets the core standards, therefore how staff can meaningfully contribute towards this needs isolating.

Further to this, there are some methodological issues that reinforce the need for an approach inclusive of frontline staff. Firstly, both NHS arenas report findings that are from a management or office-based perspective and neglect the view of practice-based workers, which is vital in determining impressions of realistic and achievable pathways. While Campbell et al's study goes some way towards highlighting PCT ethos in staff involvement, little is known of the strengths or weaknesses of the approach and there is an assumption that such an approach is acceptable to staff. In addition, indicators for the relevance of this project also lie with the NAO review, whose findings highlighted the importance of staff commitment and their willingness to change. It will important to explore these issues.

Alongside the narrow range of informants of previous studies, there are transferability issues with some of these findings to the current situation. For example, the primary care research was not conducted within the current and changing context of PCT capacity and sphere of influence. All findings were based on understanding of previous standards and requirements. However, they do provide some indication of areas for further exploration, such as communication, leadership and change management.

This brief overview highlights a number of interesting features of clinical governance implementation. It demonstrates gaps in our knowledge of PCTs and that even in acute trusts where systems have been developed for some years, there remain challenges to implementation. This is not surprising, given the complex and multi-faceted nature of NHS organisations, and the equally complex clinical governance requirements. This project is timely in providing the opportunity to reveal the main clinical, professional, managerial and environmental strengths and shortcomings.

2 Method

2.1 Design

This service development project adopted a qualitative approach using focus group design. The use of focus groups is well documented in health and social care research as a means of probing issues and exploring experiences from the participant's perspective (Morgan 1997). Careful facilitation is however needed to ensure equality of involvement and diversity of opinion (Kitzinger 2000). A total of eight focus groups were conducted across one PCT,

2.2 Sample and Access

A total of 220 staff working in the PCT were sent letters of invitation. From this, 39 people took part, giving a response rate of 27.9%. The focus groups for this study coincided with a consultation being conducted among staff using similar methods. Difficulties with recruitment were encountered, and efforts were made to improve recruitment through meetings and PCT media, with some effect.

As table 1 demonstrates, respondents were from diverse backgrounds and included professional and non-professional staff from acute and community settings, those working in uni- and multi-professional contexts, nurses, therapists, managers and specialists. Flick (1998) describes this sampling 'mix' as credible and appropriate for qualitative research approaches, in order to maximise richness of data in the area under study. We were not able to recruit ophthalmologists, dentist, GPs and pharmacists working within the PCT.

Table 1: Number of respondents per staff grouping

Staff grouping	Number
Nurses Representatives from district nursing, school nursing, specialist areas, practice nursing, health care assistants, students; roles included field workers, team leaders, matrons	11
Health visitors Health visitors and health visitor assistants	6
Therapists Representatives from physiotherapy, occupational therapy, speech therapy; roles included assistants, basic grades and senior staff	7
Managers Representatives from nursing, occupational therapy, physiotherapy, health promotion, counselling and non-professional staff; roles included professional managers, development managers, directors, heads of department.	8
Health Promotion/public health specialists Field workers and team leaders	6
Total	39

Staff were recruited with the assistance of a PCT contact in liaison with senior management of all professional groups, who put forward a large selection of staff. In addition, some senior management themselves were targeted. To protect identities, names were picked at random and prospective recruits were sent an information sheet (appendix 1) with focus group details and consent form (appendix 2). Respondents returned the consent form to the researcher if they wanted to take part, and they were recontacted prior to the pre-booked sessions to encourage attendance. Each focus group contained a wide range of staff, and numbers varied between five per session to 12.

2.3 Instrumentation

Semi-structured interview schedules were used. Each focus group explored a different domain and corresponding core standards within Standards for Better Health, in addition to respondents' wider understanding and application of clinical standards. The Governance domain was split into two sessions to accommodate the larger numbers of core standards. The schedule (appendix 3) was separated into two sections:

Section 1 explored participants' general understanding of and attitude towards clinical governance, clinical standards and how they currently incorporated standards in their practice. This section also revealed the strengths and shortcomings of the current infrastructure and arrangements. The question areas contained probes from the literature such as communication, leadership, how lessons were learned, motivation and willingness to change practice.

Section 2 focused on each of the domains (safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, environment and amenities and public health). Participants were given an information sheet that summarised the domain they were involved in and the core standards within the domain.

2.4 Data Collection

The focus groups took place at the University of Kent and were relocated to community settings in an effort to improve recruitment. The group interviews were recorded via audiotape to ensure maximum capture of information, and field notes taken to record contextual information and early analytical thoughts. Each session lasted approximately two hours.

2.5 Data Analysis

The focus groups generated qualitative data from verbal transcription of recorded sessions. This was blended and analysed using a content analysis approach as suggested by Flick (1998), which entailed applying a pre-defined thematic template to the data. This template was constructed using the interview schedule as a basis. Information was sorted into the themes and sub-themes using Microsoft Word documents, taking care to remain faithful to the original recorded

discussions. Respondents' quotes were used verbatim when justifying thematic interpretation, and coded using a group number and transcript page to prevent identification.

As Flick notes, this is a useful way of reducing data into meaningful themes, but can be constraining and artificially represent the data. Categories brought to the data therefore were repeatedly assessed for their relevance, to avoid missing important themes and misrepresentation. An accompanying open coding system was used alongside this approach to capture data not fitting into the pre-defined template.

2.6 Ethical Issues

This project was conducted within the model of a service development project and an audit framework. Ethical principles were strictly observed. Besides strategies used to protect identities, provision of an information sheet and the obtaining of written consent to participate, the following principles were upheld:

- at the start of the sessions a full explanation of the study was given with particular reference to how the findings will be used;
- verbal consent was obtained from group members to record discussions;
- everyone participating in the focus groups was assured that any comments would remain confidential and the possibility of identification from a report would be removed;
- ground rules were established in each group whereby discussion of any issues raised in the course of the sessions would not be discussed outside of the group, unless otherwise requested
- participants were informed that they could withdraw from the study at any time

3 Findings

The findings have been separated into five main themes and a number of sub-themes. The main themes are:

- Standards of care: attitudes and understanding
- Application to practice
- What helps implementation of standards
- Exploration of Standards for Better Health
- Supporting the application of standards: what the PCT can do

Each of these sections contain some commentary that summarises and discusses the main issues raised.

3.1 Standards of care: attitudes and understanding

Within this theme, respondents' views, attitudes and understanding of clinical standards are represented. It is separated into four sub-themes that explore issues related to the internalisation of standards, how standards can be seen as a form of encouraging compliance and as an 'insurance' policy, and the importance of professional responsibility and implementing standards.

3.1.1 Degree of internalisation

There was an initial clear and positive consensus from all groups signifying an understanding of what standards were there to achieve in relation to guidance for professional practice and equity of care. The following quotes are typical of what respondents thought:

I think they're excellent, for me it 's something to work towards, so how do you know you're doing a job right? (3:1)

I think it's important to have equity as well. It's about making sure we all have the same standards (5:1)

To some extent, this came over as an embedded professional 'internalisation' as illustrated in the following quotes:

I don't know anyone that hasn't taken it on board.....I think it goes with the job, something that's handed down isn't it?So yes I'm used to them. (2:7)

It's embedded. And that's what you want it to be isn't it? And the more embedded it is sometimes the harder it is to forget. (5:2)

Closely linked to these sentiments were connections with evidence-based practice and the need for change in response to research:

.... if you are working to research practice you should always be not relying on someone else's what they say so, there should always be good standards written out. (2:2)

....to ensure people are working at the same level, the standards are always improving and being looked at, so it'll be integral to change of practice. (3:2)

3.1.2 Standards as an 'enforcer'

Other respondents saw standards as a persuasive means to encourage degrees of acceptance and compliance:

It is useful in a sense that you can ...say, well ..these are the standards that we work to, these are the government guidelines... [staff] do tend to listen a little bit more ...and these are tried and tested so to speak. (2:1)

....you have actually got to be quite forceful and say that ...it has to be done and it just has to be more authoritative than just allowing people to ...pay lip service to it (1:7)

Given this approach, it is perhaps unsurprising that this view emerged:

I think probably initially they might have been seen as a threat, as a check... but you get use to the idea that they're not a threat, but a support. (3:1)

3.1.3 Covering your back – 'litigation culture'

A number of respondents described standards as a form of protection or insurance against the possibility of persons or organisations being accused of professional malpractice:

I suppose if you are taking care of yourself as well, if you followed the standards then should something happen you would say "well actually these are the standards I was given, I followed these standards" (2:3)

Respondents identified the importance of striking the right balance to avoid paternalism and unnecessary squandering of resources:

I think a lot of the standards as well are to cover the Trust's back..... we have a scissor standard.... it's the way you carry them, ...and I just think... for Gods sake if someone got in a room and wrote that and sent it out, is it really necessary? I think that is covering the Trust. (2:10)

...because of all litigation we have to cover our service so much. You wouldn't dare send out a letter to someone without photocopying it first, it's evidence and that is our culture that we work in isn't it? But ...it is such a waste. (2:22)

3.1.4 Professional responsibility

Accountability emerged as a sub-theme, attached to the general views relating to how standards were perceived. Despite agreeing with the positive consensus view, there was sometimes scepticism about how standards were operationalised and an apparent divide between managers and frontline staff emerged. On the one hand, managers felt

that staff should be trusted to carry out best practice through a blending of professional responsibility and pride:

I think a lot we have to base on trust. And a lot of the professionals are responsible for their own conduct and if they're responsible enough to be professional we have to accept that they're responsible enough to carry out their work to the standard needed. (6:3)

...clinical standards I suppose as a manager is people's pride because I think that people do have a pride in their work so I think that makes it easy. (5:10)

On the other hand, a number of frontline staff suggested the realities were different in relation to consistent application, relevance and priorities, limiting the opportunities for standards to be met:

I think people probably know about them but whether they stick to them all the time, I don't know. (2:3)

There's a lot of avoidance and therefore there's a lot of mediocre work going on. I just... I have to be honest it just astounds me because if it was private business they would go bust. (5:5)

The information's there alright but it's whether the individual, the HCA on the ward or the domestic or whoever sees it as relevant. (3:8)

I think for a lot of people still it is not high on their agenda really. (1:4)

3.1.5 Commentary

The overwhelming feeling that standards are satisfactory solutions to assisting best practice was evident in this section, indicating a high level of acceptance among the respondents. Their efficacy was however described from competing perspectives.

The notion of standards as an insurance policy was of interest. As in many societies, the fear of litigation has the potential to engender an extreme response that can have a counter effect of reducing relevance and saliency (Green & McConnochie 2002). Respondents in this study gave an indication that this type of response has extended to standards of care, using the example of the 'scissor standard'.

In addition, for some, standards of care seemed to be an internalised and legitimate entity, linked to a sense of professional responsibility. For others it was less about legitimacy and trust, and more about persuasion and avoidance. The final sub-theme starts to construct a reality perspective: the complex relationship between standards and application to practice is a strong feature of this study and is elaborated on in other sections.

3.2 Application to practice

This theme explores respondents' experiences of applying standards to practice, and involved a variety of processes. This included a description of mechanisms already in place, the extent to which staff are included in setting standards, and the general limitations to the processes of setting standards.

3.2.1 Established mechanisms

It was clear that among many of the professional groups there are recognised and established mechanisms in place to facilitate the application and monitoring of standards in the workplace:

Well we have standards for our service and we do monitor those regularly..... we will do what we call a `standards' check every so often in each programme just to make sure that even the simple things are being done.... (1:2/3)

At school we have standards for just about everything we do and it is very very clear, it's set that if we're launching anything we do have a standard for it. (4:3)

We have sort of monthly meetings with each of the other OT departments in the area and just see how they're running their clinic and their procedures ... sitting and discussing what we think is best practice ... (6:4)

Within some disciplines, access to information about standards was organised with the use of coloured folders, and the access process was also monitored. District nurses, for example, described the following:

In district nursing we have a red folder, and all the policies, protocols and guidelines are ratified and printed and come down to a red folder and they have all now got a form with them and each member of the team is supposed to read it, whether it is a new or updated policy, and signed to say they have read it. We also do an appraisal system, which highlights training needs which is another way of ensuring the standards are kept. (1:3)

Many respondents felt that this information was reliable, easy to retrieve and dynamic, and created a certain sense of security for them:

we can access that and that's in the process of being recalled and that's being updated as well, everything's in place. (5:2)

Where I was it was happening, and there is also a person allocated to make sure it is kept up to date, so that's one thing you can be sure is happening well. (2:2)

Other professionals used supplementary sources from the internet to support clinical standards and ensure best practice, although this was heavily dependent upon ease of access to information technology. This is explored in more depth later:

We can access the internet from our computer. ... we will actually do a search of what's going on in different areas and we will be looking to see what other areas are doing and looking about effectiveness. (4:14)

However there were respondents who expressed a word of caution about folders and the provision of written information:

I think training is more effective actually. I know it takes time... but actually if you put them in a room and physically discuss standards they might not absorb 100% but they will absorb some of it. Putting it in the folder, well I don't think it's absorbed as well. (6:3)

.. how do you keep this dynamic? You can write the policy and have difficulty rolling it out or ... people appear to adhere to it in maybe six months time .. for me it should be a continuous dynamic process... and I think that's why policy becomes a folder exercise a lot of the time (1:8)

3.2.2 Process of setting standards: inclusiveness

A clear message from respondents from all staff groups related to their awareness of the standard setting processes and the fact that they were able to be involved:

We are kind of aware of things changing, lots of things being written and adapted ...most of the time there are certain things that people will go to and know what they're doing and other things that they're not quite so keen on, so there is a choice. (3:6)

Most standards are put together between people who work in the ward or in the community so they all have their own say which I think is the best way of doing things. (2:5)

Most respondents were aware of development groups, sub-groups or strategy groups where standards were reviewed and developed. Several respondents reported having the opportunity to be part of committees or to be included on a consultative basis at some point, and others were leading developments. The following are examples of the types of activity they were involved in:

We write them. We are very happy because we can write them around process, we can make sure that they are regularly up-dated and they are equitable if anybody's got any issues with them then we take it into the focus group and it can be changed. They are always changing and they are much more user friendly. (4:3)

We work with the ward manager and if you think that you can do something a bit better in a different way, you can have a go and if you have got the knowledge to back it up, she'll come in and ask you about it and... It's very practical (2:4)

I think ownership is really important, and that's where I think relationships are really important,if you can get relationships right then actually people are far more likely to do what you are asking (1:8)

These quotes indicate there was considerable professional activity in this area that was pervasive, coupled with a strong sense of ownership. In addition, overtones of professional pride are echoed once more.

3.2.3 Limitations to standard setting processes

Some respondents however expressed reservations about some of these processes. Problems about the formation of development groups were expressed, summed up by this respondent:

I think the danger is you can get the same people who perhaps are always at these groups and the management do try to sort of invite... and you have to keep saying, well you know, send the invitations out to other people to see if they want to join (1:5)

This respondent highlighted a frequently expressed sentiment concerning the difficulties working in a multi-professional team when setting standards:

I think it actually takes a lot of work. We have a... team which obviously covers all the disciplines there are some house struggles that go on and actually the thing that holds it together is the combined vision I guess, you would call it, because we all want the same thing – an excellent ...service.(1:6)

Further issues concerned the pace of standard setting or updating. The need for inclusiveness and ratification by the necessary boards meant that it was not always the speediest of processes:

....they don't seem to change that quickly...take resuscitation standards for example, ... even the decision making for that, it took us 18 months to get a consensus from everybody involved. (7:1)

I think sometimes the parents can be more well read and knowledgeable than we are and our standards haven't been updated quickly enough like the weaning policy ...parents are questioning it. (2:5)

There is a big gap there between being ratified and actually getting down to the staff and I would say that was a big problem. They are being written and they are a good policy but they don't get down to the staff. (1:6)

For other respondents this created a tension between pressure to implement and lack of guidance:

We have recently been asked to give Methotrexate by injection to rheumatoid patients in the community. It has come from a hospital consultant and it is not something we have done before ... there is no real guidance.... quite worrying. (4:1)

3.2.4 Commentary

The concepts of acceptance and internalisation seem to follow through to this theme, being largely present in descriptions of the processes

involved in applying standards to practice. In the main, respondents have portrayed a system that appears to be well set-up and industrious.

Among the respondents there appeared to be a high level of awareness of these processes coupled with opportunities to be involved. Recognised mechanisms seemed to be in place to maximise the potential for staff to access information about standards, with apparent pathways to inclusion for the disciplines represented. Hence, from the perceptions of this sample of respondents, the Department of Health guidelines on clinical governance implementation appear to have been successfully executed (DoH 1999).

Aside from a few reservations, there was a perception of a favourable degree of reliability about the processes and this contributed towards the viability of the standards. In addition, the workforce appears to have systems in place to be responsive, should new information become available. Hence a readiness to change is apparent in some of the quotes. The sense of ownership among those centrally involved and those undertaking more peripheral roles was tangible, and this appeared to be an important central plank driving the implementation process forward. Within the professional and managerial environment, ownership and control are seen as key factors that create motivation and stimulate change (Procter et al 1999; Daiski 2004).

3.3 What helps implementation of standards

Within this theme, factors that were currently seen as instrumental in assisting standard development and implementation were explored. This included the training and appraisal system, and issues relating to leadership, communication and presence.

3.3.1 Training and appraisal system

Most groups articulated the importance of training and appraisal as conduits through which standards and best practice could be implemented. It was recognised that universal training could not be directly attached to standards in most cases, but organised through the assessment of individual needs at appraisal:

I think that in order to achieve certain standards people have to identify what training they need ...they might want to do that through the appraisal system to see obviously what they need for the forthcoming year to achieve meeting the standards and meeting the job description, and perhaps planning their career structure for the future. I suppose the standards are core, core to the service and other things develop from around that. (1:4)

Training. I think that there are actually certain types of training that open up your mind and give you more lateral thinking (2:15)

There were other imperatives connected to standards propelling the need for training forward, as described by this respondent:

Apparently with the new knowledge and skills framework there's an extra bit added on to appraisals and I think for us that do appraisals we all need up-dating and training on the new things that are coming in.(2:25)

From the perspective of those rolling standards out, the training process was seen as challenging but vital to facilitate implementation:

We have got [a standard] at the moment in health visiting and has gone for ratification and when it comes back we are going to have to do some rolling out to the staff persuading them that it is a good idea to actually take on board filling in yet another form, but it is going to be absolutely crucial that we do enter it into our work. (1:6)

3.3.2 Leadership, communication and presence

A number of respondents from all levels of the organisation articulated issues in connection with leadership, relating in particular to communication and presence. Team leaders were especially expressive in recognising their role in the implementation of clinical standards and had developed distinct strategies in some areas:

....What I try to do at our particular place was to set up a meeting about once a month, quite informal. I just took the red folder with meone of the things that came out from a lot of the nurses was that just reading it was really quite difficult whereas if you have got a group of people and you are reading them and discussing them it actually makes them a bit more alive. I think it is definitely about how it is promoted if you like.(1:5)

I get together with the staff ...it's communication with them listening, two-way, (3:10)

The effects of this supportive approach were positive for some and link to the views expressed earlier, that discussion of standards may help to increase understanding and application:

I think we are very lucky because our manager is a basic team leader but she isvery open and although the managers are down in Dover we actually do have regular contact with what's going on through her and I think in general we feel confident.(4:10)

We know where we're going and we know what we're meant to be doing. We get good support. You know I've got no qualms about that (8:3)

Most groups mentioned the 'listening visits' undertaken by the chief executive as being a positive leadership move in improving accessibility to the strategic viewpoint and 'shop floor' presence:

[the Chief Executive] did come out with my E grade, he was left in our office, he was totally unaccompanied, we were asking open questions which was good. (4:36)

Some also highlighted the team brief as being an important way to find out about the latest PCT information, especially as people worked disparately. The method by which this was communicated was variable however, some being fully aware of it and others not.

3.3.3 Commentary

In this section there were relatively few examples from respondents of what currently helps with implementation. However, the strong connection between applying standards and training came through, but the role of appraisals and leadership seem to be necessary to link the two together. Appraisals were particularly perceived as a tool to help organise training through the identification of individual need. Hence people are expected to work to a professional level and training supplements clinical skill. It appears the connection to standards and best practice could be fractured when appraisals and leadership are absent or weak.

With reference to leadership, some models in operation within the PCT appear to be effective; for example listening visits were generally well-received. In addition, the team leader model highlights the potential impact on confidence, direction and motivation among staff. There was considerable variability of respondents' experiences with this model, particularly with respect to the background of the manager. It appears that an individual seen as wholly connected to the professional grouping of the majority of staff is viewed as legitimate and hence accepted, and their leadership and authority is seen as valid. Degeling et al (2001) found similar cultural empathy in their hospital-based study when investigating skill-mix. In the community setting however, this cannot always be the case, especially now that community working is progressing much more to multi-professional and interagency teams. The difficulties some professionals appeared to have when managed by someone not akin to their professional grouping is described in later sections.

3.4 Exploration of Standards for Better Health

This section starts with an exploration of respondents' general attitudes towards and understanding of the Standards for Better Health. It is followed by a more in-depth investigation of the core standards and their relationship to current practice. As explained in the methods section, each focus group session explored a different domain; hence opinions are restricted to the views of participants within single groups. The intention here is not to generalise from the findings but to give initial impressions only. This section also contains respondents' views on how standards could be measured.

3.4.1 Attitudes and understanding

It was clear that the majority of respondents were not aware of the standards or only had a vague knowledge of them, and that taking part in this study was the first opportunity to gain some insight. Senior staff

who had attended a study day earlier in the year appeared to be more knowledgeable. Among this sample, there was some agreement that the potential benefits to clients were clearer, and that the standards seemed to provide a greater opportunity to make their use more dynamic and 'live':

They do look a bit simpler to understand actually. You can read them and actually see a patient in mind whereas before I found them quite difficult to understand and you couldn't really see where the patient came into it. It was really a target affair whereas, that is a bit clearer. (1:15)

the NHS is just changing so rapidly and modernising which it needs to. However I feel that sometimes we lose sight of the client/patient being the centre of all that is going on and I think these standards give us that opportunity to put the client back at the centre of it all (8:7)

all these documents/standards have got to be living, working documents. They are not designed really to sit on the shelf and be forgotten... we need to keep them working and up-dating them because obviously things change, things happen (1:23).

Others were keen to highlight that the standards were globally relevant and not far removed from what was currently understood.

I think it's really important to invest in making sure that we understand that these new clinical standards have an impact on all working practice in the areas we're in. ...When people say I don't know about these standards, they start reading the bits and they do know about them. ... And it's not until you break it down, then it starts getting relevant doesn't it? (5:20)

For some respondents there were difficulties with understanding the terminology used and with their interpretation of the standards. In the Clinical and Cost Effectiveness domain, the term '*technology appraisals*' mystified one group. Other examples included the '*physical assets of the organisation*' (C20 Care Environment and Amenities), and '*NICE interventional procedures*' (C3 Safety domain). In addition, standards in the Governance domain were not largely understood or seen as relevant from the standpoint of people on the ground. This was especially so in relation to risk assessment.

3.4.2 Taking Standards for Better Health forward

When core standards were discussed in the focus groups, respondents were asked to give an opinion about the extent to which they were already being achieved. In general, the discussions transcended a simple answer to this question, as there were often a complex range of wider strategic, professional, organisational and managerial issues at play. Debates were more concerned with the application of standards rather than their achievement. The extent of application could be looked at along a continuum of 'there or thereabouts' to situations

where there were too many challenges. In the main, responses seemed to fit into three main categories:

- (i) **Being applied or planned for** – where there was general consensus that systems were largely in place, or there were definite plans being made towards achieving this standard.
- (ii) **Inconsistent application** – where experiences were ‘patchy’ (evident in some areas but not others), not really known, or they were partially being applied or achieved.
- (iii) **Not being applied** – where respondents were clear in their opinion that there were very few or no systems currently in place, or significant and specific impediments to achievement existed.

For each of these three categories, a table of the core standards will be given, which includes quotes of experiences and views that reflected the consensus opinions. In table 3, efforts have been made to demonstrate the inconsistency through opposing viewpoints and practice examples. Some commentary on the tables is also provided at the end of this section. From a total of 49 core standards, 31 were discussed here.

Table 2: Consensus views of core standards being applied or planned for (n=12).

Domain	Core Standards		Comments
Safety	C2	Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.	We have very robust procedures that are updated regularly but it's about trying to actually train the staff to use the procedures and... I mean we've recently taken on sort of responsibilities for other ways of training staff such as independent contractors and we've just got new systems and that sort of thing (6:11)
Clinical and Cost Effectiveness	C5(b)	Clinical care and treatment are carried out under supervision and leadership	Supervision isn't just about saying "yes, yes, that's ok, go away for a couple of minutes and have a cup of tea" and that's over. It should actually be around supporting the staff and it's your responsibility to help them develop. (1:17)
	C5(d)	Health care organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.	What we are trying to do is that as we set things up we build in an audit as we go along so in fact we will writing guidance for GPs with regard to children and in that guidance will be built in an audit process so that we start auditing straight away.(1:21)
Governance	C9	Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	Record keeping and recording information has got to be the backbone of professional work, and we all know where we get records from and where we have to send them to. Certainly. I think all staff are aware of the importance of it...legally and professionally (5:12)
	C10(a)	Health care organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.	Yes, the checks around this are very tight, I'd say as a manager...also employment policy is something that we try and use more and more for people who aren't performing. The more you use it, the more you get acceptance... It's a slow old roller coaster but I do think we're getting there (5:13)
	C10(b)	Health care organisation require that all employed professionals abide by relevant published codes of professional practice.	

Patient Focus	C13(c)	Health care organisations have systems in place to ensure staff treat patient information confidentially, except where authorised by legislation to the contrary.	<p>...there's a huge awareness, so its in the forefront of people's minds when they're working with patients that this information is sensitive, whatever it is, it can be just their name and address – this information is sensitive.(3:19)</p> <p>I do think that within our own environments we are responsible for ensuring confidentiality because you know things like leaving notes out and things like that every place should have procedure for storing notes...Becauseif you've got notes out of the desk you can get any strangers walking through..we are very hot on that (8:21)</p>
	C14(a)	Patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.	<p>We do a very positive policy around complaints, which are looked at thoroughly by members of the public. It's looked at, dealt with, the appropriate people are informed. And it feels like a thorough good process that helps build trust with the public and people working so there's no hidden agenda. Everything is in the open and inclusive really. It's quite a transparent policy. now I think the NHS is taking on it's responsibility now the PCT is there. (5:14)</p>
	C14(b)	Patients, their relatives and carers are not discriminated against when complaints are made.	
	C14(c)	Patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.	
Accessible and responsive care	C19	Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.	<p>We're still in the process of this and working very hard towards achieving itAnd the other thing to do is to work with community services to get patients into intermediate care beds so they don't even go to the acute hospital. They would go straight into a community hospital. (7:13)</p>
Public Health	C22(b)	Health care organisations promote, protect and demonstrably improve the health of other community served, and narrow health inequalities by ensuring that the local Director of Public Health's Annual Report informs their policies and practices	<p>..... we see our Director of Public Health quite a lot and he came to a meeting so we've actually got good links. (4:34)</p> <p>I've emailed it to lots of partners and some of them have come back and it's been used as a starting point for discussions (4:34)</p>

Table 3: Consensus views of core standards being inconsistently applied (n=17)

Domain	Core standard		Comments
Safety	C1(a)	Health care organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.	<p>(re reporting a drug error) in fact a lot came out of it, so it was used as a good example in the team and some more training was done, so it was positive and I got a feed back. (2:13)</p> <p>I've completed [the forms] recently and filled them in. I haven't had feedback on any. ... nobody ever gets back to you apart from complaining that you haven't filled out the form correctly (6:10)</p>
Clinical and cost effectiveness	C5(c)	Clinicians continuously update skills and techniques relevant to their clinical work	...you should have ... skills up-dated regularly and you should actually be given the opportunity to up-date your skills so that when someone comes for supervision you can support them. This doesn't always happen (1:17)
Governance	C7(b)	Health care organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	They like to tell us how much a certain dressing costsso the ward clerk quite often puts little notices up on boxes;...so you get to know cost of dressings. (2:18)
	C7(d)	Health care organisations ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;	We are supposed to be budget holders for G grades but that means absolutely nothing to me because I don't see the money and I don't know what's in there and I don't know what I can use it for.(2:18)
	C7(c)	Health care organisations undertake systematic risk assessment and risk management (including compliance with the controls assurance standards)	I am part of a working group and we are trying to devise risk assessments in relation to lone working ...but it is pretty impossible to do until you are through that door ...you don't know what you are getting yourself into ... we go on gut instincts to be honest (2:16)
	C7(e)	Health care organisations challenge discrimination, promote equality and respect human rights.	<p>...there is a lot being done to tackle discrimination ...we've had a lot about gay issues, ... ensuring that people are treated fairly and that sort of thing.(2:24)</p> <p>I couldn't get hold of leaflets in certain languages the government just aren't producing themwe are getting more and more different cultures.....into Thanet I think they should have the right to have that in Bengali or whatever (2:23)</p> <p>...and finding interpreters...there are cost implications with interpreters and it's quite hard to arrange for these ethnic minorities (2:23)</p>

Governance (cont)	C8(a)	Health care organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services	... you have got to have faith in your manager that if you go to them they are not going to go straight back and say "oh so and so said to me"....(2:14) I am sure there are places where we are not encouraged to be open and honest....sometimes this is poor standard of work from another colleague.(2:13)
	C11(b)	Health care organisations ensure that staff participate in mandatory training programmes	...it's trying to get the balance and making that there's enough provision for that and that it's the right person at the right place at the right time because I mean we've had cases where we've had trouble getting staff through their basic life support.We just need more flexibility...it's not one size fits all. (5:14)
	C11(c)	Health care organisations ensure that staff participate in further professional and occupational development commensurate with their work throughout their working lives.	...a huge problem emerging is actually finding the right training. The rooms aren't suitable for training; they're too hot, they're too dark, they've been made to feel undervalued by being shoved in these rooms and yet I don't have a budget to go and rent a nice room. (6:8)
Patient focus	C15(a)	Patients are provided with a choice and that it is prepared safely and provides a balanced diet	There's no doubt that ethnic choices could be improved...but outside of hours they say light meals, we can't do that, we can't meet that standard at the moment because there's implications of staff going into the kitchen (3:24)
	C15(b)	Patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.	
Accessible and responsive care	C17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.	It's a very complicated balance because we say well what do you think you need? What do you want us to do? ... But at the end of the day we can only offer things around healthy eating, losing weight, stopping smoking....it's not sort of real community consultation (7:11)
	C18	Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	we've been reconfigured several times and services have developed in different ways This works in some patient's favour but we've got a huge problem at the moment with learning disabilities. it's the generic adult service who take it over, but they haven't got the specialist skills....and all we can do is record it as an unmet need. (7:11) I see some needy families and families with very complex problems ...they say that everybody is going to have access to services ... but they don't promise to fulfil the needs and I think this is where standards fall down. (7:12)

Care environment and amenities	C20(a)	Health care services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation	Office accommodation for people is....very good in some areas and very patchy and very poor in others. These are the things that actually help promote good working environments for staff and it has a positive or a negative effect on them (8:20) I found some very old hoists that look like they'd come out of the ark ...and hygiene levels concerning the equipment.... You've got patients that are incontinent and they are put on the hoists... Maybe there could be disposable covers. (8:18)
	C21	Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	Some areas are ok...but the environment that I work in has literally got paint peeling off the walls ... carpets that need to be removedHow do we get this done? Patients should be able to walk into a clean environment and then go out feeling better.and they're laying on a couch in a dressing gown with paint next to them falling off the walls (8:15)
Public health	C22(a)	Health care organisations promote, protect and demonstrably improve the health of other community served, and narrow health inequalities by co-operating with each other and with Local Authorities and other organisations;	I think that we work alongside other agencies much much more than we used to and we're aware of how they are working and they're aware of how we're working, especially social services (3:19) ...you've got the bigger bodies like Kent County Council ... reorganising and changing yet again.and I mean they're into clusters, foundations schools,, and now we've got BEST, we've got BIP and now I'm waiting for 'bop' to arrive (4:22) I work mainly with elderly people, you don't know until you go out and see them - that's if they ever tell you - that they've already got a care manager from Social Services. ...Often the information we get is very basic but nothing tells you what has been implemented for that person to return home. (5:17)
	C22(c)	Health care organisations promote, protect and demonstrably improve the health of other community served, and narrow health inequalities by making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.we are excellent at partnership working at strategic level, the PCT has become very good, ... because they view the partnership working so importantly, butat quite a low localised level some of it works but a hell of a lot of it is getting there by accident and ...not by design. (4:27) ...it can be complicated around other organisations' expectations or their professional perspectives..... it is really complicated just agreeing the service level agreements with those organisations also forming a partnership agreement, it's how you behave with each other it has to be worked at and managed quite carefully to be effective (4:18)

Table 4: Consensus views of core standards not being applied (n=2)

Domain	Core standard		Comments
Clinical and cost effectiveness	C5(a)	Health care organisations ensure that they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care	<p>...you have got this whole thing around children's centres, but they are not there.the processes are going to be very very slowit's going to take an awful long time, years before it is actually developed (1:17)</p> <p>There's different sets of standards that we have to meet,.....and things like the NHS Plan, the Health & Social Care Act, and the problem is a lot of them are asking to report on the same thing...you are also duplicating work (3:3)</p> <p>....how do the core areas ...match up with the skills framework, and other framework competencies?... It's how they all get co-ordinated together really. That's the worry (4:2)</p>
Patient focus	C13(b)	Health care organisations have systems in place to ensure that appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information	<p>...there's huge problems with who knows where [the information] comes from, do the parents know it's happening, have they given consent, no they haven't, but it's a child protection concern, so the information is passed on, in supposedly the best interest of the child and it's a minefield, an absolute minefield.(3:16)</p>

3.4.3 *Measuring Standards*

Respondents were asked to consider the measurement of standards; what is currently being used and what should be considered in relation to the new standards. A key factor considered the ability of established and any future methods being able to fully capture the complex realities of practice and the long-term nature of community work:

...we can onlyput one thing in the Comcare ... we might have done a lot of things – therapeutic listening, ideas, advice, all sorts of things will happen but how do we get that across? (1:2)

.....it's the areas of public health that are the most difficult isn't it, because it does take a long time to change and those things cannot happen overnight but they always want measurements that show something immediate rather than in the long term future, that's the difficulty (3:3)

However, in some areas such as health promotion there seemed to be monitoring systems based on audit methods to ensure equity of service delivery:

we would look and see if somebody was continually not having any successes. We would go and talk with them and see what's going on so we have a standard that's delivered in training that we monitor and hope to maintain. (5:1)

In addition, speech and language staff have developed children-friendly feedback mechanisms using smiley faces, which help to monitor service delivery from the user perspective.

With respect to the new standards, most respondents were unable to comment specifically on how they could be measured, however general remarks focused on the potential difficulties:

I think they are being achieved in a lot of areas but how do you actually evidence them – like treating people with dignity - it's almost impossible to, unless somebody's going to stand in an area and listen and mark you off. (3:14)

....you could get a general feeling about whether you are meeting standards or not but as I say it's all very anecdotal and you can only actually guess sometimes by looking at it, but not really measure it. (6:2)

Associated with this discussion about standard measurement was the issue of the current target-oriented approach, where the application and measurement of practice was seen as being manipulated to give an artificial impression of achievement. Many felt strongly that there was a contradiction between client-centred best practice necessary to achieve standards, and what they were being asked to do to achieve targets.

I would much rather have someone in my team who thought about clinical standards far more from the perspective of the client like 'I do it this way – this is going to get the best possible outcome' rather than thinking 'If I do this it will meet target 57',We are not meeting tick box targets, which causes a lot of difficulty and conflict but we are actually making better outcomes.(1:14)

...they set these targets that are put there and they don't seem to relate to individual patients but to groups of patients. So you've got a patient who's completely unsuitable for that information but you've got to have that box ticked. You've got to have given them that information.Patient centred care from a managerial point of view seems to be the last thing of importance. Ticking boxes is a much more important thing because they've got their bit to do and they've got to show the government that they've done that. (8:3)

Other respondents highlighted that the focus of their work had changed in response to meeting targets, with more time spent on areas where they were assessed the most. Some felt that they were no longer able to use their expertise, which created tension, as seen in the example of smoking cessation:

... . so all our attention went into that, which created quite a lot of resentment, as technically to get someone to stop smoking for four weeks may not mean that their health's been promoted (3:3)

A number of respondents emphasised other consequences in relation to overall relevance:

.....and I think it also creates a degree of cynicism that you know some people will work the system very quickly and it's easy to work the system and work out how to get your boxes ticked regardless (3:4)

I mean they sort them out very statistically.....with no reference to us. The PCT doesn't get a say. Then they're passed on down and nobody actually will feel that they are relevant (5:8)

3.4.4 Commentary

There was an apparent divide in awareness and understanding of the new standards, and the comments made were positive and knowledgeable. Such opinions were perhaps influenced by the management seminar that had taken place prior to the study. Communication methods in the Trust are discussed in later sections; it is worth remembering the apparent effectiveness of this approach among senior respondents.

With reference to the tables, table 2 demonstrates that there were several statements that participants felt confident as having the necessary systems in place. The health visitors were especially united in their agreement about child protection guidance, being an important part of their role.

Systems for incorporating and participating in audit appeared to be established, with some moves being made for audit to be incorporated into clinical effectiveness policy, as the quote implies. However, the execution of audit did come under criticism from one group. There was an illustration of a recent documentation audit where questions were raised about some inherent bias within the sampling to over portray a positive image. In addition, feedback mechanisms were variable. These differences indicate that there may be scope for further monitoring of the processes involved.

There was evidence of clear systems for complaints procedures. With the support of the Patient Liaison Service, there were additional and supportive ways of feeding back information to patients. The setting up of action plans seemed to be instrumental in optimising practice changes. This finding is similar to Freeman & Walshe's (2004) national study, which indicated that such systems were in general well established due to the relative ease with which they can be set up and measured.

As demonstrated in table 3, there were more core standards here that appeared to have inconsistent application. This is not surprising, given the diffuse nature of community working, as well as individual differences in professional practice and understanding, and reflects the NAO (2003) study. Furthermore, Maynard (2005) continues to comment about persistent national variations in NHS performance; it is likely that professional disparities have a part to play.

Table 4 highlights that only two main core standards emerged as having significant challenges to their application. The standard in the Clinical and Cost Effectiveness domain relating to the inclusion of other guidance when delivering care, provoked considerable debate about the difficulties in blending different competing policies and standards, and how priorities can be determined. This was reflected in discussions in many of the focus groups. It is evident that the interplay with other developments and agendas is dependent upon organisational cohesiveness and other infrastructures being in place. Superimposed on this already complicated picture are overarching, competing and ever-changing political requirements. Similar observations are noted in other recent primary care studies (Fitzgerald et al 2003; Macdonald & Harrison 2004). It is not surprising that respondents here appeared unable to see clear pathways through to implementation.

Despite this, the general theme when discussing the core standards was of a desire to apply and achieve them, but recognition that there were sometimes significant caveats to doing so. These are wide-ranging and will be made evident in section 3.5 where the focus is on actions the PCT can consider. What is clear is that in some workplaces, there are good models of practice, for example learning from a safety incident or improving financial awareness, that would benefit from greater exposure and shared learning practices.

With reference to measurement of standards, comments reflect the current confusing overlap between the varied information requirements and different methods in operation. The difficulty respondents had in offering precise ways of capturing achievement with core standards is therefore understandable, and may be developing into a general problem. However we do glimpse here the demotivating nature of the ways in which measurement imperatives can erode professional control and autonomy over how they work.

3.5 Supporting the application of standards: What the PCT can do

This section reports respondents' suggestions of the ways in which the PCT can best support staff to apply and achieve the standards. Blended with this section are experiences and views extracted from focus groups discussions that revealed challenges faced by the respondents in relation to their working environment. This has helped to underpin the suggestions. Areas here covered support to frontline staff, issues about decision-making, tackling poor levels of communication, resources and training, and improving multi-professional working.

3.5.1 Improving support on the ground

While there were good examples of supportive management styles, respondents felt that greater contact was needed with managers to improve understanding and motivation for enhancing best practice. This was particularly expressed by professionals not managed by someone of their own profession. The desire for more support was to counter the feeling of distancing and lack of appreciation of the realities of working practice. Sentiments were often connected to the previous discussions concerning the mismatch between policies, standards, targets and what was actually achievable in practice. In addition, issues relating to 'openness' and 'whistle-blowing' called for more trustworthy and robust systems that would engender a greater sense of confidence when reporting incidences.

A number of respondents thought that the 'listening' visits conducted by the Chief Executive should be replicated by other managers. Occupational therapists were particularly keen on this idea, but this feeling was reflected by other professional groups:

One of the things that we've suggested before is that some of the managers actually come and spend specific time with us. unless they actually come down to the coal face at times and actually spend some time with us to see how the team works it's very difficult for them to get a good understanding (8:5)

.... at the end of the day we are human beings. You know, they have to invest some time in us if they want us to deliver (5:21)

Managers themselves, as illustrated by these respondents, echoed the importance of this:

How could I possibly understand what my team members are saying to me if I've got no idea of what they face day to day and talking about clinical standards and stuff like that, ... It's all very well handing out a document saying "we have got to stick to these" but if someone is saying "well actually in practice that doesn't seem to work" and then you turn round and say "tough – you've got to do it anyway", that's not ideal is it? (1:11)

There is a great willingness for wanting to move things forward and there are very few people that actually don't want to move forward and change is always difficult and we want to support people through that more (8:8)

There was clear recognition of the important role managers have to play in the PCT with respect to motivation and maintaining professional pride:

...there is an understood code of practice which people operate and take pride in, and I think .. the managers are at the interface between kind of the human side of the PCT and the operational side.... we rely on the managers to do that (3:7)

3.5.2 Inclusive and clear decision-making

The desire for an improved decision-making process throughout the organisation appeared to be a recurrent theme, and was connected to a feeling of lack of direction in the Trust. While there was recognition that the constant changes had a part to play, it affected practice priorities and caused some frustration:

The problem is that all of the decisions about the development and the direction we're moving in seem to be made 'up there', put into place and then we're told from next week we'll be doing it this way ...and it's very rare that we're actually consulted on with enough time to actually make a difference to them making a decision about the service. (8:2)

I was told that somebody would be looking at documents attaining to my service and ...telling you what that meant for my service, I am a specialist practitioner and I should be looking at those documents and making those decisions... there should be a dialogue about what I perceive the policy should be for my service (1:11)

The importance of including those responsible for delivering care in the decision-making processes comes through, and echoes the relevance of ownership and control highlighted earlier for those respondents involved in standards setting. Managers appeared to understand this themselves:

Some of these things coming up here ...could act as a wake up call to those of us who are involved in making decisions to actually realise thatthe best solutions always come from people doing the job not from the manager. (4:39)

3.5.3 *Improving Communication*

Comments concerned with improving communication centred on two broad issues, (i) feedback about audit, incidents or changes and (ii) how information is disseminated in general.

(i) Feedback about audit, incidents or changes

While some respondents were satisfied with feedback, most peoples' experiences were not so positive. Feedback could be improved in these areas:

...if you get no feedback or no action plan then people are going to question why they are doing it and I think that's a big drawback at the moment.... we can see audit as threatening (1:20)

The following quotes are focused more on the anxieties created as a result of the impending PCT changes and what this will mean for staff and clients, demonstrating the need for developing appropriate forms of communication to field instability and uncertainty:

There's a lot of gossip and lot of rumour about what will happen, which in turn does unsettle people. (8:10)

Information feedback is not very good really because ... we always tend to find out about changes once they've actually occurred and then we're told that this is what we now need to be doing. (8:2)

[There are] constant changes and we never see a new structure settle down before the next change. And at times you sort of stick your head up and you can actually see yes it's all necessary but I do get concerned that the clients are lost in it all... (8:8)

Aside from the wider structural PCT changes, there were uncertainties about future roles for other professionals, indicating further the need for reassurance, as this health visitor explains:

.... there is a move towards more geographical working and locality working ... There's a lack of information at the moment with the trust about the future ...It just makes you feel almost like you're in limbo and you don't know ... how far you can plan your service before ... an outside influence changes it for you. (8:1)

(ii) Disseminating information more effectively

While some perceived the need for improved communication on specific issues, others were more concerned about the general 'deluge' of PCT, policy and practice information being passed down to them. Respondents emphasised the importance of developing systems to sift and prioritise, as well as making the information more 'digestible'. Staff appeared to feel overwhelmed with information that was not always appropriate, and unable to find the time to read everything sent to them:

...they just bombard you with a whole load of stuff that actually doesn't seem relevant to you, it's stressful having to sift your way through it all. (3:6)

...we've got no process, no arrangement with the PCT that says these couple of people will do a quick summary, and once it's in their directorate they will make sure it's cascaded out to their managers (4:39)

A tension surfaced between different points of view. On the one hand some perceived a responsibility to universally inform people, and on the other an insistence that relevance will vary between staff:

...if we don't need to know about it then don't send it to us because we don't want this on our desks if we really don't need to know about it, Think about what you are sending down to us, prioritise it, if you think we need to know about it, if you think we need to read it then please send it to us. (4:39)

I think that's something that has to be recognised, that the staff are doing a very good job on the one level and they don't all need to know exactly what it going on above them, it doesn't mean that they're not going to be able to perform well (3:8)

This manager sums up the tensions surrounding information dissemination to workers, highlighting well the paradox between overloading staff yet creating a sense of ownership:

we've heard lots of comments about relevant information, and I have to decide should I be consulting them or should I not be consulting them? If I do consult them are they going to say 'For goodness sake why don't you just make that decision?' If you don't consult them and the decisions are made then they'll probably say 'Oh I didn't know anything about that.' And it is quite a catch 22 situation because you're desperately trying not to overload with information... but a lot of it is service issues ... nowadays we have to have ownership of our own services. (7:8)

In some areas, staff had team briefings, although as previously mentioned, experiences varied. In the main, where it was well organised this was an effective way of disseminating information:

we always had a team brief where at least every month information is sent down from the trust and passed on to our managers who passed that on to us and we would discuss it and they were regular feedback. Now it seemed to keep you informed of what was going on and because there was this avenue to feed information back as well you felt that even if you weren't being listened to your ideas were actually moving further. (8:5)

This section highlights that a comprehensive local and international review of systems and approaches is needed to indicate the most appropriate forms of communication.

3.5.4 *Investing in resources*

Respondents had much to say about the resources that support them in their work. This section is separated into (i) human resources, highlighting staffing issues and time management; (ii) equipment and information technology, indicating where respondents felt greater investment was needed; and (iii) environmental considerations, such as accommodation.

(i) Thinking creatively about human resources

Most groups raised concerns about staffing levels, but were well aware of the difficulties surrounding recruitment and the financing of new posts. There were few suggestions as to how these issues could be resolved, more a need to raise awareness about and gain acknowledgement of the challenges that militate against the professional responsibility of meeting practice and policy requirements, and ultimately standards of care. Respondents from the therapies were particularly keen to point this out:

...it's very difficult to achieve some of the standards which are about giving people more choice. It's not possible to achieve them.... I have actually taken days out of my clinical practice to brainstorm ideas with staff and apart from more staff we can't see a way round it (6:2)

The public, they know what they're entitled to. They've got different expectations perhaps to what people had 15 or 20 years ago and demand thingsand the resources don't always follow. And certainly from a physio point of view lots and lots of areas are expanding and ..there's not the staff or resources to match it. (7:2)

The demotivating nature of staff shortages was felt in other areas:

...a lot of people have left and nobody has been replaced. You can adjust a few things This can be quite disheartening because you don't feel that your work is valid, that this whole service is not a priority (7:5)

For others there were specific practical issues that could be considered. For example, administration duties that distracted from clinical work could be improved with better administrative support:

...if we had a proper office systemwe could be out ...organising staff and doing public health and doing all sorts of things instead of scratching around trying to actually do the basic administration bit.(1:19)

...we organise our own case studies, we are involved in doing filing, paperwork, sending out everything. We might have a token clerical for a few hours a week. That's not the way to run an office. (1:18)

Leading on from staffing issues, there were concerns relating to the management of time in relation to keeping up-to-date and developing practice. Many respondents were investing their own time in doing this, but felt they needed more support:

We have to take our own responsibility to ensure that we're promoting best practice and using best practice. But we also need the support to facilitate us to have the backup, whether it be training or time to sit down and read some of these things and update yourself, to be able to ensure that it happens really. (8:15)

...the only way that I could keep myself on top of things would be to spend a lot of my own time do reading up or reflecting or challenging myself and I think it would be helpful if that was built into the organisation (1:18)

Given the national shortages of trained manpower in the public sector, what respondents' views highlight is the need for a review that considers issues of time management and staffing more creatively.

(ii) Investment in equipment and information technology

Focusing initially on equipment, there were some areas that were considerably more under resourced than others, as this respondent suggests:

You name it Deal Hospital could do with it really. Fibre-optic equipmentany equipment ... for the procedures for the patients. You know it's not to make life easier for us, it's to make life right for the patients. (6:8)

In addition, previous quotes used in table 3 have indicated that old and unsanitary equipment is still in use.

A further area of concern related to mobile phones, with staff expressing unease about using their own phones and the implications of late and lone working:

It's part of the lone working that we are supposed to report back in at the end of the day but we have to use our own phones (2:18)

I know a lot of our nurses were going out late at night, especially with winter coming along in the dark and stuff and they don't have access to mobile phones (8:14)

The area that generated the most comments however was information technology. Experiences were variable, with those working in an acute setting benefiting from a more stable and useful system than those in the field. The vast majority of respondents were frustrated and dissatisfied with their IT infrastructure. Requirements did not seem to keep pace with expansion, leaving too many sharing too few computers, or none at all, with a system that left much to be desired. These respondents collectively describe the impact on their daily work:

It's not easy to accessand we've got one computer with 4 or 5 people sharing....so I have to drive 5 miles if I want to look at a computer and then I have to wait. (7:4)

...if I want to find out who's going in to a patient, I will ring social services and ask them to get it up on the computer and then I will ring my surgery and ask them because that is my only way of finding out (4:13)

I have e-mails that just disappear and I don't know where they've gone. At [workplace] there is a complete problem with the e-mails other agencies think you're shouting at them because they come out very large and in capitals. (6:6)

The perfect example is I wrote a huge report the other day and as I put the final save in the computer crashed ... You know so actually doing a basic job is impossible (6:6)

In the dialogue below, some resistance to embracing IT was also detected within the discussions, connected to the difficulties experienced:

R1: Well I don't have an e-mail address because I don't want one.

R2: I don't blame you.

R1: What's the use of having one? They want me to have one and I don't want one, too much trouble.... To tell the truth I have got one but I don't like it. (6:6)

In addition, the relevance escaped others:

...we're not getting away from the paperwork, we're just getting the extra computer work too. I mean I wouldn't mind if they were saving the trees but they're not, they're printing everything (6:7)

While these examples may indicate a training issue, this may not be easy to arrange, as this manager pointed out:

I have staff who need IT training but we've had to prioritise and we have more desperate mandatory training (5:7)

This 'plea' to the PCT from this respondent about what can be done forms the consensus opinion of many others:

I think an up to date IT system that works... You know if huge companies can manage it then so should we. (6:7)

(iii) Consideration of the working environment

Alterations within the workforce structure coupled with mergers in response to policy requirements has meant changes in where staff are housed in the PCT. For some, this has resulted in cramped conditions with too few workstations, telephones, storage space and confidential meeting areas, ultimately impacting upon their ability to carry out duties in a professional manner. This in turn has created a highly stressful situation, augmented by a feeling of lack of control and support. The difficulties experienced by groups of school nurses illustrates this point:

...[someone] is making decisions about where we should be and how we should be jammed in without having any understanding of the fact that we are real people with real needs who shouldn't keep being submitted to this..... what we do need is adequate accommodation (2:13)

...the last few months with accommodation ...we had a real struggle to keep sane and I find it really distressing every week (4:8)

For others, peeling paint and dirty carpets in clinics were problematic as highlighted in table 3, and felt to impact also on the patient experience, and as in this quote below, poor heating was at issue:

When I worked in Deal we had a portakabin in the grounds of the hospital and all we had were 2 storage heaters and on a Monday morning, when it had been shut up over the weekend and very cold, it could take 3 to 4 hours for the temperature to rise to an acceptable level where you felt comfortable to actually take your coat off. And they've just extended the lease for another year on that. (8:20)

Again, there was awareness that accommodation problems are difficult to resolve. But it is clear that a more transparent and inclusive pathway to accommodation decisions needs to be developed, avoiding the negative impact upon staff morale, practice and the patient experience, as highlighted here.

3.5.5 A review of training and role development

The importance of continuous training and education was highlighted in a previous section that indicated factors supporting the implementation of standards. The current inadequacies and potential improvements in this area were also revealed when discussing supportive action the PCT could take. This sub-section describes the main emergent sub-themes, namely (i) training contracts, (ii) training to enhance roles, and (iii) mandatory training

(i) Training contracts

There was a strong call to review existing training contracts. A primary concern was connected to those that exist with the local university. They were seen as of poor quality, inadequate for the needs of a specialist workforce, and not responsive enough to new NHS developments:

...because of the trust policy, basically it's Christ Church or nothing and ...if they can't offer the course that we want at the level we want it, I shall continue to battle. (1:19)

I think the PCT does try to support training as much as possible...
...but the training contracts don't always provide the training that people would necessarily want (8:12)

For some this resulted in funding their own courses:

I am doing my Masters but I'm not being funded by anybody for that. I have to secure private funding because they wouldn't pay for any of it for me, even though it was being used towards my job. (8:12)

(ii) Training to enhance roles

More training in response to new agendas, like 'Agenda for Change', personal development programmes (PDPs) and appraisals was also suggested. The importance of linking PDPs to organisation objectives was raised, and identifying individual training needs through appraisal reiterated. But on the ground staff felt that support systems were not in place or not used sufficiently well (such as the training matrix), and that there was a lack of confidence in existing structures:

We've got to be upgraded and go through gateways. But I don't think we're going to get the training that it says that we've got to have because ... they're very limited on spaces and the amounts of courses that they can run. So I think that's going to be a bit difficult to get through to your gateway and the training. (8:10)

.. they should look at the training that suits your role. so it's no good me going off and doing PowerPoint because when do I use PowerPoint in my role? You know that's a waste of a resource. (5:3)

Added to this were suggestions for how roles could be improved through training to support a more co-ordinated and competent approach in the community. These ideas came particularly from non-professional staff, who were keen to augment their skills to improve care to the client:

Our roles could be extended seeing as you're going out to visit somebody in their home already. you could say well while I'm in that house this is what I could also do....The PCT needs to help us with this (5:16)

(iii) Mandatory training

There were many comments relating to mandatory training, most describing travelling inconveniences and issues associated with attending the study days. A common perception was that training should be more locally based to reduce travelling time.

I think the mandatory ones should be done locally because I have still got a hospital room upstairs and [trainers] could come to us rather than us be left to go to Folkestone or Canterbury and some groups are only two hours. (2:25)

In some areas this has been arranged and has added benefits to team working:

We try and get the fire chappy to come along and do it as a team thing and we are going to get the handling people up to try to do it as a team – we work all the time as a team anyway so it sort of means more (2:26)

In general however, respondents expressed difficulty in time allocation through competing practice priorities:

You know there are a lot of battles really to try and get people on to training and finding the time (6:3)

I think it is very hard to find time out to go on study days to increase your knowledge ...without feeling guilty (2:25)

Sometimes other difficulties in relation to attendance decreased motivation:

We have so much mandatory training that we have to do. You book yourself on and you can't get on or it's cancelled or it's miles away, then you just lose heart in the end and think why should I bother. (2:26)

I went on one of the training courses and I think there were 12 people booked on it and only 5 turned up and she said this happens repeatedly. (5:15)

In some areas, respondents were aware of a list where staff wishing to attend a full course could be put on 'stand-by', and there was a system to notify the relevant departments for non-attendance. This was not universally known.

3.5.6 *Putting the spotlight on multi-agency and interprofessional working*

Without doubt, effective interprofessional and partnership working is an essential component of achieving some of the new core standards. Many respondents were involved in this activity to varying degrees and discussion revealed some areas of multi-agency working that the PCT can capitalise on, and some that would benefit from improvement. Comments differentiate between managerial perspectives, and the views of those on the ground.

From a managerial perspective, strategic connections were felt to be in place and the PCT was working towards creating and maintaining effective partnerships at a senior level. The difficulties tended to emerge at the sharp end of practice. These managers offer an explanation:

there are a number of posts now where in order to perform the post properlyyou have to work strategically across a number of organisations, we are not empowering staff to think in that strategic wayit makes partnership working difficult (1:12)

If you're going to have good multi-agency working...you've got to learn how to communicate with every different statutory body that is available. I'm not sure it's as effective as it could be (5:18)

Building on the above quotes, observations from staff working on the ground provide further illustrations of practice situations that militate

against effective working, creating frustration for professionals and a potentially less than positive experience for the client:

:

I'm habitually trying towork out the pathways for a young person. There could be five different agencies involved with the young person,, why do you need five people? I think somewhere those pathways have got to be better sorted out, the resources have been badly used the number of times we ... find there are three or four agencies involved and for that child there is some Social worker up in London even (4:24)

If you had a camera on a house ... all you see is health professionals going in there ... There was this older lady waiting for us to arrive to do an incontinence assessment and someone arrived from Interflora and the older lady started to give her continence information to Interflora before he could hand the flowers over. (4:24)

In the area of sexual health there appeared to be a confusing array of people to refer to with varying degrees of expertise, resulting in service overlap and duplication of effort. This appeared to create some tension:

...some have no child protection knowledge or and are not sexual health trained. [Referrers] don't see that there is another more expert agency out there. ... they have got all these little links and preferences and it all becomes very precious. (4:18)

...there are various charities, voluntary agencies, who have got money from somewhere who are doing almost the same thing that all the other groups are doing, and I'm not sure the kids are getting the best deal (6:4)

Despite these difficulties, some good models of practice were evident. Victoria House in Margate was often cited as a successful example of multi-agency working, as was the project 'Healthy Minds'. Other professionals stated that better professional relationships had improved communication and activity, especially between health and social services. It will be important therefore when reviewing multi-agency and interprofessional practices that knowledge from these models is transferred to other areas.

3.5.7 Commentary

Linking with previous sections, innovations that currently help with standards implementation also have their disadvantages, and there were clear indications of issues to consider for the future. In addition, it can be seen that many of the issues raised in this section are connected.

The dual recognition of both managers and staff of the importance of support on the ground has been evident throughout the study, and was particularly articulated here. While 'listening visits' were suggested, other strategies by which this could be achieved were not apparent. The desire for greater managerial input can manifest itself when a

workforce is under increasing pressure, and can often be a 'reflex' response, see also Pettigrew et al (1992). When concrete solutions to pressures are limited, regular empathetic interpersonal contact based on reassurance and recognition of the pressures staff are facing can reduce anxiety.

Again, with respect to inclusiveness and decision-making, the empowering nature of those being part of these processes in their working practice was contrasted with the frustration of respondents who were not. There are important associations to be made here again with respect to motivation, ownership and control, with best practice. It is important to note that people who feel that their opinions count and are able to be influential are more positive about their work (Robinson 2001). In relation to Campbell et al's (2002) study, it would appear that the unevaluated staff involvement methods instigated by managers could be an effective way forward.

Moving to issues concerning communication, there are long-standing problems in community work, connected in part to the different systems of managerial contact and support, and the wider 'change culture' that can leave staff feeling adrift (Cowley & Billings 1999). Fitzgerald et al (2003p.224) observed that the primary care sector could be characterised as a network organisation 'drowning in information overload'.

The variability of practice and different contexts within which people work appeared to have resulted in a variety of methods of communicating information, some more useful than others. These methods cannot always remain stable due to changes in personnel and infrastructure. This means that information dissemination is fractured and inconsistent across and within professional groups. It was not surprising that most respondents were unaware of the new standards, as the communication processes do not seem conducive to the succinct relaying of information to staff. As illustrated in the data, communication needs are often contradictory and peculiar to different professional or even individual requirements. Strategies are often based on local needs, and therefore wider models are not easily transferable, but some lessons can be learned from experiences in other areas. There were clear indications that some work needs to be conducted around smooth-lining these processes.

As this study is suggesting, the ability to apply standards effectively is dependent upon a number of factors, but having adequate resources is no doubt a key component. The findings here are no different from the wider national situation, especially with respect to personnel (HM Treasury 2002, Pearson et al 2004). The ability of primary care to keep pace with the necessary technological changes however is becoming increasingly a cause for concern. In a recent Barometer survey, confidence in being able to deliver the National IT programme has slumped among PCT Chief Executives (HSJ November 3rd 2005).

According to our respondents, given the extent of improvement needed, providing staff with adequate IT infrastructure may be an even bigger obstacle. The data indicated that the current IT weaknesses are engendering a natural tendency for staff to see it as untrustworthy and more trouble than it is worth. When this situation is coupled with concerns about information dissemination, the implications for how knowledge is generally managed are significant.

Continuing with resources, some respondents expressed difficulty with getting basic accommodation needs fulfilled. The importance of a pleasant well-resourced working environment in creating high staff morale is well documented (Pearson et al 2004). What came through from these respondents' comments was the acute sense of disappointment and frustration this created for staff and patients.

With respect to training, more respondents were critical of current training than satisfied with it, particularly with reference to training contracts, mandatory training and that associated with 'Agenda for Change'. Obviously geographical dispersion of the workforce makes meeting need more difficult, but resource issues and time, coupled with a culture of guilt when leaving the workplace, compound these difficulties. When variations in accessibility and choice are added to the equation, it seems a paradox exists between a strong perceived need to adequately train the staff and the realities of trying to do it.

Finally, the experiences of respondents with interagency, interprofessional and partnership working mirror the challenges encountered in other studies. Pettigrew & Fenton (2000) for example note that partnership-based organisations operate in a consensual, non hierarchical way at the top (although there may be differences in status), whilst within practice there are distinct hierarchies and tensions between the professions that can be counterproductive. Indeed, in this study there appeared to be considerable knowledge about the 'how to' of interagency working with a parallel understanding of the difficulties involved. Again with seemingly successful models in operation in the PCT, the need for full evaluation to promote transfer of knowledge is evident.

3.6 Summary of Key Findings

- Most respondents regarded standards as acceptable and legitimate solutions to assisting best practice, and there seemed to be a high level of associated professional responsibility connected to their application. Others perceived standards more in terms of an 'insurance policy' or an 'enforcer'.
- Recognised and reliable mechanisms were felt to be in place for staff to access information about standards, such as through folders and regular meetings. Many were involved in standard

setting or updating, and there seemed to be apparent pathways to inclusion for the disciplines represented in the study. A clear sense of ownership and professional pride was evident among those centrally involved. Reservations about the process included concerns about the slow pace of standard setting, and pressures to implement without sufficient guidance.

- Two aspects emerged as facilitating standards implementation. The training and appraisal systems were seen as useful conduits through which to identify and rectify skills deficits, however this did depend on the adequacy of appraisals. Secondly, some leadership models were identified as being effective, such as the team leader model and 'listening' visits, however experiences were variable.
- With reference to the Standards for Better Health, only senior staff in the sample were fully aware of their existence, most were vague or unaware. When core standards were discussed in individual groups, of the 31 core standards reviewed, 12 were seen as being applied in practice or planned for, 17 were seen as being inconsistently applied and two were seen as not being applied. In general, there was recognition of their importance but an understanding of the impediments to achieving them. These came in the form of competing policies, priorities and targets, organisational cohesiveness and available resources.
- With respect to measuring standards, there was some difficulty in offering precise ways of reflecting achievement with core standards. Respondents were primarily concerned that any measures used would be artificial and not capture the complex realities of practice.
- Suggestions for what the PCT can do to support the application of standards focused on six key areas, namely improving support on the ground; inclusive and clear decision-making; improving communication: investing in resources; a review of training and role development and putting the spotlight on multi-agency and interprofessional working with respect to learning from good models of practice.

4 Conclusion

This study has provided insight into current understanding and application of standards within one PCT, with a particular focus on Standards for Better Health.

It appears that in general terms, standards have become accepted and embedded within clinical practice, and seen as legitimate components of professional care. The findings also suggest that within the workforce there are staff who are highly motivated to respond and pervasively lead practice change. In some quarters, there was proactive development of standards and efforts to include other staff; this had a very positive empowering effect on those involved and the keen sense of professional pride was evident.

Variability and **inconsistency** of standard application were however major themes of the study. Data here and from previous studies suggests that many aspects of the differences in patterns and experiences can be accounted for by the influence of the local context. The data in this study disclosed a unique but well recognised situation that comes about through managing a disparate and multi-professional workforce against the backdrop of NHS modernisation. The discussions revealed a paradox between a stoical, client-centred, positive but often vulnerable workforce. This vulnerability seemed to be engendered by the lack of stability created through constant change and shifting professional boundaries. Such findings are a recurrent theme in NHS health service research (Cowley and Billings 1999).

For respondents in this study, diverse factors compounded the situation and contributed towards the inconsistent manner by which standards seem to be implemented. This included the different levels of managerial support, communication and inclusion, coupled with varying degrees of material infrastructure and resources. In addition, while there were areas where staff experienced some ownership of practice decisions, in the main there was a perceived lack of direction and control over practice due to the competing policy requirements.

Against this backdrop, it is important to review the implications of the new PCT organisational and strategic changes that connect to the findings. What must be acknowledged is that PCTs will have to make heavy management savings resulting from the new restructuring proposals, so the availability of local managers to respond and lead will dwindle rather than increase. Greater divestment of provider functions will be a further factor here. The desire for more management support runs counter to future policy intentions. Hence new ways of supporting practice will have to be considered.

This is particularly so with respect to technological support. With devices such as personal digital assistants (PDAs) and smartphones, technology has been developed to assist field workers with information

management. Given the overwhelmingly negative experiences of respondents, there are implications on risk management with respect to ensuring staff are operating with sufficient knowledge at any given time. There will therefore be an urgent and widespread need to implement robust systems that will facilitate the accessing, using, recording and sharing of information more effectively. This testifies to the importance of having a clear knowledge management strategy in the context of a disseminated workforce, working against a backdrop of significant organisational and service change.

Overall, efforts should be channelled into creating better uniformity and improved organisational systems. This could be through the generation of strategies that capitalise on existing expertise, and harmonise approaches to managing, supporting and conducting best practice with an impact on how standards can be met.

4.1 *Limitations of the study*

This study was conducted within a qualitative paradigm and therefore sought to gather rich contextual data for a thematic representation of perceptions. While sample size was hampered by recruitment to another competing PCT project and time commitments, a total of 39 respondents still constitute an adequate sample size. This is particularly so, given that no new themes emerged in the latter focus groups and the data were deemed saturated (Glaser & Strauss 1967). If the results are credible and 'believable' by readers, this provides some measure of content and face validity (Lincoln & Guba 1985). One area that did not reach saturation however was the discussion of individual core standards, which was restricted to single groups per domain. The findings therefore can only give an indication of perceptions around degrees of application to practice.

It is important to recognise that, as with all types of qualitative research, there can be an inherent problem with selection. Respondents coming forward may have demonstrated some biases in favour or against the subject matter discussed. The results however do not give a polemic view; both strengths and weaknesses were captured. Strong opinions and opposing views were expressed, and achieving consensus in some areas where this was warranted was testing.

It must also be stated that studies of this nature are not generalisable, yet do not seek to be. The themes that emerged were instead amenable to analytical generalisation, which is comparable to the wider knowledge. If more traditional generalisability is required, themes from this study could be developed into questionnaire items for further statistical testing.

5 Recommendations

When considering the recommendations, it will be important to ground them to the findings and the key areas for the PCT to consider are summarised here:

- 5.1.1 *Improving support on the ground:*** enhancing managerial contact through possible listening visits and increased face-to-face interaction
- 5.1.2 *Inclusive and clear decision-making:*** greater transparency and inclusion in decision-making that affects practice.
- 5.1.3 *Improving communication:*** improving feedback from audit, incidences or changes, and reviewing and improving information dissemination.
- 5.1.4 *Investing in resources:*** progressing administrative support, developing strategies to help staff deal with time management, improving experiences of work accommodation and tackling the technological support needed by a mobile and geographically dispersed work-force.
- 5.1.5 *A review of training and role development:*** focusing on developing more 'fit for purpose' training through a review of training contracts, and as assessment of requirements connected to 'Agenda for Change' and mandatory training.
- 5.1.6 *Putting the spotlight on multi-agency and interprofessional working:*** developing methods to learn comprehensively from good models of practice.

It is however important to consider strategies that will thread across the different identified strands and take into consideration the implications of new organisational changes, and three are put forward here.

- 5.1.7 *Learning from success – investigating good models of practice***

Following on from 5.1.6, it is recommended that the PCT capitalises more on existing successes. What was evident from this study was that while some models worked well in some areas, they were counterproductive in others. What is needed is a fuller exposure of the organisational and contextual processes that are the ingredients of success in identified areas. How and why this worked well was revealed to some extent, such as levels of leadership, communication, support and motivation, but more evaluation is needed to isolate the processes.

Particular identified areas that could act as a starting point include:

 - Team working model of supportive leadership – district nursing and school nursing
 - Listening visits
 - Team briefings

- Inclusiveness and ownership in standard development – school nursing, specialist services
- Dissemination and training around standards – health visiting
- Multi-agency projects – Victoria House and ‘Healthy Minds’ project

5.1.8 Developing new operational models – front-line ownership

This recommendation focuses on the question of how to manage a disseminated workforce where there are significant variations in practice as well as shifting organisational and infrastructural support. It also capitalised on staff ownership, control and inclusion, strong emergent themes from the data. There is a need for an operational model that moves towards staff on the ground, creating a milieu that allows professionals to act independently from traditional, direct management but within a shared management environment. One way forward could be the establishment of a multi-professional management board. Such a forum could begin to harmonise the current inconsistency within standards implementation and start to develop ways of improving knowledge management. Functions could include

- the development and dissemination of consistent best practice approaches using (amongst other sources) information learned in 5.1.7
- the speedy ratification of new or existing standards in order for the workforce to keep pace
- reviewing methods of information dissemination, such as how knowledge can be shared

5.1.9 Managing knowledge

Any successful organisation needs to manage knowledge in a way that reduces variability, promotes innovation and reduces risk; the PCT is no exception. Running through this study has been a theme of challenges that centre on developing, acquiring and sharing knowledge across distance and between groups of staff. The PCT needs to regard knowledge as the prime currency of its business and manage it accordingly. This means developing a comprehensive knowledge management strategy that underpins the above recommendations and starts to define outcomes for the initiatives they imply.

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Appendix 1



Dear

The Primary Care Trust is inviting you to take part in a staff development project which is being carried out by the University of Kent. The title of this project is:

Taking Health Care Standards Forward in East Kent Coastal Teaching PCT

Before you decide, it is important that you understand what the project is about and what it will involve. Please take time to read the following information carefully.

What is the project about?

Last year, the recently formed Healthcare Commission launched a new set of health care standards, which replace previous standards against which the NHS was assessed. The purpose of the new standards continues to be to enhance best practice by improving the overall quality of care. The standards have been separated out into different areas such as safety, cost-effectiveness, patient focus and public health.

As the Primary Care Trusts will now be taking a leading role in achieving these standards, there is an urgent need to find out from members of staff how we can take them forward. As well as getting your impressions of the new standards, we want to find out what you feel the PCT needs to do to make sure we have the necessary professional, managerial and organisational arrangements in place.

If I want to take part, what do I have to do?

We have asked an independent researcher to run a series of eight focus groups at the Centre for Health Service Studies, University of Kent with about eight to 12 health care workers in each group. You are being invited to attend the group from 2pm to 4pm on:

Wednesday...

At this group, you will be asked to contribute your views firstly about clinical standards in general. We want to find out how you manage to incorporate standards in your everyday practice at the moment, and what helps or hinders you in doing this. Secondly, you will be asked to look at some of the new standards. We want to know your views on how they can be achieved, and what policies, protocols or resources are needed. The researcher will tape

record the discussions in the groups to make sure all comments are captured. These tapes will be destroyed when the project has finished.

If you want to take part, please complete the consent form and contact details, and return it to the researcher in the prepaid envelope. If you want to take part but the date is not convenient for you, please contact the researcher (details below) to arrange attendance at another time. Once the researcher has received your consent form, you will be sent details of how to get to the location.

We would like to reassure you that your participation will be strictly confidential; we will be sending invitations to a number of people and will not know who will eventually be taking part. The researcher will make sure that you are not identified through any comments you may make.

Do I have to take part?

It is entirely up to you whether or not to take part, but if you do not want to take part, this will not affect you in any way. If you decide to take part but change your mind, you are free to do so, and this will also not affect you.

If you would like some more information about the project or there is anything that is not clear, please do not hesitate to contact the researcher, Jenny Billings. Her contact numbers are 01227 823876 or 07809051133, and her email address is j.r.billings@kent.ac.uk.

Yours sincerely

Dr. Sandro Limentani
Director of Public Health

Appendix 2



Taking Health Care Standards Forward in East Kent Coastal Teaching PCT Consent Form

1. I confirm that I have read and understand the information sheet for the above study and have had the chance to ask questions.

Please initial box

2. I understand that taking part in the project is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected.

Please initial box

3. I give my permission for the focus group discussions to be tape recorded

Please initial box

4. I agree to take part in the above project.

Please initial box

Please print your name: _____

Signature: _____ Date: _____

Contact details: your address and email or phone number

Appendix 3



Taking Health Care Standards Forward in East Kent

Focus Group Interview Schedule

Section 1: The Current Situation

(i) Attitudes and Understanding

Tell me what you think about clinical standards

What are they and what is their purpose?

What contribution do you think they make to clinical practice?

(ii) Application to practice

Give me some examples of how you use clinical standards in practice

What helps you?

What hinders you?

(prompts: organisational factors, professional factors, environmental factors, communication, leadership, motivation, willingness to change practice)

Section 2: Health Care Standards

Participants will be given time to read core standards within their allocated domain.

(i) General views

Tell me what you think about these standards in general

(ii) Taking the standards forward

Looking at each of the core standards in turn

To what extent do you think this is already being achieved?

Give an example of how you think this is being achieved

(prompt: organisational, professional, managerial and environmental factors)

What other things need to be in place?

(prompts: policies, plans, protocols, resources [physical/educational], other support needs, organisational/management structures)

How do you think you could measure progress with achieving these standards?