chronic disease nursing

a rheumatology example

Edited by **Susan M Oliver** RGN, MSc
Independent Rheumatology Nurse Specialist, North Devon

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Preface

These are exciting yet challenging times for nurses. In the last few years the contribution of nurses and practitioners has been recognised and yet, along with this recognition comes the hope that we can develop appropriate services. For chronic disease patients the support of specialist expertise is imperative. Providing this support is no small task with the increasing elderly and chronic disease population and spiralling healthcare costs, accompanied by a shortage of healthcare professionals.

This book aims to provide practical support to the new or aspiring nurse in chronic disease care whether they work in primary or secondary care. Although the examples used in this book are those from the rheumatology community, they have relevance to other areas and can provide nurses with an insight into why nurses are recognised as key players in healthcare as well as how to make the best of this new found recognition.

From my own personal experience there seemed to be a dearth of books that provided a step wise approach to many new 'service development needs' or business planning proposals. Much of the information was learned by word of mouth, luck or trial and error! The jargon that managers used and the pitfalls in planning the appropriate resources for service delivery are all potential minefields for the enthusiastic but uninformed! Healthcare services can ill afford to lose valuable nurses who become disillusioned with trying to improve care and fall foul of inappropriate planning and unresourced services. It is for this reason that the first two chapters set the framework for the provision of specialist nursing care. Chapters one and two provide the background to the development of nursing and go on to explain how to identify the infrastructure and resources required to develop a service.

Telephones have become an essential component of everyday life and their use has been shown to provide a wealth of support to individuals in a range of settings with minimal overheads. Equally in the provision of chronic disease care they provide an essential and efficient method of supporting the patient at a time of uncertainty or need. Yet for many the telephone helpline services have been developed in an ad hoc way, with good

intentions and often no funding. Telephone helpline services are not without risk. In fact it could be argued that providing safe and effective clinical support using only the telephone as a means of communication is fraught with potential problems. Chapter three provides the nurse with an understanding of some of the issues that need to be considered when setting up a helpline service.

Three chapters are structured around nurse led clinics. They include advice on the considerations that a nurse must make before setting up a clinic and why it is important to consider the use of various outcome measures. Although historically nurses have been recognised for their valuable contribution in providing care to patients, all too often the hard evidence that can demonstrate the potential benefit to patients and services is lacking. The healthcare system can no longer provide valuable resources if the benefit is not clearly identified. Equally, evidence based care has encouraged us to review our management and our opinions based upon data that demonstrates the value of an intervention or care provided. As can be seen in these chapters we have an opportunity to set up nurse led clinics, having adequately resourced them and then, hopefully be able to identify the right objective measures to see if the care we provide improves the outcome for patients.

With the rise in chronic disease management has come the increasing need to monitor the safety and efficacy of drug therapies. In primary care the burden of drug monitoring has proved a challenge with much of the monitoring being managed in a task orientated way providing little opportunity to enhance the expertise of the individual patients. It is time now to look at new ways of working that can capture the monitoring opportunity and empower the patient to manage their disease more effectively. They, after all are the ones who have the greatest vested interest in the safety and efficacy of their treatment! Nurses can develop models as highlighted in chapter six, using the opportunity to improve patient management as well as diminishing the unnatural divide between primary and secondary care.

Chapters seven and eight focus on the need to understand the role of biologic therapies and their implications for the management of many chronic disease patients. Although the example of rheumatology is used, these biologic therapies are set to make a dramatic impact on the management of a number of other chronic disease areas within the next few years. There are an increasing wave of new therapies 'on the bench' and set to be introduced into clinical practice in the next few years. Areas such as respiratory medicine, gastro-enterology, diabetes, hepatology, nephrology and many other autoimmune driven disease areas will be the focus of these therapies. It is for this reason that two chapters are devoted to bio-

logic therapies. The first chapter explains how biologic therapies work and the second chapter explains the importance of expert nursing practice in the assessment, management and administration of therapies.

It would be remiss if this book did not include topics such as leadership and clinical governance. Chapter ten informs nurses of some of the key components in understanding their roles as a 'clinical leaders' and follows on with an overview of clinical governance in the context of nursing development.

The final two chapters are rather special to me as the editor of this book. Individuals with long term chronic diseases become experts, over time and illness transition, and yet in the busy healthcare environment the patient's perspective can sometimes be overlooked. In Chapter eleven three individuals provide a personal reflection on coming to terms with their disease. The stories demonstrate the need to understand the complex inter-related factors that affect the individual's ability to cope with their disease and the daily consequences of chronic illness.

The final chapter – working with patient and professional organisations is one that should be invaluable to nurses. The chapter provides insights into political lobbying and the benefits of working together with combined strategies to improve care and promote the general understanding of chronic diseases and the structures that need to be in place to support management.

Collaborative working as a member of the nursing profession within the wider community of professional and patient groups is a rewarding and empowering experience, allowing personal and professional development.

In conclusion, I would like to thank the authors of the contributed chapters who have been brilliant in providing a wealth of expertise enabling this book to have a depth and breadth of knowledge that I believe will be invaluable to aspiring nurses within the field of chronic disease care.

Susan Oliver
March 2004

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Thanks also go to the great team who contributed to this book.

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Chapter 1

An overview of developing a chronic disease nursing service

Susan Oliver

Introduction

It is important to clarify that, although this chapter focuses on developing a chronic disease service based on the nursing perspective, the core principle running through chronic disease management is that of multidisciplinary teamworking. It is therefore not explicitly stated but taken as an essential prerequisite throughout the book that collaboration and communication with the team form the first part of any discussion on the provision of care for patients with a chronic disease.

The aim of this chapter is to provide an overview of the key components that are needed to support a nursing service in chronic disease management. It includes the professional, managerial and practical aspects that need to inform any decision making. The chapter should provide the nurse with some of the 'tools' needed to enhance the development proposal. Many of the issues discussed are based on the information needed to 'set out' a case and how these steps need to be taken. Nurses may be fortunate enough to have role models and managers who will support an initiative and aid their pathway through the process; this will help greatly but is not always guaranteed. Nurses engaged in providing care can often see the need for change but find the process of making a change frustrating and complex. Vision alone may not be enough. A significant factor in implementing change has to be the sharing of ideas, but the most important factor is being prepared for a difficult path ahead. It may take much longer to convince others of the vision.

The overall philosophy of chronic disease management focuses on patient empowerment and user involvement in decision making. This chapter outlines some of the issues relating to chronic disease management from the perspective of those charged with implementing the changes. One aspect of this will be how to understand the agendas and

difficulties experienced when submitting a nursing proposal to support or recognize the 'needs' of patients within the context of the wider healthcare provision. In the discussions, essential health agendas and supporting evidence will be highlighted.

This chapter will:

- Introduce the principles of chronic disease management planning.
- Describe nursing development in the context of providing care in a specialized field.
- Provide an overview of healthcare structures.
- Provide the practitioner with 'tools' to support decision making.

Fostering excellence

The expertise of the specialist nurse will be that of fostering a philosophy of excellence across all healthcare settings. The nurse at the bedside is responsible for providing and co-ordinating inpatient care, and the specialist nurse should be an easily accessible link between the patient's home environment and that of other healthcare professionals in all settings. In many cases, the specialist nurse–patient relationship will have been formed at, or soon after, the time of diagnosis. This caring relationship will develop over time and illness transition. Excellence in providing continuity of care can thrive only if it encompasses the cascading of knowledge and skills to the wider healthcare teams, allowing an empowering relationship to grow between patient and healthcare professionals.

So it is clear that the way forward requires a multidimensional approach to improving patient care. It is not only about providing the right sort of care, but also collating the data, researching the evidence and then leading the way in inspiring change. Cascading knowledge and skills are an essential prerequisite for the specialist nurse. The value of the role relies on demonstrating a wide range of abilities to inform and improve care not based purely on the nurse–patient relationship. The difficulty will be in juggling all the essential aspects of the role while providing inspiration with limited opportunities to develop an experienced nursing workforce.

Specialist nurses will need to focus not only on the specific skills that may be required for increasing responsibilities, but more importantly on the personal attributes which encompass high quality nursing practice.

The key qualities essential to the role of the nurse are empathy, maturity, teamwork, communication and flexibility, and although there is a need for additional management expertise these should be balanced with developing the core qualities of providing holistic care. The attributes of the specialist nurse or advanced practitioner need to be cultivated and supported to enable each individual to extend and develop not only within their professional role but in their abilities to improve patient care across all organizational boundaries. With this in mind it is necessary to look at where the future specialist or advanced practitioners are coming from. How do we provide the opportunities for nurses to develop the skills needed to fulfil an encompassing role that informs and supports the development of the empowered patient negotiating their pathways through healthcare? Nurses need to be proactive and forward thinking, specifically in the development of service provision and nursing resources.

The wider healthcare team and patient empowerment

Many trusting nurse–patient relationships are formed when providing personal care to patients. This leads the way to enhancing a closer psychological relationship. However, workforces have changed, and it is widely acknowledged that a significant amount of care is now performed by healthcare assistants. Increasingly this 'wider' healthcare team includes colleagues working in primary care. Chronic disease patients will meet many different healthcare professionals from phlebotomists to outpatient staff, practice and community nurses, and members of the wider multidisciplinary team. The general philosophy of empowerment and developing a therapeutic relationship needs to be reinforced and supported every time the patient is in contact with various members of the healthcare team. As a senior nurse, an integral part of care is that of supporting other members of the healthcare team in recognizing the benefits of patient empowerment and identifying ways to demonstrate the value to the patient's experience.

In the past, healthcare has failed to recognize fully the immense knowledge and expertise patients have in managing their daily lives in the context of their chronic disease. Today, it is recognized that patients are experts in their field and their 'voices' are increasingly powerful in terms of service development. The Commission for Health Improvement (CHI) reviews standards of care in a range of ways, but probably one of the most informative is that of following the 'patient's journey' through

healthcare. The principle of following the patient's journey highlights the unnatural barriers to providing healthcare at the same time as fully recognizing 'patient need' (Department of Health, DoH, 2001b)

The patient, and organizations that represent patient groups, should be consulted, not only for their ability to mould the service provision towards their needs but also because of their expertise in the lay perspective on the disease (DoH, 2003b). The Primary Care Trusts (PCTs) will not consider commissioning services that fail to demonstrate the view of the patient or the role of primary care in ensuring continuity of care.

Patients want to have confidence in the provision of care and to believe that they are an active participant in decisions about their care. It has to be remembered that the individual person's previous experiences will set the framework for how they will cope and communicate their needs as they set out on a new pathway managing their disease and the daily consequences of having a chronic illness. This includes coping with various illness 'crises', often on their own, at home with minimal healthcare support on a day-to-day basis.

The increasingly complex and technical nature of healthcare interventions, together with the difficulties in accessing their general practitioner, can leave many patients with long-term incurable conditions feeling that there is 'little hope or value' in their frequent attempts to seek 'specialist advice or support' from healthcare teams (Oliver, 2001). A wealth of research has highlighted the range of difficulties and emotions that form the patient's perspective about seeking healthcare support at times of chronic illness exacerbations (Bury, 1988; Corbin and Strauss, 1988; Kleinman, 1988; Gerhardt, 1990; Blaxter, 1992). From these initial discussions a picture should be developing of some of the social and psychological issues that need to be considered when planning a service development.

The patient's point of view

In recent years, some established practices have been questioned and found wanting, none more so than the traditional concept of 'care', with the patient as a passive recipient. At the same time, nurses and other healthcare professionals have advanced their skills and expertise in supporting the concept of empowerment for patients. The increasing emphasis on patient involvement is now at the centre of healthcare decision-making (Ryan and Oliver, 2002), and the paternalistic approach to care is, at last, no longer supported or sustainable.

It is interesting to reflect that the current agenda for change has been driven not only by the wish to empower the patient but also by the need to reduce the huge burden of chronic disease management by improving patient self-management strategies (DoH, 2001b). The Patient's Charter developed a 'dependent' approach to care that left many users recognizing their 'rights' within the Charter without recognizing the individual's responsibility to support the effective use of resources (DoH, 1989).

Healthcare providers have had to recognize the fact that the growth in the elderly and chronic disease populations will require increasing resources in the long term. Yet the ability to provide high-quality care for a growing number of patients is compromised by the shortage of trained healthcare professionals and finite resources available to implement care. The shortage of nurses and other trained healthcare professionals also presents a challenge to implementing change. A flexible and patient-centred workforce will require dynamic leadership and nursing is in a good position to effect these changes.

The patient is probably the nurses' most powerful ally in improving services. The nurse–patient relationship is one of strength and shared ideals. It can often begin with intimate personal care or advice relating to the patient's disease and the resulting social and psychological support needed at vulnerable times. This, combined with a strong principle of the nurse as patient advocate, forms a unique and strong bond that builds over time and illness transition. The nurse's main focus is on the patient's perspective of their disease and how to aid their coping. Yet nurses can be protective of this relationship and often fail fully to recognize the power of the 'patient's voice'. Fortunately in recent years the patient is being given a powerful voice in healthcare planning and provision of care (DoH, 2001b).

The Commission for Health Improvement expects to see a strong user involvement and will seek to explore patients' views. These views and how they can be included in healthcare strategy will vary according to the healthcare provider or hospital trust, but some examples include the following:

- Patient groups to review patient information leaflets prior to publication
- Development of patient networks. This includes areas in chronic disease where a number of support groups have joined together to have a combined and more powerful 'patient voice'.
- Links to large organizations that represent groups of patients, e.g. Arthritis Care.
- Voluntary clerical or clinic officers.
- Independent patient support groups set up to support a local need.
- Patient group representatives on trust management boards.

- Support groups and informal networks in fund raising and providing lay telephone support to patients.
- A patient representative nominated to attend planning meetings.
- Many patient groups join together with like-minded patient groups or professional organizations (for example, Arthritis and Musculoskeletal Alliance (ARMA) or the British Lung Foundation for respiratory diseases). These alliances can have a significant impact when working as a combined force to lobby Parliament with the aim of changing government policy. Work undertaken by the British League Against Rheumatism (BLAR), now called ARMA, has resulted in a document that sets out standards of care based on a consensus approach to best practice (BLAR, 1997).

Working with specific patients groups has advantages and disadvantages, depending on how organized the group is and whether they can demonstrate a consensus or a strong 'patient voice'. It is also important to remember that some patient groups are quite large and may be more skilled in representing their views than others. Each patient group, speciality, PCT or government body will have its own perspective on the issues and each of these groups will be competing for a slice of the 'funding cake'.

The culture for change

There is no doubt that, as nurses, we are now in exciting, yet challenging times. The culture is now ready for the development of chronic disease services that ensure a philosophy of 'empowerment' for all patients. The emphasis on a caring, holistic relationship has placed the nurse in the position of key worker in developing a strategy for improving care for those with chronic diseases. Yet nursing has undergone numerous transitions and 'reforms' and, although it will continue to do so, we need to ensure that changes encompass the essential essence of care that supports the nurse–patient relationship, based on a holistic approach to care (DoH, 2001c). The urgent need for changing roles in nursing has meant that policy and legislation have occasionally lagged behind daily clinical practice. In an attempt to clarify what defined nursing in the context of current healthcare provision, the Royal College of Nursing (RCN) published *Defining Nursing*. This defined nursing as: 'The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death' (RCN, 2003b).

The test for the future is how well nurses can continue to make developments that will improve care yet have a clear vision of what constitutes a 'new philosophy of caring'.This is particularly pertinent when many of the new developments encompass what used to be considered the domain of the doctor. These caring activities will be subject to scrutiny as changes are implemented. For nurses there will be a particular interest in the changes that may affect the nurse–patient relationship.

The new culture emphasizes the need for nurses to develop their leadership skills and stay at the forefront of healthcare services. Nurses will need to be creative and responsive, working as 'change agents' pioneering new roles, yet be guided by their professional principles. This sounds easier than it is. To understand what we mean by 'principles' we have to question the nature of the nursing professionalism and the wider changes of role expansion. The Nursing and Midwifery Council (NMC) recognizes these difficulties in its *Code of Professional Conduct* (NMC, 2002b). Some principles of being a nurse are not simply a matter of acquiring knowledge or skills, but must include attitudes and values relevant to being part of a professional body.

Nursing – the changing workforce

The healthcare assistant

In discussing the principles of nursing it is important to recognize not only our own changing boundaries and constraints, but also those of the workforce that supports us, such as the healthcare assistant. Nursing needs to recognize that some caring activities provided in the past are no longer the total domain of the trained nurse and cannot be as the nursing role continues to be extended. The healthcare assistant role was developed first to enhance the ability of the trained nurse in working more autonomously, and second to reduce the overall nursing costs. This is chiefly due to the lack of expert nurses and the need to focus on providing increasingly complex care at the same time as co-ordinating the overall provision of care within a team structure. Although these caring activities still encompass key aspects of nursing care, they are increasingly being delegated to healthcare assistants. The NMC has highlighted a wide range of developments that employers are asking healthcare assistants to undertake, often requiring specific training (see www.nmc-uk.org). The NMC states: 'the Council has recognised that the registered practitioners require support in their work' but goes on to stress the responsibility of the practitioner to:

'ensure that all actions carried out under their responsibility have met the standards set by the regulatory body' (www.nmc-uk.org, 2002).

Yet healthcare assistants continue to increase their knowledge and expertise. In the context of nursing responsibilities and supervision of healthcare assistants, it is important to clarify the difference between a 'system' responsibility and 'action' responsibility. The system is a service (for example, the NHS) and the structured frameworks that are imposed on that individual to work within. If a system of working is defective, then the nurse, as a competent professional, would be subject to scrutiny for their role in supporting a system that failed. However, the failing of a healthcare assistant to perform their duties within an identified procedure and role would not be the responsibility of the trained nurse unless they actually condoned or supported inappropriate practice. The registered nurse would not be held responsible for an untrained member of staff undertaking a wrongful act. On the other hand, it is the responsibility of the nurse to demonstrate acceptable levels of supervision, ensuring that the healthcare assistant is given appropriate support and is competent to undertake the task requested (Hunt and Evans, 1994). The development of training schemes for healthcare assistants has enabled a structured programme of learning that provides an effective educational pathway based on the clinical needs of the service. The National Vocational Qualifications (NVQs) provide an excellent framework for healthcare assistants to develop their expertise. NVQs can be achieved at level one, two or three.

Specialist nursing

So do we have our own house in order? Probably not. Although there are important distinctions to be made between practising within a speciality and being a nurse specialist, there remains intense debate about how to document clearly and develop roles according to clearly defined and measurable standards (RCN, 2003b).

Why is the definition of an advanced or higher level of practice relevant when aiming to review and develop care for chronic disease patients? The overall provision of care, together with the ability to develop and maintain excellence, relies on trusting relationships between healthcare professionals and the patient. Equally, in the light of clinical governance, clarity in levels of expertise and responsibility of staff must be demonstrated to employers, as well as consumers of healthcare. We cannot allow assumptions to be made about our competencies based on a title.

The earliest recognition of 'specialization' in nursing in the UK came in 1919. This Nurses Registration Act identified four major specialities – sick children, mental nursing, care of the mentally handicapped and fever nursing (Dimond, 1994). The United Kingdom Joint Board of Clinical Nursing Studies was formed in 1970 to respond to the need for more 'specialized' courses for nurses (Castledine, 1994). In the early phases of clinical specialism, Castledine was instrumental in setting out to identify the essential components of the specialist or advanced practice role (Castledine, 1999). This was followed very quickly by the increasing acceptance of a need for a more 'academic' focus to specialism. These developments went hand in hand with the expansion of the role of nursing in general (Castledine, 1994).

Specialist nursing – setting a 'standard'

The Professional regulatory body preceding the NMC was the UKCC. In 1992 the UKCC document *The Scope of Professional Practice* attempted to clarify the issue of role development, stating that the terms 'extended' or 'extending roles' were rejected as limiting rather than extending the parameters of practice. *The Scope of Professional Practice* initially led to professional and legal concerns about this new ethic of openness towards evaluating competencies (UKCC, 1992). How were standards and competencies to be monitored? To some the working of the UKCC was seen to be ahead of the medical regulatory body, the General Medical Council (GMC) in developing an ethic of openness (Hunt, 1994). The UKCC (2002) stated it was for the individual practitioner to recognise their competencies and develop their expertise according to changing circumstances.

The door had been opened to wide-ranging developments in nursing expertise – it remained to be seen at that time whether the developments would encompass the 'holistic' aspect of nursing or generate a new technical doctor's assistant.

Excitingly, the opportunities afforded by the new code of conduct have enabled nurses to truly evaluate their expertise and find new ways of working that encompass the holistic nature of care. In 1993, the UKCC defined specialist nursing practice as:

> Practice for which the nurse is required to possess additional knowledge and skill in order to exercise a higher level of clinical judgement and discretion in clinical care and to provide expert clinical care and leadership, teaching and support to others.

In essence, the qualities required have been distilled into six key components (UKCC, 1993):

- clinical management
- leadership
- standard setting
- quality assurance
- audit
- practice development and research.

The emergence of clinical governance and the rapid expansion of nursing roles, together with a wide range of 'nursing titles', drove the need to have a clearer focus on the essential components of the 'advanced' practitioner. The UKCC's statutory responsibility was to protect the public. It was acknowledged by the UKCC that there was a need to address the variation in specialist and nurse practitioner roles and it set out to clarify the confusions in defining 'advanced' practice (Jeyasingham, 1999).

Extensive consultation led on to the pilot project to evaluate 'higher level of practice'. In 1999, a pilot project was carried out to test a proposed regulatory framework for 'higher level of practice'. The results of this project were published (UKCC, 2002).

The individual practitioner had to demonstrate their expertise using a range of supporting evidence. In essence, the pilot project evaluated seven standards that nurses needed to achieve (Table 1.1). They identified two levels of practice beyond the point of registration: advanced and specialist.

It remains to be seen how these standards will form the core regulatory framework for 'advanced' or 'higher level of practice'. Although these standards are robust and encompass a detailed analysis of the individual practitioner's role, it is the individual pieces of evidence presented in support of these standards that show the real nature of the empathetic and caring aspect of the nurse's role. However the process requires detailed documentation and evaluation processes.

It appears that the proposed new pay structures set out in *Agenda for Change* (DoH, 2003d) have included some of the principles used to define skills and competencies set out in the 'higher level of practice' pilot scheme.

Table 1.1 Seven standards set out in the higher level of practice pilot project

1 Providing effective healthcare
   • Nine subsets to this topic
2 Leading and developing practice
   • Six subsets to this topic
3 Improving quality and health outcomes
   • Eight subsets
4 Innovation and changing practice
   • Three subsets
5 Evaluation and research
   • Three subsets
6 Developing self and others
   • Four subsets
7 Working across professional and organizational boundaries
   • Five subsets

Source: UKCC (2002)

Succession planning

The need to evaluate the individual practitioner goes hand in glove with the need to know where the next 'clinical nurse specialist' is coming from. Don't be fooled into believing that advertising will bring a ready-made specialist or that the manager will naturally recognize the need for an additional specialist nurse! As specialists we need to be inspiring and develop leadership skills and opportunities for nurses who have an interest in improving patient care. A single-handed clinical nurse specialist is likely to stay one, unless they have the ability to inspire other nurses. The formal term for this is 'succession planning'. Succession planning focuses on the view that, as clinical leaders, nurses will always be moving forward in the development of the service and the specialist role. To move forward, nurses need to have a confident workforce coming up from behind. The support and supervision should be based not purely on the clinical aspects but on those managerial and professional skills that make the individual an effective leader and role model. Experienced nurses will be serving their nursing colleagues well if they start the process early, enhancing their expertise and allowing others the opportunity to develop with specific support and supervision.

In the current climate of nursing shortages, the lack of experienced nurses to take up specialist posts is probably the biggest confining factor

to development opportunities. However, for chronic disease care, securing funding and demonstrating a need has to be tightly defined. Key outcomes need to be highlighted, demonstrating relevance to government agendas and how care will be improved as result of a development. The government has recognized the vital role that nurses have in healthcare and the opportunities to be active and powerful participants in providing patient-centred care have never been better. However, we will struggle to provide high-quality care without the expert workforce.

Modern matrons

Modern matrons have been introduced in England and Wales with the aim of providing strong leadership by improving standards and empowering nurses (DoH, 2003c). It is envisaged that the specialist nurse will be able to work collaboratively with the modern matron role to support developments and enhance aspects of nursing that improve patient care and build a patient-centred service.

Developing services – preparing a proposal

Managerial issues – the underlying concepts

If there are plans to implement a change and this change involves recruiting new staff or increasing hours or grades, it is likely this will require resources or general funding. This means that an outline proposal or business case will need to be prepared. This section provides a brief overview of some of the fundamental aspects that the nurse should consider when preparing a change or development in the department. It is worth considering issues highlighted in Table 1.2. However, Chapter 2 provides a more detailed explanation of the processes required when preparing a business proposal.

The initial proposal often forms a point of discussion and may highlight issues that the team and those involved need to review. Be prepared to have to review the first document. Preparing a detailed document focuses views and clarifies issues. It will help to form the initial views and provide a good starting point. With each proposal the nurse's expertise will develop and provide a valuable experience in preparing a framework for the next one. If the foundations of the work are strong and well thought out, it will ensure a more robust proposal and stand up to scrutiny by the business managers and PCT commissioners.

Table 1.2 Implementing change: some questions to ask

- What is the nursing provision and expertise available to implement an effective change?
- How does the proposal fit with the multidisciplinary team's overall philosophy?
- How do the multidisciplinary team view the development?
- Does the development have implications for other members of the team?
- Is the development a specialist role and is it extending/advancing current practice?
- What level of expertise is needed for the proposed provision of care?
- Are there sufficient healthcare professionals able to provide that care?
- Do the team know the patients' perspectives?
- Has the primary healthcare team been consulted?
- How can primary/secondary care work effectively together to develop changes in care?
- If there are funding issues identified, are the consequences of the change discussed?
- Have specific trust or government targets been identified in the proposal? If so, check whether financial resources have been included in achieving the targets.

Organizational knowledge

Each week papers are circulated and emails sent that draw attention to the need to focus on a specific target/agenda that has been identified nationally. These often come in the form of a Chief Executive bulletin, government White Paper, NHS Executive paper or identified needs highlighted by the local commissioners of healthcare. They may highlight the need to devolve more responsibilities to nurses and other allied healthcare professionals, or identify a set target over the next year with a specific sum of money allocated to support the change. Nurses need to scan these documents and identify agendas that fit with the patient group or proposal. It is often the case that a proposal may fail to gain approval at the first hurdle. This can be for a variety of reasons. But don't lose faith, there are also times when sums of money are made available by the government, often with little time to turn around proposals for consideration. It may be that an earlier proposal lies resting in a filing cabinet or on a shelf – it can be dusted off and, with a little work, it could be refined and brought up to date. The current issues, as well as costs, will need to be reviewed. Ensure that changes include latest policies and DoH targets or key points.

Clinical governance and networking

Clinical governance is 'a framework through which NHS organizations are accountable for continually improving the quality of their services and

safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (DoH, 1998). All health organizations have a statutory duty to work within a framework of clinical governance. The National Institute for Clinical Excellence (NICE) and the CHI also form part of the overall strategy to support clinical governance. A detailed explanation of clinical governance in the context of leadership is set out in Chapter 10.

Current healthcare provision is expected to comply with the principles of clinical governance:

- Patient-centred care should be at the heart of every NHS organization.
- Information about the quality of services should be available to all healthcare staff, patients and the public.
- The framework should reduce variations in process, outcomes and access to healthcare.
- NHS organizations and partners work together to provide high-quality care.
- All healthcare professionals work as teams to provide consistently high standards and strive to identify ways of improving care.
- Risks and hazards to patients are reduced to as low a level as possible, creating a culture of safety.
- Good practice and research evidence is systematically adopted.

So what does clinical governance mean for nursing? It is the framework that forms the basis of all aspects of care and requires change at three levels:

- individual healthcare professionals
- groups of workers, such as multidisciplinary teams
- organizational.

The principles inform all healthcare professionals about the process to adopt and the pitfalls to avoid in developing or changing service provision. Some see this regulatory framework as a threat to professionalism. Managed in the right way, allowing for variations in clinical decision making, it should be viewed as a positive approach that improves the quality of healthcare and reduces variations in care. In practical terms, this means that any intervention or proposed change should recognize these frameworks. The practitioner should consider the following.

- Is the proposal based on patient need and does the service know what the patients think about it?
- Will the service be able to explain the value of the planned change to patients, managers and healthcare professionals, and the general public?

Has the project and planned intervention been explicitly and simply explained?

- How can the nurse demonstrate that the proposal will provide high-quality care? Have other centres of excellence been visited to ensure supporting evidence of good practice within the speciality?
- Best practice – where is the evidence that the proposal has a value and is well researched/audited?
- Have the wider healthcare professionals in the team been included? Has the proposal included the team philosophy of care and does the team support the overall philosophy of the proposal? Can it be demonstrated that their views have been fully explored? What about their expertise?
- Evidence? Has the proposal a potential to reduce risk and improve quality? If so highlight this.

National Institute for Clinical Excellence (NICE)

It is also worthwhile remembering that an integral part of clinical governance is the interface between clinical governance and reviews undertaken by NICE. NICE authority has an important remit to evaluate new treatments and interventions using an independent body of professionals who apply a systematic analysis to review new therapies. In recent years, the length of time that new treatments have been waiting to be reviewed by NICE has caused concern, as patients have been denied the opportunity to receive newer treatments pending NICE reports. However, the government has also stated that while awaiting NICE reports 'no person should be denied access to treatment if there is a clear clinical need for treatment' (NICE, 2001). It has also been reassuring for healthcare professionals caring for patients with chronic diseases that social and quality-of-life issues have been included in the calculation of benefits to interventions.

Commission for Health Improvement

The CHI undertakes a rolling programme of clinical governance reviews for NHS organizations. It has a rigorous process of evaluating NHS trusts using patient diaries, observational studies and interviews, as well as the usual reviews of data collected. The results of these reports are published nationally and the Secretary of State has the power to sanction special measures if there are specific failures identified (see Chapter 10).

Quality improvement is built into the clinical governance framework with a strong emphasis on the use of audit and the audit cycle. It is proposed that CHI should become the Commission for Health Audit and