

LETTER TO THE EDITOR

A framework for effective management of change in clinical practice

EDITOR,—Moulding *et al* eloquently describe those theories derived from social and behavioural sciences that may help to bring about change in clinical practice through the use of guidelines.¹ Occasionally, the behavioural approach of providing incentives related to specific actions may be all that is required to achieve the desired change.² Early in the winter of 1996 the health authority notified general practitioners (GPs) in Cornwall and the Isles of Scilly that a pharmaceutical company was offering to supply pneumococcal vaccine at a favourable discount, giving a profit margin to the general practice of £6.15 per dose. This notification also advised GPs as to which groups of patients were deemed by the Department of Health to be at risk of invasive pneumococcal disease and therefore required immunisation. The table shows how the prescribing of pneumococcal vaccine has changed over time. During the winter of 1996 GPs displayed an obvious greater enthusiasm for prescribing this particular immunisation.

Table 1 Changes to the prescribing of pneumococcal vaccine over time

Financial year	Number of doses prescribed
April 1994 to March 1995	3724
April 1995 to March 1996	4170
April 1996 to March 1997	9254
April 1997 to March 1998	5362
April 1998 to March 1999	2766

Although this simple approach of a single mail shot did not achieve the same dramatic results as seen in the multifaceted campaign reported by McDonald *et al*,³ and though we were unable to ensure that immunisation was offered only to the at risk groups, we would suggest that in this instance compensation had a positive effect on clinical behaviour.⁴

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BOOK REVIEWS

Clinical governance: making it happen.

Edited by Myriam Lugon, Jonathan Secker-Walker. (£17.50). London: Royal Society of Medicine Press, 1999. ISBN 1 85315 383 4.

Busy clinicians, by and large, do not have time even to sample the many courses currently on offer that discuss clinical governance. The subject is one which divides doctors firmly into two groups. The minority believe that clinical governance will prove to be a useful tool for introducing quality improvements into health care, whereas the majority consists of those cynics who believe the topic is another “flavour of the month” which will go away if ignored. A comprehensive and up-to-date book on this rapidly developing subject will be welcome and should go some way towards converting the disbelievers while providing new ideas and inspiration to the converted.

The authors of *Clinical Governance: Making it Happen* focus on problems of implementation in secondary care. They acknowledge the fact that there is no right way to do this and describe lessons learnt from personal experience.

Some of the chapters do not make easy reading, but without exception each contains a useful idea or new perspective and it is likely that there is something of interest for everyone. An excellent second chapter reminds us firmly that everything we do should be assessed from the patients’ viewpoint, while the rest of the book concentrates on those positive aspects of clinical governance most likely to bring about change and hence quality improvement. Thankfully, little space is afforded to areas on which the professional bodies are concentrating—namely, monitoring and inspecting poor performers, be they individuals or institutions. The chapter on evidence-based medicine is particularly stimulating. It is approached from the angle of organisation behaviour and examines some of the barriers to implementation of what must be one of the most important tenets of clinical governance. It contains much food for thought in addition to helpful and pragmatic suggestions as to how these barriers can be overcome.

The description of the emerging legal implications of clinical governance should allay any doubts that it is here to stay while the tantalising potential described in the chapter on information and data quality should stimulate even the most cynical critic. The book ends with a valuable guide to sources. A problem apparent in several chapters is that of terminology, particularly when referring to the plethora of committees and posts which have sprung up. This is not the fault of the authors, rather is inherent in the subject matter and it is clearly going to be important to identify these new groupings by

the roles they fulfil rather than the names attached to them.

There are many useful and positive messages in this book, but neither the difficulties involved nor the time required for implementation of clinical governance are underestimated. If we are serious about improving quality in health care, then the way forward is becoming clearer.

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Hospice without walls. By Andrew Bibby. (Pp96; £5.99). Calouste Gulbenkian Foundation, 1999. ISBN 0 903319 86 1.

Palliative care has undergone a rapid expansion in the UK over the past 30 years, resulting in the development of inpatient beds, home care services, day care services, and hospital palliative care teams. Evaluation of these services suggests greater patient and carer satisfaction, improved symptom control, and a reduction of hospital stay. This book documents the development of a hospice-at-home service in West Cumbria, providing a home nursing service, medical domiciliary visits, day centre twice a week, and access to a specialist lymphodema clinic. It is, in essence, an uncritical description of the development of this service from the initial fundraising meeting to the service 10 years on. It reviews the role of the members of the team involved in the development of the service in an uncritical way, but there is no clear discussion of multidisciplinary working within the local area. For example, it is not clear how the hospice-at-home team interacts with local services such as physiotherapy, occupational therapy, social services, and chaplaincy. Although there is reasonable detail outlining how patients physical needs are met, I was unclear as to whether specialist psychosocial needs were adequately addressed within the structure of the hospice-at-home team.

Although the book suggests that dying patients spend less time in hospital in West Cumbria since development of the service, it is not clear whether there has been any change in patterns of place of death, in particular a rise in home deaths, since the establishment of the service. It is also not clear how many dying patients in the geographical area in which it operates have access to this service, and what the potential levels of unmet need are.

This readable book has been written for a largely local audience with no specialist knowledge of palliative care, or palliative care services. It does, however, give a good discussion as to why a hospice-at-home team was particularly suited to the geographical area and why inpatient beds and a building were rapidly discounted by the development team. I am sure it will be of great interest to a general audience interested in palliative care, in particular in rural populations, but is unlikely to be of interest to specialist palliative care providers.

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