TEAM WORKING

A Report from the

SOCIETY OF BRITISH NEUROLOGICAL SURGEONS

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1. BACKGROUND AND INTRODUCTION

The Society of British Neurological Surgeons needs to respond positively to the General Medical Council's request that the independent practitioner status as defined in the Consultant contract should be reviewed with the aim of encouraging team working and to facilitate clinical governance. The recommendation was stated as part of the GMC's determination in October 1998 arising from the Bristol Case. The time frame set for the determination and actioning of future plans was set at two years from that date.

This would allow for review and recommendations to be made at local level that would:

- Build on existing best practice
- Allow for local differences in the size and composition of surgical units
- Meet the needs of practitioners and patients
- Dovetail with the requirements set out in the GMC's guidelines for Maintaining Good Medical Practice.

"Good medical practice" requires that every doctor must:

- **Be an effective team player**
- Be professionally competent
- Perform consistently well
- Practice ethically
- Do patients no harm
- Take action if poor practice places patients at unnecessary risk.

It has long been accepted that although accountability for the quality of patient care rests with an individually named Consultant, the performance and quality of care, provided from diagnosis to completion of medical treatment, is the result of the combined efforts of a number of professionals. The Bristol Case amongst others demands that the existing ways of working be reviewed to further improve patient care and minimise the risks and consequences that these cases have exposed. It is the view of the Society that greater emphasis on teamwork will have a direct and positive impact on patient care.

2. THE CASE FOR TEAM WORKING

The provision of consistent and mutual support through utilising the skills and knowledge of others with greater depth of experience and/or with differing specialist expertise will provide a strong basis and rationale for working together more effectively thereby increasing the level of shared intellectual capital.

Putting the principles of "Lifelong Learning" into practice will provide strong role models for trainee surgeons and those aspiring to Consultant status by sharing "best practice".

Working in team-based ways will improve communication and understanding between colleagues and help to achieve consistent and clear communication with patients.

In summary the aim is to seek ways and means of providing even better patient care and improving clinical outcomes.

3. THE CURRENT SITUATION - CULTURAL CONSIDERATIONS

Although the need for change arises from a model of apparent deficit implied by the Bristol Case it will be important to describe the logic for change in constructive ways that acknowledge the generally high standards that already prevail and frame these as a necessary means of pursuing excellence. The current cultural values of professionalism, commitment, pride, caring, achievement and service delivery need to be protected at all costs.

Ethical as well as clinical issues are relevant to the quality and duty of care provided and the shared wisdom of the team make this burden less onerous.

There is some evidence to suggest that the existing high levels of sole accountability placed on the Consultant results in a highly individualistic approach to the work, which may displace the will to work collectively.

Professional pride and the ascribing of "expert" labels and expectations may also add a defensive dynamic when faced with critical or evaluative feedback leading to a tendency to hide incompetence or incapacity from others.

In a system that is arguably chronically under-funded resources are at a premium and the burden of responsibility places an even greater emphasis on Consultants to seek and find effective and creative ways of increasing their capacity to meet the ever-increasing demands on their time and skills.

Increasing levels of specialisation that require narrow but deep understanding of clinical processes and practice may produce a felt need to divide into more discrete and individualistic pursuits of skills acquisition. This may require the need to seek support from clinicians outside the operational unit with similar clinical interests.

Introduction of ideas that involve appraisal and assessment of performance may be regarded as implied criticism of current and long-standing practice. Therefore changes in the contractual conditions and working practices will need to be sensitively handled to avoid or, at least, manage natural resistance that almost always automatically results from imposed change.

The current status of Consultants accords them a great deal of power and autonomy. Any plan to change may also be regarded as a means of disempowering them and usurping their current position.

4. TEAM STRUCTURE

The organisation of teams within the Neurosurgical department has to be flexible and is largely dictated by the size and nature of activity within the department. Because of the diversity of the Neurosurgical departments team working will by necessity have to be tailored to meet the needs of individual departments. In a number of units the whole department could work as a single team but within this there will be several small teams, which would work in parallel rather than in competition.

It is essential that these teams be based on clinical and not managerial requirements.

4.1 Neurosurgical Teams

Consultant Neurosurgeons will continue to be the pivot around which a Neurosurgical team will function and the core of the team has traditionally been the Consultant and trainees under his or her supervision. However with the reduction in trainee numbers and hours it is more than likely that trainees will share their time between Consultants. It therefore seems appropriate that Consultants sharing trainees work as a "team" and in large departments this arrangement will be enhanced if the Consultants in the team had complimenting sub-specialist interest. This would also allow for trainee rotations to be sub-speciality based rather than Consultant based. Formation of such teams will promote clinical interaction between Consultants and facilitate the development of formal or informal peer review structures.

Interaction with other Consultant teams is essential and combined clinical meetings, postgraduate teaching programmes and audit activities already achieve this in most cases. Further interaction will occur between Consultant teams when multidisciplinary care is required in specific cases.

Team working in smaller departments is probably easier as there are often a small number of surgeons who share a limited number of trainees. There is also a greater interdependence of Consultants in providing academic and clinical support while it is also likely that communication between Consultants is easier to maintain in a small department.

4.2 Sub-speciality teams

It is well recognised that most Neurosurgeons in the UK have or will develop sub-specialist interests. In larger units it is quite likely that more than one person will cover sub-speciality interests. These Consultants would work as a team providing a sub-speciality service and cross referrals from other Consultants and departments should be encouraged. Within smaller Neurosurgical units it is unlikely that there would be more than one person with some sub-speciality interest and it is important that in the absence of the main specialist the other Consultant members of the Neurosurgical unit have sufficient experience to be able to assess, manage or if necessary, refer to another Neurosurgical department.

4.3 Multidisciplinary teams

Individual Consultants can no longer claim to have complete autocratic control of the care that is provided to their patients and have to recognise the role and responsibility of other clinicians and professionals.

With the increasing range of treatment modalities it has become necessary to tailor treatment to an individual patient's need and this has lead to interaction with clinicians in other specialities resulting in "disease specific" teams in areas such as spinal surgery, Vascular surgery, Functional surgery, Skull base surgery and Paediatric Neurosurgery. This is particularly true where the "surgical procedure" is only an event in the continuum of care and outcome measures in these situations reflect the quality of the entire team rather than purely that of the surgeon. On occasions it will be necessary for each of these "disease specific" teams to interact towards providing optimum patient care e.g. in a child with a complex spinal condition it will be necessary for the Paediatric team (neurologists and Neurosurgeons) to liase with the spinal team (Neurosurgeons and orthopaedic surgeons).

The need for team working with other clinicians is particularly obvious in the care of the critically ill patient where a close working relationship with the neuro-anaesthetists or intensive care specialists and their staff is required.

Neurosurgeons have always recognised the need to work together with nurses and other professions allied to medicine such as physiotherapists, occupational therapists and speech therapists in providing holistic care for their patients. The current emphasis on professional development in these professions naturally draws them into the multidisciplinary teams where they are to be viewed as equal partners in providing patient care.

4.4 The Consultant Neurosurgeon in a Multidisciplinary Team

As Consultants move increasingly into working in multidisciplinary teams it is important that their role within these teams is defined. Under current arrangements the concept of the "named Consultant" remains and has several advantages. Most importantly patients and their families can identify an individual as having ultimate responsibility for their care and offers them a single point of contact. However, with individual clinicians now having responsibility for differing aspects of care the traditional arrangements will have to be reviewed and the resistance to change will probably be strongest in this area. Within a multidisciplinary team it should however be possible to have areas of responsibility clearly defined without seeming to undermine any of the team members position.

During a given "patient episode" it is essential that there is a named Consultant who has overall responsibility for the patients care. For in-patients this will be the Consultant under whose care the patient is admitted (unless transferred to another Consultants care) but for out- patients this responsibility could be shared for various aspects of care. For patients undergoing surgery the Neurosurgeon will clearly be the "named Consultant" for the peri-operative period and during this time will take ultimate responsibility for the patients care.

In a multidisciplinary setting all members of the team should be seen as equal partners, but the Neurosurgeon should take the lead role in matters relating to surgery and surgical management.

4.5 Continuity of care

Under current arrangements the "named" Consultant remains ultimately responsible for providing continuity of care for their patients and this effectively implies that a Consultant is available at all times to deal with problems relating to patients under his or her care. However with the increasing demands being placed on Consultants and with the reduction in trainee support these arrangements will have to be reviewed. The "named" Consultant cannot be expected to be always available to oversee the care of his/her patients and in these situations, structures must be in place to continue Consultant based care. Team working in this context offers major benefits by the ability for the "team" rather than an individual Consultant to provide continuous care for patients.

The precise arrangements will vary between departments largely depending on their size. For planned absences Consultants will normally designate another Consultant colleague to be responsible for the care of his/her patients but if at other times or "out of hours" the named Consultant is unavailable it is expected that the Consultant "on call" will deal with emergency care. In smaller departments where the Consultant carries an onerous "on call" commitment it will be appropriate that all out of hours activity is dealt with by the Consultant on call.

4.6 Team working and the new Consultant

In the current career structure there is a very sharp and abrupt change from the trainee to a Consultant Neurosurgeon. While concerns have been expressed about the clinical expertise and experience of the post-Calman trainees there is little evidence to support this concern and the problems they face in dealing with this change are likely to be the same as that faced by their predecessors. While trainees are usually well equipped to deal with specific pathology in the early years as a Consultant the sudden burden of responsibility for patient care can be a daunting prospect. This will be further complicated by the sudden exposure to the intricacies of management and administration. At this vulnerable stage it is essential that the new Consultant be provided with support from his/her more experienced colleagues.

While an informal system of mentoring may be an option the current career structure does not lend itself to a more rigid arrangement of mentoring. However with effective team working the new Consultant could readily obtain help and guidance without having his/her position undermined. If the new Consultant has a sub-speciality interest and there already exists in the unit another Consultant with similar interests it would be wholly appropriate that they work together as a team with mutual benefit. Along with such arrangements it is important that there exists a degree of openness in the unit that gives the new Consultant an opportunity to seek advise when required and be guided in his/her activities.

4.7 Team working and the administrative structure

There is an increasing demand for doctors to be involved in the managerial structure within Trusts and Neurosurgeons will be expected to participate in these arrangements. The precise arrangements will vary between departments but it is likely that in most departments one of the Neurosurgeons would be designated to be the "Lead Neurosurgeon", "Clinical Director" or "Consultant in administrative charge". This Neurosurgeon has a major role in bringing together to the various Neurosurgical teams into a cohesive structure that provides optimum patient care though he/she could not be

expected to oversee routine patient care which will remain the responsibility of the individual Consultants and their teams. In conjunction with the Medical Director and the Chief Executive he/she has a role in ensuring that appropriate facilities and arrangements are in place for Neurosurgeons to provide the best care for their patients. Within a department it is however usual that individual Consultants will have designated but often overlapping administrative roles to ensure the smooth and safe working of the department.

5. THE CHARACTERISTICS OF THE CHANGES

In order to provide holistic but at the same time specialised care and to discharge their responsibilities for continuity of care current arrangements and structures will need to be reviewed or changed to formalise the teamwork that exists or develop new teams.

Alongside this ultimate accountability can rest with the named Consultant provided the team relationships are characterised by intrinsic trust and supported by requisite levels of functional and behavioural competence.

The changes need to be owned by those involved in order to create the necessary climate for effective team working. This implies that some time will need to be invested in communicating the logic for the changes and ensuring "buy-in". In other words people need to see and experience the benefits.

The differing needs and size of departments at local level requires a flexible approach to the composition of teams and a high degree of self-determination in this area is recommended.

The transition from the old to new ways of working can only be managed over time. Structural and systems changes will need to be planned and piloted. More time consuming is the need to change the attitudes and behaviour of those involved that will ensure the changes are sustainable in the longer term.

Some level of resistance is to be anticipated and this will require to be handled and managed sensitively.

What seems to be needed is a network of teams with clearly defined roles and responsibilities, which share a common team culture.

6. TEAM DESIGN

I Size

Research from Belvin et al reports that this is a critical factor in creating effective teams. Optimally a high performing team will have 6-8 members.

The larger the team the more it will tend toward the functioning of a group which is characterised by a strong focus on the leader and a dependence on the leadership to take the decision making role. Depending on the terms of reference and output requirements of the team/group size needs to be considered in team design.

II Purpose

A clear sense of purpose is critical to provide the membership with something to convene around. This needs to be articulated and terms of reference created relating to the organisational context and needs. The primary purpose of the clinical team may be extending learning/peer performance review/assessing competence. In another it may be research and development of speciality areas. In the multi-disciplinary team it may be defining process and setting quality standards for continuity of care. Once the purpose is established objectives can be set and goals agreed and shared.

III Balanced and Complementary Roles

Establishing the part that each member has to play and the individual responsibilities that attach to membership gives everyone a part to play, balances the power relationships and safeguards against duplication or omission of the necessary function and process skills.

IV Willingness to Give and Receive Feedback

A successful team needs to demonstrate a high level of disclosure of facts and feelings and for this to happen a climate of internal trust needs to develop. Constructive behaviours need to be become the norm and these are most often trained in by developing feedback and interpersonal skill to manage openness and the confronting of "difficult issues".

V Supportive Relationships

This demands a pragmatic approach to adherence to a set of operating ground rules, which include honesty, predictability, consistency and mutual loyalty. The aim is to promote a sense of mutual respect and belonging.

VI Surfacing and Handling Conflict

The ability to constructively manage conflicting ideas, interpersonal styles and interpersonal feelings combine here to achieve creative and constructive outcomes.

VII Sound Procedures

This requires a team to work out in operating systems and may cover everything from agenda setting, date collection, the decision making process to documentation and communication of results/outcomes.

VIII Leadership Style

Leadership in a team setting is shared and distributed throughout the group. The style should in the latter stages of team development tend toward facilitation and coordination rather than directive and controlling behaviours.

IX Regular Review

In order to adapt to changing external circumstances and demands and to ensure the integrity of the internal team culture and performance a strong team will submit itself regularly to a period of reflective process and output review.

X Positive External Relationships

In a complex network of teams it is important that sufficient attention is paid to sustaining the external image of the team and the management of the interfaces with other related teams.

The above may be seen as the raw material or building blocks that constitute effective team working. By definition they demand strong interpersonal and group process competences.

7. APPLICATION

As previously stated the structural composition of the teams is probably best left to be decided locally. The requirements are to:

- Provide a basis for continuing professional support and development
- Monitor standards of performance and capacity.
- Above all improve patient care and outcome.

In terms of all three requirements learning teams can come together to challenge and support each other in their learning, provide peer review and assessment and improve results rigorously and effectively if the 10 building blocks (I – X) are applied and the membership of the group is relatively small

Prior to forming the teams it would be advisable to create and document a set of leadership and team working behavioural competencies for Consultants inferred by the 10 building blocks. These might well include people and interpersonal skills, influencing behaviours, feedback skills and self-development behaviours.

In addition a set of well balanced benchmarks relevant to the purpose of each team would need to be agreed in order to set the qualitative and quantitative standards for team working and outputs.

In terms of the continuing professional development requirement appraisal and personal development planning systems would need to be designed and implemented.

8. TEAM WORKING - SOUTHAMPTON NEUROSURGICAL EXPERIENCE

Practice, conditions and team working

Changes in working practices are recognised to improve performance and the publication of the Bristol Royal Infirmary enquiry report stresses the need for a proper working environment. It highlights the fact that for far too long surgery has been affected by lack of resources, outdated equipment, insufficient support and pressure to deliver volume rather than quality all with inadequate levels of staff. The problems in Bristol arose as a result of a combination of factors including interpersonal difficulties in the Unit, lack of leadership, Hospital and Trust management deficiencies, organisational system failure and reluctance on the part of individuals to acknowledge that a problem exists. Much has been made about the need for effective team working to provide a safe environment for the patient and necessary support for the Surgeon. The Kennedy report recommends this approach. "For example, it should be the norm for surgical teams (Surgeon, Anaesthetist, Theatre Nurses, Operating Department Assistants) to have time together and with other teams, such as those in the ITU to review and develop their performance as a team". We felt it important to highlight these points before discussing the experience of team working in the Southampton Neurosurgical Unit.

There needs to be a preamble before setting out the practical details of the pilot study in Southampton. It was clear that there needed to be change in working arrangements and structures in order to formalise the teamwork that already existed in the D Lang/G Neil-Dwyer team. It was recognised within the team that the ultimate accountability rests with the named Consultant but that this could only work if the relationships within the team were characterised by intrinsic trust and supported by competence in professional function and behaviour.

We recognised that changes would take time and that core members of the team would need to be involved and experience the benefits of effective team working if theory was to become practice.

It was emphasized from the start that there had to be a flexible approach not only to the composition of the team but also the working relationships of the members of the team. Interestingly we recognised that there would be some level of resistance and if it occurred it would need to be handled and managed sensitively and sympathetically.

The central core of the team was two Consultant Neurosurgeons, two Specialist Registrars, two SHO's, Senior Sister in charge of Surgical Wards, Senior Sister involved in running of the paediatric Neurosurgical practice, Senior Sister from Neuro Intensive Therapy Unit, Senior Physiotherapist, Nurse Specialists in Neuro-oncology, Head Injury and Subarachnoid Haemorrhage and Surgical Assistants. The Consultants Personal Secretaries - who are also organised to work as a team, supported the team administratively. The secretarial service prides itself on its team working and efficiency, which results in a quality service to patients and a high level of support to the surgical team. There is a dynamic element to the team in that various sections of the core team would need to become involved in other teams depending on the demands and circumstance (paediatric, skull base, neuro-vascular, rehabilitation, research, teaching).

The primary purpose of the clinical team was to plan and manage in-patient care and follow-up. The team would be involved in audit, research, education and the monitoring and discussion of adverse events. There was an initial run-in period followed by an assessment of the team performance after four to five months and from this objectives were set and aims agreed.

The assessment threw up many problem areas. It was clear that there had been a successful planning side in particular getting patients in to the limited number of beds and using efficiently the limited theatre space available. Recently an educational programme has been put in place. There are plans for audit and the monitoring and discussion of adverse events but an important area relating to patient care and the setting of quality standards for the continuity of care has not been implemented. There has been insufficient in-put from the in-patient nursing side and this has produced major difficulties in establishing overall quality.

We are still trying to establish the part that each member of the team will play and the individual responsibilities that are attached to membership. There is a need to involve everyone (this includes in-patient nurses and all other staff mentioned specifically in the Bristol report) to balance relationships but these are early days and such a development will require time, continued discussion, education and management support.

There is openness about the team and difficult issues have been discussed. This has required constructive behaviour and will in time lead to a high level of disclosure of facts and feelings though this will require a continuing climate of trust.

In other areas there has been little development such as supportive relationships, handling conflict and developing sound procedures.

The team meetings occur once a week. These have been run by the senior trainee. He has developed a patient database, which has been extremely helpful in managing patients. There has been no development in terms of how the team functions, how its performance is reviewed and how it links with the rest of the Unit.

It is fair to say that while these are early days this pilot study has provided an opportunity to see exactly how difficult it is to develop team working in the current Neurosurgical environment.

The team approach and the patient database has demonstrated the problems of patient management because of lack of resources, insufficient support and pressure to deliver volume rather than quality all with inadequate levels of staff precisely the criticism levelled at Bristol. If team working in this Unit is to succeed in developing quality standards for the continuity of patient care then the infrastructure has to be developed, support guaranteed and some aspects of the culture within the Unit changed.

November 2001

9. TEAM WORKING - EXPERIENCE AT THE WALTON CENTRE FOR NEUROLOGY AND NEUROSURGERY, LIVERPOOL

It was agreed by the Neurosurgeons at The Walton Centre to try and implement the principles of Team Working as laid out in the draft document from the SBNS. It was recognised that what was required was the formalisation of what already existed and that this could be expanded to improve on the concept of team working.

Consultant Teams

Two Consultant Teams were formed after taking into account sub-speciality interests.

Neurosurgical trainees were then allocated to each of these teams with an equal spread based on levels of training.

An attempt was made to see if trainees could provide a team based approach with trainee surgical input based on the stage of training rather than being attached to a named Consultant.

A lead nurse was allocated to each team to oversee the care of patients under the care of the team. Additional input was obtained from the critical care outreach team, physiotherapists and occupational therapists.

A weekly audit meeting was held to review the care of all the patients belonging to each team. This allowed for a peer review of patient management on a weekly basis with the ability to obtain additional expert input into patient care.

Within the two teams sub-teams evolved with joint ward rounds and shared operating lists.

Multidisciplinary Teams

Multidisciplinary teams already existed and no attempt was made to assess the benefits or the problems associated with these teams. There are multidisciplinary teams that include a variety of specialities that meet regularly in clinical and academic activities. These included Paediatric Neurosurgery, Neuro-oncology, Skull base surgery, Neurovascular surgery, Pituitary surgery, Spinal surgery and Functional Neurosurgery. There is regular interaction between the specialities with combined clinics and joint surgical lists when required.

Evaluation of team working

The advantages of the formalised team working were easily recognised but cannot be easily quantified.

There were however some obvious advantages:

Working in tandem with colleagues has allowed for a sharing of clinical burden with mutual support being obtained from other members of the team.
The weekly audit meeting provided a valuable resource both in terms of data collection and peer review of clinical activity.

It has been possible to develop a database of clinical activity that has then progressed to a computerised production of operation notes and discharge letters.

Flexibility in the utilization of operating facilities based on the needs of the team was a major advantage.

There was a clear advantage in providing cover when colleagues were unavailable due to annual leave/ study leave etc.

The difficulties we experienced related mainly to the available facilities, nursing organisation and issues relating to trainees.

It has proved difficult to regularly find a suitable room with audio-visual aids for a team audit meeting!!

An attempt to ensure that patients belonging to a Consultant team would be preferentially housed on one ward proved singularly unsuccessful.

A regular input from the nursing staff has not been possible because of difficulties relating to rostering and availability of the nurse identified as a team member.

The idea of a team based approach for the trainees met with resistance from both trainees and trainers who preferred an arrangement of trainees being attached to specified Consultants rather than to a team of Consultants.

10. Addendum

Experience of Pilot Sites

The principles of Team Working as set out in the SBNS document were implemented at two pilot sites –both were large Neurosurgical departments. At one centre all the Consultants were involved in the pilot while at the other only part of the department was involved. Despite this the experience highlighted similar difficulties with implementation but also commonly perceived benefits.

The teams were based on groups of Neurosurgical Consultants but included anaesthetists, Neurosurgical trainees, nurses (ward, critical care and nurse specialists), operating theatre staff (nursing and non-nursing), PAMs, IT and coding staff. The extent of input from the groups varied amongst the teams but the importance of the teams being widely inclusive was recognised at both sites.

Benefits

Though no specific measurement tools were used there were several commonly perceived benefits from a formalised team structure.

- A weekly team meeting where the clinical and non-clinical issues relating to individual and collective patient care was openly discussed provided a focal point for the teams at both sites. Attempts were made to rectify deficiencies while at the same time strengthening good practices.
- A database of all inpatients was developed and data verification was undertaken at the team meeting. In time this will allow for a formal audit of all in-patient activity.
- It has been possible to identify some areas of "system failure" and introduce changes by developing protocols and care pathways.
- Both sites saw the open sharing of clinical information with peers as a major advantage especially when there were difficulties in patient management. It also allowed for better continuity of care when the named Consultant was not available.
- By working in teams it has been possible to improve utilisation of resources such as operating theatre time.
- Several multidisciplinary sub-speciality teams exist at both sites but were not included assessed in this pilot study.

Difficulties

Despite these benefits several difficulties with implementation were experienced at both sites.

- Inability to integrate the ward nursing staff into the team structure was identified at both sites. This was not due to an unwillingness to participate but more to do with the rigidity in working practices. This was further compounded by chronic nurse shortages and rapid turnover of staff.
- Attempts to integrate the nurses into the teams by placing all patients of the team within designated wards failed due to a combination of bed shortages and resistance to change.
- Trainees in general preferred to work with a single named Consultant rather than work in a team for a group of Consultants.

- The shortage of staff in many areas resulted in variable input into the teams weekly meetings. Despite recognising the importance and advantage of the team meetings the work schedules of the Consultants made it difficult for all Consultants to regularly participate in these meetings.
- The input from support services such as IT has been limited though this has recently improved at one site and is seen as a major advantage. simple issues such as a suitable venue for team meetings have lead to difficulties in retaining enthusiasm for participation.
- No formal training in team working has been possible and issues such as supportive relationships and handling of conflict as identified in the SBNS document have not been addressed.

11. SUMMARY

Despite the obvious advantages of team working these early pilot studies have provided an opportunity to see how difficult it is to formalise this concept in the current Neurosurgical environment.

The team approach and the patient database have often demonstrated the problems of patient management due to lack of resources, insufficient staff and pressure to deliver volume rather than quality with inadequate levels of staff – precisely the criticism levelled at Bristol. If team working in neurosurgery is to succeed in developing quality standards for the continuity of patient care then the infrastructure has to be developed, support guaranteed and some aspects of culture within the service changed.

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