King's Fund

Clinical Governance in Primary Care

A review of baseline assessments

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This report has been produced to disseminate research findings and promote good practice in health and social care. It has not been professionally copy-edited or proof read.

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EXECUTIVE SUMMARY

This report summarises a review of the clinical governance baseline assessments prepared by 36 London Primary Care Groups (PCGs). Baseline assessments are only one of a range of documents in which clinical governance activity may be reported, so the information extracted from them and presented here provides only a partial representation of how primary care groups are developing their clinical governance work. Nevertheless, every PCG was required to undertake and publish a baseline assessment. As such, they provide insights into the range of approaches being taken to implementing clinical governance though much more will have happened since their completion.

Baseline assessments were requested from the 66 London PCGs between January and March 2000. A total of 36 (55%) were returned, with seven PCGs reporting that they had not yet completed this work. We received a minimum of one baseline assessment from 15 of the 16 London health authority areas, and a complete set from one. A wide range of documents were submitted, ranging from completed reports to blank questionnaires and raw data sets.

Content analysis revealed variability in the aims of assessments and the way they had been conducted in the range of topics being addressed by different PCGs and in the extent to which they provided the overview of current capability and capacity required by central guidance on clinical governance. Key findings were:

- Two-thirds of the PCGs had conducted the baseline assessments in such a way that they could carry out the same process in the future to measure progress.

- About a third of PCGs explicitly aimed to use the baseline assessment exercise to start building open, consultative relationships between the practices and the PCG.

- Strategic integration of clinical governance with Health Improvement Programmes, local priorities and commissioning was proving difficult.

- Resources available for clinical governance were discussed in 15 reports. Some PCGs were pooling resources from a number of sources whereas others had small clinical governance budgets of about £10,000 to £15,000.

- Poor performance was a sensitive area with few PCGs collecting data on 'problem' services and only six mentioning under-performing clinicians.

In conducting baseline assessments, many PCGs were trying to develop the relationships of trust and openness that are needed for effective clinical governance. PCGs are still working out the most effective ways to create the participative, open, learning, "no blame" culture described in the Health Service Circular 99/065. But they are grappling with a major dilemma. How do you begin to create that type of culture, which requires major effort in building relationships and fostering trust, while at the same time carrying out a monitoring tasks or 'policing' functions?

There is a tension in government policy between the need to create open, learning cultures for clinical governance and the requirement for PCGs to measure and monitor the specifics of implementation. PCGs need to find a way through this to create both more open *and* more accountable cultures. One way of reflecting on a successful balance between the two will be through continued dialogue and peer learning.

1.0 Introduction

Improving the quality of health services is a central aim of contemporary health policy and clinical governance is the vehicle through which to achieve this. Encapsulating the many diverse activities required to improve health care quality, effective clinical governance represents a major challenge for all NHS organisations.

Policy documents on clinical governance stress that it should be seen as an organisation-wide approach to quality improvement encompassing audit and effective practice, risk management, poor clinical performance and continuing professional development[1]. Effective clinical governance was to require explicit systems of accountability for the quality of care[2] and a multi-disciplinary approach to quality improvement. [1,3]

Early guidance required primary care groups to complete four key tasks during the first year of the new NHS: establish leadership and accountability arrangements, conduct a baseline assessment of 'capacity and capability'; develop an action plan and develop reporting arrangements for clinical governance.[4]

Primary care groups and trusts have had to develop their organisations at break-neck speed, working to engender a sense of corporate identity and shared aims among often disparate member practices. Similarly, clinical governance arrangements are being developed across groups of practices with little or no history of co-ordinated quality improvement work. Undertaking a baseline assessment thus represented a major challenge to these new organisations, the main aims of which were outlined in Health Service Circular HSC 99/065:

- Carry out a searching analysis of strengths and weaknesses in performance,
- Identify problem services
- Look at quality surveillance data and identify deficits in key mechanisms (e.g. risk management, patient participation, audit etc.)
- Ensure integration of quality activities and systems
- Establish links to Health Improvement Programmes (HImP) and National Service Frameworks (NSF)
- Design ways that Information Technology (IT), Research & Development (R&D), education & training etc. could underpin clinical governance.

The baseline assessments were to be "organisation-wide" and "participative" and answer the question "where did we start?". Furthermore, the Health Service Circular repeatedly emphasised the importance of creating an "open, no blame, learning" culture.[4] Faced with such a daunting task, how have London PCGs responded?

To answer these questions, we undertook a review of baseline assessments from London PCGs. We were aware that other documents could provide additional information about the implementation of clinical governance in PCGs. We nevertheless asked only for baseline assessments because of their intended role in defining the starting point for implementing clinical governance. We recognised that they could offer a snapshot of each PCG at a particular point in time. However, collectively they could provide an overview of how London PCGs have tackled the first step in developing clinical governance.

Our aims were to obtain an overview of how PCGs were developing clinical governance, identify common approaches to clinical governance and feed back useful information to PCG clinical governance leads.

2.0 Methods

2.1 Data Collection

From January to March 2000, we collected baseline assessments from London PCGs. We requested the documents from PCG Chief Executives and Clinical Governance Leads, assuring them the overview would be developed confidentially with no material attributed to individual PCGs. To maximise the reponse rate, we contacted non-responders by e-mail and telephone and advertised the study in the primary care newsletter *Primary Care Network*.

2.2 Analysis

We devised a data extraction form to obtain general details about the assessments (date undertaken, number of practices covered, method, who administered, who responded etc.) We also identified stated priorities; categorised the content into clinical and non-clinical activities, noted whether they described past, present and future activity and examined the ways in which practices had been involved in producing the baseline assessment (see Appendix 1).

2.3 Response rate

Thirty-six of the 66 London PCGs submitted a copy - a response rate of 55%. At least seven other PCGs had not completed them at the time of contact. Less than a fifth met the September deadline; and the majority (22/36) were completed by November. We received a minimum of one baseline assessment from 15 of the 16 London health authority areas, and a complete set from one.

3.0 Results

The documents we received varied greatly indicating very different interpretations of the meaning of clinical governance and highlighting the multiple approaches being taken to its implementation.

3.1 Content of baseline assessments from London PCGs

3.1.1. Aims of baseline assessment exercise

Often, the authors did not set out the aims of their baseline assessments, although one PCG described eleven aims. Of those that did comment on aims, the most common was to find out what was going on in practices (9/36). The next was to get ideas from practices (6/36). Others were:

- Guiding resource allocation
- Helping practices to understand clinical governance
- Creating a "learning" or "the right" culture
- Giving practices practical advice
- Finding out what practices do well
- Identifying practice clinical governance leads
- Developing relationships
- Identifying barriers to clinical governance.

One PCG stated that its aim was to "satisfy requirements".

3.1.2 PCGs' data collection methods

Questionnaires

Three-quarters of the PCGs (28/36) used a questionnaire for their baseline assessment (see table 1)

Table 1: Data collection methods for baseline assessments

Question-naire only	Questionnaire during visit	Question-naire after visit	Questionnaire method not known	No questionnaire
15	8	2	3	8

Of those using a questionnaire, about half (15) asked practices to complete and return self-assessments while just under a third (10) combined questionnaires with visits. Of those visiting, the majority administered the questionnaire during a visit (8). Two others visited first and then sent out a questionnaire. In one case, this produced a response rate of 100%. Three other PCGs were planning to visit practices after the baseline assessment exercise was conducted.

Questionnaires with visits

Of the eight PCGs combining surveys with visits, the individual chosen to administer the questionnaire varied. Half sent one or more people from the PCG. A third sent someone from outside the PCG, such as an external consultant or a member of the local medical audit advisory group (MAAG).

PCGs also varied in whom they asked to complete the questionnaire. An appreciation of the multi-disciplinary nature of general practice was evident in four PCGs, two of which asked for team responses and two of which devised separate questionnaires for key staff (e.g. practice nurse, practice manager, GP). One PCG sent in a team of interviewers to meet the practice clinical governance lead.

Table 2: Groups to which baseline assessment questionnaires were directed

Multi-disciplinary group responded	Separate questionnaires for Prac Mgr, Prac Nrs & GP	Practice lead	Patients	Not Known
2	2	1	1	3

One PCG used a questionnaire for patients (for more information see 4.4.2). One PCG organised and trained staff from one practice to interview practice staff from neighbouring surgeries. This was organisationally complicated and expensive (about £10,000), but enabled staff from local practices to learn about others in their patch.

PCGs not using surveys

Eight PCGs did not collect any systematic data from practices, although one submitted a copy of the questionnaire they planned to use along with a discussion document. Two others also submitted discussion documents with one illustrating an "ideal" practice and the other outlining some of the main issues to consider in quality in primary care.

One PCG developed a guide to setting up a CHD register. Two others submitted action plans, one of which was dated May 1999 a full five months prior to the deadline of the baseline assessments. Another carried out a mapping exercise noting sources of primary care data in the health authority (but did not include the practices themselves). Another had contact with the practices through a series of workshops that they held instead of visits.

> *The rationale behind such an approach (as opposed to individual visits by the Clinical Governance leads or a large conference) was to place Clinical Governance within the overall activity of a practice.*

3.1.3 Questionnaire design

Practices as 'partners'

Eleven PCGs combined data collection from practices with questions aiming to gather views on clinical governance and on setting "reasonable" targets. Not all such opinions were reported in the final documents.

Four of these eleven PCGs stated that they wanted to begin to change the culture as well as gather intelligence. One, for example, stated that its aim was:

> *To create a learning culture within the PCG so that practices can develop the necessary ways to demonstrate the quality of their services in the main HImP domains.*

All four combined baseline assessment questionnaires with practice visits, encouraging the involvement of local clinicians and using the assessment process as a way of developing relationships between the PCG and local practices.

3.1.4 Choice of quality indicators

While some baseline assessments presented information on clinical services, others focused on the processes of care. Twenty-eight PCGs presented the results of an audit of selected clinical and/or non-clinical factors in practices, five of which were preceded by a short report updating progress. Of the 28, four PCGs focused almost exclusively on clinical indicators, with one producing detailed research into aspects of CVD and diabetes management. Half (14/28) concentrated more (and sometimes exclusively) on process measures. Over a third (10/28) balanced these two approaches.

The most commonly measured clinical indicators were:

- Prevalence and use of registers for CHD, diabetes, asthma and hypertension
- Targets – usually for cervical cytology and child immunisations
- Past and current audits – again in areas of CHD, diabetes, asthma and hypertension
- PACT data
- Guideline "usage" (although it was not clear if this meant the guidelines were to hand or if they had been fully implemented)

Others mentioned less frequently were:

- Annual reviews
- Recall systems
- Adverse incident reporting
- Provision of services and clinics such as family planning

Non-clinical, process measures collected include:

- appointment systems
- health and safety regulations
- fridge temperatures
- medical records
- telephone advice
- complaints
- resuscitation equipment and policies
- staff training and employment situations (e.g. contracts, part-time, full-time)
- patient satisfaction surveys

In general, the balance between the clinical and non-clinical topics varied. One PCG chose one clinical area (CHD management) and one non-clinical (availability and usage of IT). But for many PCGs, Health and Safety protocols, viable contracts for all staff and training in first aid were more of a focus than clinical indicators such as those listed above.

Scope of what was reviewed

Half (18/36) of the PCGs had interpreted clinical governance broadly and looked at a wide variety of measures of quality. Three had produced different questionnaires for members of different professional groups (GPs, practice nurses and practice managers). Around a fifth (8) of the assessments focused on a narrow range of topics. For example, one asked five general questions about current activity and audit in two HImP areas and one local priority area.

3.1.5   Overview of current quality improvement work

The Health Service Circular on implementing clinical governance described one aim of the baseline assessments as giving an overview of quality improvement activities in the PCG as a whole. Just under half (16) of the reports gave a good sense of the overall strengths and weaknesses of the PCG. Of those that did not (12), some never intended to, with one report stating

> *The report is not designed as a stocktaking exercise.*

Eight gave a partial picture. Two focused on process data, with limited clinical information so it was hard to develop an overall impression of local work on quality. One was so focused on clinical issues, that again key elements, such as the organisation of local practices, were missing. Two others collected data on one aspect of local practices (e.g. IT or diabetes management), but did not include other areas. Of the remaining three, one was a report that presented the information, in a way that was difficult to follow and the other two were action plans that gave some clues about specific areas (e.g. cervical cytology, care of the elderly, CHD management), but not a full picture.

3.1.6   Sense of direction for future clinical governance work

Over half (22) of the reports gave information on future priorities such as audits, training events and developing risk management policies. Of the 14 that did not, two were datasets and one a blank questionnaire. Three were clearly written for the Board

to decide what to do next. Some mentioned that future aspirations were included in the action or development plan.

Two PCGs used identical questionnaires to collect their data. One subsequently reported eight well-defined, concrete objectives balanced between clinical and non-clinical areas. The other included suggestions for future action, but their plans were mixed with information on past and on-going activities and so it was difficult to pick the future work out.

The majority of PCGs linked their future plans almost directly to the deficiencies and activities they found in the practices. For six, this has led to the identification of multiple objectives, while five other PCGs were taking forward only one or two tasks. For example, one PCG looked at a broad range of quality indicators (the majority of which were process indicators such as protocols and procedures in place), but identified only one priority for the coming year - developing an integrated care pathway for CHD.

Nine others had developed what appears to be a manageable agenda. For example, one planned to audit various conditions within the next six months, appoint a clinical audit facilitator, train practice managers in risk management and practice development plans, ask the CHC to carry out a patient satisfaction survey and contract an academic institutution to map IT training needs. Although this was a challenging set of tasks, they were delegating work where possible and recruiting staff to meet their objectives.

3.2 Repeatability of the baseline assessments

Two-thirds (23/36) of the PCGs could go back and repeat the same exercise to evaluate progress; thirteen could not do so easily. Of these thirteen, we have already mentioned the eight PCGs that submitted action plans, discussion documents, progress reports, a guide manual or a 'mapping' exercise. However, one of the PCGs that submitted a discussion document is planning to carry out a baseline assessment survey that could be repeated in the future.

Five others would have difficulties because:

- No numbers were included in the final report (just words such as "many", "most" etc.). Raw data would need to be re-analysed to get totals, unless totalled returns are located somewhere else.

- Practice returns were anonymised and there was a low response rate (<60%), so the PCG would not know in future if they were getting responses from different practices (that were always doing well) or if the PCG had genuinely made progress.

- The framework for analysis did not follow the questionnaire. A questionnaire was used to collect the data, but a completely different framework was applied which did not relate to the original questions for the analysis (e.g. opening times put under "poor performance"). They could re-use the questionnaire, but they would again have to super-impose the analysis framework to be able to make comparisons.

- No quantifiable data were included as the questionnaire asked general questions about past and on-going activities (e.g. what activity is there in the practice around CHD?). Results were presented practice by practice, not for the entire PCG.

4.0 Key themes emerging from baseline assessments

4.1 Relationships

4.1.1 Relationships between PCGs and health authorities
Health authority involvement in designing or carrying out the baseline assessments

Most health authorities were not involved in the baseline assessments with two exceptions.

In one health authority, the Clinical Governance Leads from all of the PCGs developed a standardised questionnaire, which drew on some work carried out by the Regional Office's clinical governance group in primary care. We had returns for two-thirds of the PCGs. The majority used the standardised questionnaire, but one mentioned a number of difficulties in using the agreed survey in its report. Another used it to collect data but then analysed them using its own framework. Another did not use the central survey at all and devised its own. Although the health authority may have been responding to requests for help, a few PCGs were not entirely comfortable with the centralised approach devised in response.

The second health authority also worked closely with their PCGs, mainly through providing staff to help collect and analyse data. Although there is a standard questionnaire, their PCGs seem to have adapted it to such an extent that one report comments

> *One questionnaire for all PCGs would have made life a lot easier.*

Health authority involvement in PCG clinical governance activities

A fifth of the PCGs' reports mentioned activities that involve their health authorities. The health authorities were:

- bidding for resources for clinical supervision of practice nurses or contracting services on behalf of the PCG

- carrying out specialist tasks for the PCG such as needs assessment or audit

- working with the PCG to develop strategies on difficult issues such as poor performance

- passing on relevant health authority data on quality, which is not the case for all PCGs (one Clinical Governance Lead mentioned that her PCG still did not have "permission" to receive these kind of data).

These health authorities and PCGs seemed to be developing a relationship whereby the health authority supported the PCG in areas where the health authority had special skills or experience.

4.1.2 PCGs' approaches to working with practices

Role of the practices after the baseline assessment

As well as the methods PCGs used to carry out their baseline assessments, indications of the relationship PCGs hoped to develop with their practices comes through the approaches they planned to adopt in future. We do not have any information on this for 14 of the PCGs, but the remaining two-thirds proposed a variety of approaches.

Two PCGs were highly consultative and had asked practices to help them decide what the next steps should be. Several others set priorities, but were using a developmental approach emphasizing 'helping practices' by offering skilled support.

> *The prescribing adviser will work with practices to promote evidence based prescribing decisions...The prescribing facilitator will facilitate and encourage participation in antibiotic prescribing audit in practices...The prescribing adviser will work with practices on educational initiatives involving antibiotic usage.*

Others took an almost "Ofsted-like" approach.

> *All reports of visits contained action plans highlighting issues to attend to both by the PCG and the Practice. These have been summarised as a confidential document for the clinical governance team to monitor. Practices will be revisited either annually or sooner depending on the action points agreed.*

Leadership

As part of developing their relationships with practices, PCGs were working out their roles in terms of leadership. Some were almost autocratic, whereas others seemed uneasy with their leadership role. Still others steered a middle course whereby the PCG led, but the practices had the freedom to develop clinical governance within pre-defined parameters.

For example after carrying out an extensive audit, one PCG set targets.

> *The **board** decided on the basis of the results and the deliberations of the **HImP sub-group** that:*
>
> *Practices be asked to provide evidence that they have achieved these standards by the end of September 2000, when an incentive financial bonus for practice development will be paid. (bold italics from original document).*

Little was said about how practices would meet these targets or the barriers practices faced. The PCG expected the practices to meet the targets the PCG had set; the ways in which they did so was left up to them.

Another PCG appeared less comfortable with this top/down approach. They submitted a document highlighting 12 aspects of clinical governance (e.g. clinical audit, premises, practice staff) illustrating an example of an "ideal" practice under each of these headings.

Practices could use the Primary Care Investment Plan to improve services. An ideal practice would:
Be accessible to all disabled patients and have facilities for people with sensory disability.
Have lockable security for medical records and passwords for computers, that are regularly updated.
Be maintained and decorated on a regular basis...

The PCG left the mechanics of how practices were to achieve these standards up to the practices themselves, suggesting ideas for consideration without imposing a centrally developed agenda.

Other PCGs were trying to balance the two. One visited local practices to explore their understanding of clinical governance then sent on a questionnaire covering specific topics. Subsequently, the PCG selected six priority areas and asked each practice to choose a further two. They were pleased to find that 85% of practices' choices were in this group of six. The PCG also asked each practice to come up with its own individual clinical governance project. The PCG listed the training and resources that were available to help practices. This PCG seemed to be combining leadership and support, while allowing leeway for practices to develop the areas most appropriate to them.

4.2 Integrating clinical governance with wider PCG work

4.2.1 Health Improvement Programmes (HImP)

Many PCGs were working out how best to integrate clinical governance with other aspects of PCG activity. The majority (23/36) made the link between the baseline assessment and the HImP, by focussing on at least one HImP area (most commonly CHD, diabetes or asthma) as part of the assessment. Although several mentioned that clinical governance needed to be linked to the HImP, it was not clear how these separate audits would integrate into a strategic whole.

In contrast, three PCGs saw clinical governance and HImP work as one and the same and they constructed their entire baseline assessment around their HimP areas. Two others carried out a separate piece of work looking at several clinical aspects within a single HImP domain.

One aimed to integrate local and national priorities still further:

> *A PCG wide Health Needs Assessment will be undertaken with the Public Health Department...Included in this will be an analysis of the PCG's performance against:*
> *1.1 National Performance Assessment Framework standards*
> *1.2 National Priorities Guidance objectives*
> *1.3 National Service Framework standards – Mental Health & CHD*
> *1.4 Local Health Improvement Programme standards*

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4.2.2 Links with commissioning

Only five reports mentioned commissioning. Three PCGs made statements about linking clinical governance to commissioning, but it was not clear how they planned to do this. For example

> *Clinical Governance will provide the framework within which the PCG will develop its other HImP, commissioning and primary care priorities and will inform its work on education & development.*

Another was more explicit, although not very specific.

> *Commissioning issues in relation to the location of type 2 diabetics should be given careful consideration.*

The fifth, however, clearly integrated commissioning with clinical governance as they were negotiating service contracts on the basis of the quality of services provided. This PCG carried out two internal audits (CHD and IT), as well as an extensive survey of GP principals asking for feedback on 16 specific services offered by their main acute provider (e.g. oncology, GUM, pain clinic). Each service was rated from nought to three for particular criteria (e.g. waiting times, standard of clinical communication etc.). The PCG planned to feed this information into the negotiations for the 2000/2001 Service Agreements. Other PCGs may be doing this, but did not mention such work in their baseline assessments.

4.2.3 Integration with education & training, audit, R&D, IT

Almost all PCGs saw clinical governance as covering many aspects of internal PCG activity. But not many were clear on how all the parts fit together. One noted this difficulty by commenting

> *Clinical Governance in practice is even more complex than funding. The problems are that Clinical Goverance impinges on HImP, education & training and Prescribing in practical detail and basic philosophy. Taken separately they do not have any practical logic, but put together they do have internal logic that is precise...*

4.3 Resources

Under half of the reports (15) commented on resources. Clinical Governance Leads from two different PCGs noted the shortage of funding, with one saying

> *Lack of resources – especially money and time is of serious concern to us. Token allocation of £10,000 for Clinical Governance for the year, lack of skills and support from [the health authority] may threaten the viability, which would be a tragedy.*

Ten of the fifteen identified either current or future sources of funding. Five PCGs mentioned the one-off allocation of £15,000 allocated by the London Region Office. Four pooled money from various sources including GMS in full training budgets, educational consortia grants, audit monies, health authority grants, primary care development funds and practice nurse training budgets. They came up with a

considerable budget for clinical governance across the PCG as a whole (ranging from £21,000 to £119,000). The PCG with the largest pooled budget included modernisation monies as part of their clinical governance fund.

Six PCGs put forward a number of suggestions on how they would use extra funding if they received it. The most common was for IT or audit training for administrative or clinical staff. Two mentioned employing a clinical governance manager or clinical tutor. Three wanted resources for protected time for GP or practice nurse visits to under-performing practices. One report concluded specifically on the issue of protected time

> *GPs and nurses need paid protected time in order to improve the quality of their work and this requires resources. This will be a difficult area to address bearing in mind the difficulty in finding suitable locums and the desire of patients to see their own GP.*

4.4 Absent topics

Although we concentrated our analysis on what was in the reports (rather than what was not), we noted that there were three areas which were not emphasised as much as expected, given the focus in the Health Service Circular. These were 'problem' services, the role of patients and 'poor performance'.

4.4.1 'Problem' services

The Health Service Circular specifically asked PCGs to "identify problem services". About a third of the reports (13) mentioned specific clinical services, and this usually took the form of listing what was available; there was nothing about the standard of services offered. Sometimes only one service was mentioned such as cervical cytology or physiotherapy. In contrast, two PCGs asked about seven specific services (CHD, hypertension, asthma, etc.) and if the nurse practised at minimum (GP present), medium (some GP support) or autonomous level (without GP support). Perhaps the method of data collection (self-completed questionnaires) did not lend itself to identifying "problem services" as required in the Health Service Circular.

4.4.2 Role of patients in developing clinical governance

PCGs and practices were having some difficulty in finding creative ways to engage patients in setting the quality agenda. Over half (19) of the reports referred to patients, but they were usually in a consultative, reactive role (e.g. patient satisfaction surveys, suggestion boxes and/or patient groups). At least one Clinical Governance Lead felt discouraged

> *This section [user involvement] was disappointing with less than half the Practices reporting that they had undertaken patient satisfaction surveys. Even fewer sought patients' or carers' views when planning new or revised Practice services...*

Several other PCGs had appointed a representative, often the lay member or a representative from the CHC, to gain understanding of users' views. Although they acknowledged that the patient perspective was important, these PCGs were not clear

how to set up a framework whereby patients themselves, not just representatives, could contribute proactively.

Three PCGs would like the user role to be more proactive; they had identified 'developing user strategies' as a key objective. One recognised how difficult this would be to achieve as even the more consultative role was not widespread or perceived as worthwhile by practices.

> ...*surveys and focus groups had been tried by some [practices] but were not seen as meaningful.*

One PCG attempted to get patients involved in their baseline assessment. While a team interviewed staff, a CHC member carried out a separate questionnaire with patients in the waiting room. Unfortunately, patient responses were not included in this report.

4.4.3 Poor performance

Six PCGs mentioned the management of poor performance in their reports. Two described working with the health authority to develop a strategy. The others noted that it was something to consider, but did not give details. One PCG commented that the issue would be hard to raise with practitioners and

> ...*even if this topic could have been phrased in such a manner to elicit a response and not to cause offence, the validity of the answers would be open to question.*

Another PCG which did raise the topic confirmed that suspicion as 95% of their practices said they had measures to deal with poor performance themselves.

5.0 Discussion

Central policy requested an honest overview of quality activities on a range of suggested indicators. Our analysis of baseline assessments – while focused on only one part of the jigsaw of clinical governance activity – suggest that London PCGs have responded by taking a wide variety of approaches. Based on our understanding of the Health Service Circular, we believe there is a gap between the intentions of policy-makers, in terms of what the assessments were to include, how developments were to be monitored, and what has been realised.

Half took the broad view suggested by policy-makers and looked at many key mechanisms of clinical governance (e.g. risk management, audit, IT, education & training). A significant number concentrated on a narrow range of priorities - typically focusing on one or two common clinical problems or local health improvement priorities. This finding is consistent with the results of two national surveys of PCGs that highlighted chronic disease management as a common focus for clinical governance work. [5]

Regardless of the scope, not many baseline assessments provided evidence of the *integration* of quality improvement activities and systems with the wider work of the primary care group and few reflected explicit links between clinical governance work and HImPs, NSFs and locally identified priorities. Combining these separate aspects to create a coherent strategy for clinical governance is particularly challenging. Advice on how primary care groups might develop such an integrated approach is available. [5][6]

Of those that did provide the broad overview proposed in the Health Service Circular, many could carry out the same activity in the future to monitor progress for the PCG as a whole. But if PCGs are asked to replicate their assessment, then a third of London PCGs could not do so easily.   Policy-makers may have intended the baseline assessments to be a first step in a cyclical process, but not all London PCGs had that same understanding.

Just as London PCGs varied in what was encompassed in the baseline assessments, they also differed in the range of future priorities they plan to undertake. Some have chosen to concentrate on one or two clinical areas while others have a broad, ambitious agenda covering both clinical and non-clinical topics. We do not know what constitutes a manageable workload for clinical governance. Will PCGs with baseline assessments that identified a small number of future aspirations achieve more than those identifying a wider range of priorities, spanning the breadth of clinical governance?

Many PCGs may have felt that the baseline assessment had to be handled sensitively because it was the first major piece of work with practices. Understandably, as new organisations they may have wanted to concentrate initial efforts on less complicated areas than poor performance - whether in terms of 'problem' services or under-performing clinicians. Furthermore, loyalty between GP colleagues and a limited history of primary care peer review have mitigated against identifying and acting upon poor performance in the past.[7] However, proposals to establish assessment centres and retraining procedures for under-performing doctors may limit the role that

PCGs have to play in this process. [8] It is also not clear what role health authorities will have. Nevertheless, clinical governance will be key in the *initial identification* of under-performing doctors; PCGs will have to tackle this issue in the near future.

In conducting baseline assessments, many PCGs were trying to develop the relationships of trust and openness that are needed for effective clinical governance.[9] PCGs are still working out the most effective ways to create the participative, open, learning, "no blame" culture described in the Health Service Circular. But they are grappling with a major dilemma. How do you begin to create that type of culture, which requires major effort in building relationships and fostering trust, while simultaneously carrying out a monitoring task like the baseline assessments?

To create a genuinely participative culture, PCGs have to cede a certain amount of control amongst its constituent parts.[10] At the same time, they need to set up organisation-wide monitoring structures and processes to demonstrate quality improvements. It could be argued that the baseline assessments offered an opportunity to help move PCGs forward on both of these objectives. But many PCGs face difficulties in knowing how to meet both effectively, as demonstrated by the varied approaches PCGs took in carrying out their baseline assessments.

This is not helped by a lack of clarity over accountability for clinical governance or the lack of a clear definition of what "successful" clinical governance looks like. There is a tension in government policy between the need to create open, learning cultures for clinical governance and the requirement for PCGs to measure and monitor the specifics of implementation. PCGs need to find a way through this to create both more open *and* more accountable cultures. One way of reflecting on a successful balance of the two will be through continued dialogue and peer learning.

References:

[1] Department of Health. *A first class service.* London: Department of Health, 1998.

[2] Baker R, Lakhani M, Fraser R, Cheater F. A model for clinical governance in primary care groups. *BMJ* 1999; 318:779 – 783.

[3] Royal College of General Practitioners. *Clinical governance: practical advice for primary care in England and Wales.* London: RCGP, 1999.

[4] NHS Executive. *Clinical Governance – Quality in the new NHS.* London: Department of Health. HSC 1999/065.

[5] National Primary Care Research and Development Centre and The King's Fund. *National Tracker Survey of Primary Care Groups and Trusts: Progress and Challenges 1999-2000.* Manchester: National Primary Care Research and Development Centre, 1999.

[5] Audit Commission. *The PCG Agenda – Early Progress of Primary Care Groups in "the new NHS".* London: Audit Commission, 2000. (*available on* www.audit-commission.gov.uk/ac2/NR/Health/nrpcg.pdf).

[6] Roland M, Holden J, Campbell S. *Quality Assessment for General Practice; supporting clinical governance in PCGs. (available on www.npcrdc.man.ac.uk/).* Manchester: National Primary Care Research and Development Centre,1998.

[7] Taylor, G. Underperforming doctors: a postal survey of the Northern Deanery. *BMJ* 1998; 316:1705-1708

[8] NHS Executive. *Supporting doctors: protecting patients – A consultation paper on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England.* London: Department of Health, 1999.

[9] Huntington J, Gillam S, Rosen R. Organisational Development for Clinical Governance. *BMJ.* In press.

[10] Davies HTO & Mannion R. *Clinical Governance: Striking a Balance Between Checking and Trusting.* The York Series on the NHS White Paper – A Research Agenda. Discussion Paper 165. York: The University of York, January 1999.

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