SECTION ELEVEN

CLINICAL ACCOUNTABILITY AND SUPPORT

This section considers:

- clinical accountability arrangements in relation to GP's in the constituent practices
- clinical accountability arrangements in relation to the clinical staff PCTs employ directly
- clinical accountability arrangements in relation to the community services for which they have assumed responsibility
- processes for assuring the adequacy of the clinical accountability arrangements of those organisations from whom they commission care.

Overcoming obstacles to safe and effective care

The GMC has stressed that professional self-regulation needs to be strengthened if the quality of clinical care is to be assured. It also needs to be aligned with organisational clinical accountability so that an organisation can exercise its corporate duty of care to its patient population.

Obstacles to safe and effective care may be:

- demand-based
- process or system based
- the result of competence deficits.

The development and implementation of a system of explicit clinical accountability will ensure that organisations are able to identify and remedy these obstacles.

This need to assure the quality of care extends to:

- doctors
- practice and community nurses and health visitors
- all those other staff of the PCT or its constituent practices who directly deliver clinical care – including dentists, pharmacists and optometrists.

Supervision and support of staff engaged in the arduous and uncertain exercise of clinical judgement needs to ensure that:

- care is transparently accountable
- their own affective and developmental needs are recognised and met.

Key learning from the Pilot programme

Most PCTs recognised that few formal accountability and support structures or processes are currently in place in relation to independent contractors and that, at best, the situation is variable so far as community nurses, health visitors and AHPs are concerned.

Very few, however, had concrete strategies or action plans to address this fundamental deficit, although many recognised that the new GMS contract provides a major opportunity to define 'quality led' accountability and support needs and to implement processes whose underlying principles could then be adapted for all other professional groups.

Across all the PCTs in the pilot programme the section on Clinical Accountability and Support was scored at 5 on the progress scale (range 3.6 to 6.5).

Although the more recently formed PCTs found this more challenging than those that had more time to develop, the difference was smaller than in almost all other sections, with the more recently formed PCTs scoring, on average, 4.8 and the older group 5.2.

In general, PCTs were more confident that organisational accountability and support arrangements were in place in relation to health visitors and community nurses than they were in relation to independent contractors. Even here, however, most PCTs recognised that the picture was, at best, patchy and that more capacity and more capability was required if accountability and support was to become an embedded reality for all directly employed clinical staff.

So far as G.P.s were concerned, most were reliant upon professional self-regulation and appraisal, although they recognised that these processes did not fully assure the discharge of their corporate duty of care either to patients of to the contractors themselves. All PCTs were aware of the possible implications of the Shipman enquiry and awaited its findings with interest and concern.

With some notable exceptions, there was a widespread recognition amongst dentists, pharmacists and optometrists that these issues had, at the time when the survey was conducted, received little systematic attention. The same was true of those clinical staff who were themselves employed directly by these independent contractors.

Boards and PECs were able to identify issues that needed to be considered, and the processes that needed to be put in place, in order to secure robust organisational accountability and appropriate professional and affective support for staff (see Checklist at the end of this Section).

Developing clinical accountability – the challenge for PCTs

Clinical accountability has become an issue of significant concern within the health care community. Professional self-regulation has historically provided the major or sole foundation for individual clinical accountability.

'Our autonomy rests on three claims:

- firstly, that there is such an unusual degree of knowledge and skill involved in medical work that non-professionals are not equipped to evaluate or regulate it
- secondly, that doctors are responsible – they may be trusted to work conscientiously, without supervision
- thirdly, that the profession itself may be trusted to undertake the proper regulatory action when individuals do not perform competently or ethically.'

Irvine, 1997

A succession of well-publicised scandals, alongside a demand for greater transparency and overall accountability in the operation of all public services has undermined public confidence (as well as that of the media and politicians) in the protection that self-regulation alone affords to the public.

'Emerging themes [from the investigation] highlight the need for: greater clarity about the accountability of GPs for the quality of patient care, both individually and collectively, and explicit arrangements for auditing practice.'

Commission for Health Improvement, 2001

This concern relates equally to:

- the systematic monitoring and support of the overwhelming majority of NHS staff who seek to provide high quality care
- the regulation and improvement of those whose practice fails to meet minimum standards of safety, whether because of system-based constraints (e.g. overload, resource defects) or personal competence deficits.
- the detection and timely apprehension of extreme and pathological outliers (e.g. Shipman, Allitt, Green.) who will exist within any system.

NHS Trusts are responsible for the creation and maintenance of systems which assure the safety and standards of all clinical (and other) decisions and actions carried out on behalf of an NHS Trust by individuals or by clinical teams.

REFLECTION

What evidence exists of any steps the PCT has taken to ensure that the clinical work of staff is routinely accountable?

Targeted implementation of clinical accountability in practice

The immediate task confronting a PCT can be considerably eased if it can identify and own a number of Clinical Governance Priorities across the PCT (and, where possible, the local health economy).

The PCT can then target efforts to:

- identify and evaluate issues of clinical accountability and (where appropriate)
- pilot and evaluate new forms of clinical monitoring and support

in relation to these priority clinical topics (this theme is covered more fully in Section 8).

Professional autonomy versus organisational accountability

Even within specific clinical areas, ensuring accountability is not likely to be an easy or comfortable task. Professional groups seek to be self-regulating. There is a long-standing suspicion that clinical freedom will be unacceptably constrained if the work of clinicians is directly monitored or regulated. It is also thought that such monitoring will violate the integrity and confidentiality of the patient/doctor relationship.

REFLECTION

How confident can the PCT feel about the care that it provides, for example, to vulnerable children? What evidence exists to support your view?

Set against this is the central demand of clinical governance that care must be accountable – through an organisation's systems and processes – to individual patients and to local communities.

Since clinical governance seeks to align all the activities of a health care organisation so that they serve the clinical needs of individual patients and of local communities, there is no fundamental tension between these principles.

Despite the advent and early implementation of clinical governance, no models of clinical accountability have emerged which systematically address and resolve this tension. Nevertheless, in a number of other professions, supervision has come to be regarded as an entitlement of staff rather than as an imposition upon them.

Even where they exist (as in the case of child protection in social services), policies and procedures alone are not enough. In the face of time demands and inadequate training, even the best policies become flawed and can fail in practice. Public enquiries have identified the failure to carry out adequate supervision in social work practice as a major contributory factor to the death of every abused child. These findings date back to the death in the 1960s of Maria Colwell and continue through to the recent tragic failure to protect Victoria Climbié.

Across the caring professions there is an urgent need to develop and implement systematic processes of supervision and support that protect and improve the quality of care for patients and service users. These processes should also support and develop professional staff.

'There must be clear and understood systems of responsibility and accountability; a culture of blame is no substitute for such systems: the quality of healthcare must be guided by agreed standards, compliance with which is regularly monitored.'

Bristol Royal Infirmary Inquiry, 2001

So far as graphic examples of risk identification and reduction are concerned, a recent paper by Baker, Jones and Goldblatt (2003) describes a systematic process for monitoring mortality rates in general practice, in the wake of Shipman. It also makes a number of important and more general points about the requisite features of systems designed to:

- detect abnormal patterns of practice
- inform clinical policies
- improve overall standards.

They conclude that, in the development and implementation in practice of such systems:

'Local organisations such as primary care trusts have a key role to play'

Baker et al, 2003

GP appraisal and clinical accountability

The explosion of new research-based knowledge is one factor contributing to concerns over the currency of general practitioner clinical practice expertise. These concerns have led to calls for GPs (and other doctors) to generate periodic evidence of their continued 'fitness for purpose'.

The GP Appraisal scheme is based upon the principles of active and life-long learning, rather than static once-and-for-all knowledge acquisition. Together with revalidation processes, the scheme provides periodic assurance of the basic competence of General Practitioners.

What it cannot do is provide day-to-day assurance of the effectiveness and safety of practice. Nor can it provide all the support GPs need to cope with the time demands and the decision stress that are an inescapable ingredient of general practice. These are inherent aspects of their work. Appraisal should be viewed as an important contribution to — but not a substitute for — appropriate systems of supervision, monitoring and support.

REFLECTION

What evidence exists of progress made within the constituent GP practices in implementing effective appraisal?

GPs, nurses and AHPs with a special interest

Inevitably the specialist focus and emphasis of this growing cohort of general practitioners and other clinical staff poses specific and particular issues in relation to supervision, professional support and monitoring of standards of practice. In collaboration with the SHA and other care providers in the local health economy, particular attention should be given to the quality monitoring, peer support and professional development needs of GPs and other clinical staff who take on a designated 'special interest'. Guidance has recently been developed in relation to ENT and Dermatology and other guidance is currently in development.

Clinical accountability and the contractual status of GPs

The current self-employed status of General Practitioners introduces a further element of complexity into their line of clinical accountability. The new GP contract will go some way towards address this complexity. But for the present, contractual arrangements between

the PCT and the constituent GP practices need to incorporate an explicit model of accountability that unites the legitimate respective requirements of professional and organisational accountability. The operation in practice of these contractual arrangements will also need to be monitored by the PEC and by the Board as part of their statutory duty of quality.

Clinical supervision and community nursing

Clinical supervision was first launched for nurses through an executive letter from the then Chief Nurse Yvonne Moores, in 1994. Despite heroic efforts by individuals and organisations up and down the country, and a number of accredited training programmes for 'Clinical Supervisors', the implementation has been at best patchy and sporadic.

' Clinical supervision has entered the vocabulary of nursing, with no discernable impact on the day to day reality of the vast majority of nurses in acute or community settings'

Butterworth, 1998

REFLECTION

What evidence exists to show that the PCT has taken steps to ensure that the clinical work of nursing staff is routinely accountable?

This partly reflects the fact that clinical supervision was introduced without any funding to cover the time costs it implied.

' In a Trust of 1200 nurses, and assuming one hour of Clinical Supervision each month, we are talking about a time investment ... equivalent to us employing another six and a half nurses just to cover the time out required.'

Cooley, 1996

In part also it reflects the fact that the particular model adopted – the Proctor Model – was derived from the world of counselling and explicitly sought to isolate the clinical supervision process from organisational or line management accountability. This significantly reduced the incentive for an organisation to invest in it.

As a result, even if it were to be systematically implemented, it is unlikely that the existing model of clinical supervision would satisfy the requirements of organisational clinical accountability that clinical governance implies.

REFLECTION

What evidence exists to show that the PCT has taken steps to identify the accountability arrangements and processes in relation to all of those community-based services for which it has assumed responsibility?

Most community nurses and health visitors are employed by PCTs. The PCT must, therefore, assume direct responsibility for monitoring and supporting the quality of the care that they provide.

Clinical accountability and dentists, optometrists, pharmacists and allied health professions (AHPs)

All allied health professions have professional models of accountability; none of those that operate in primary care have a model of supervision that unites organisational with professional accountability. It is important, therefore, that PCTs develop strategies alongside the professions (and in collaboration with SHAs) to develop appropriate and effective mechanisms of supervision and support.

Managing poor performance

Supporting Doctors, Protecting Patients suggests that poor performance is characterised by;

'Failure to meet accepted standards of professional practice in medicine .. it is not common but when it does occur it can be manifested in diverse ways. For example, poor clinical performance can be associated with errors or delays in diagnosis, use of outmoded tests or treatments, failure to act on the results of monitoring or testing, technical errors in performance of a procedure, poor attitude and behaviour, inability to work as a member of team or poor communication with patients. In some cases , there may be underlying ill-health problems.'

Department of Health, 1999

In essence, systems for handling concerns about performance of GPs and other professional staff should

- protect the safety and well-being of patients
- provide a transparent, fair and effective process for all staff.

PCTs need to develop processes for the generation of robust and reliable systems that will enable them to satisfy these twin requirements and identify legitimate evidence of underperformance. They will need to develop, clear and explicit processes that will enable them to manage and directly confront these issues.

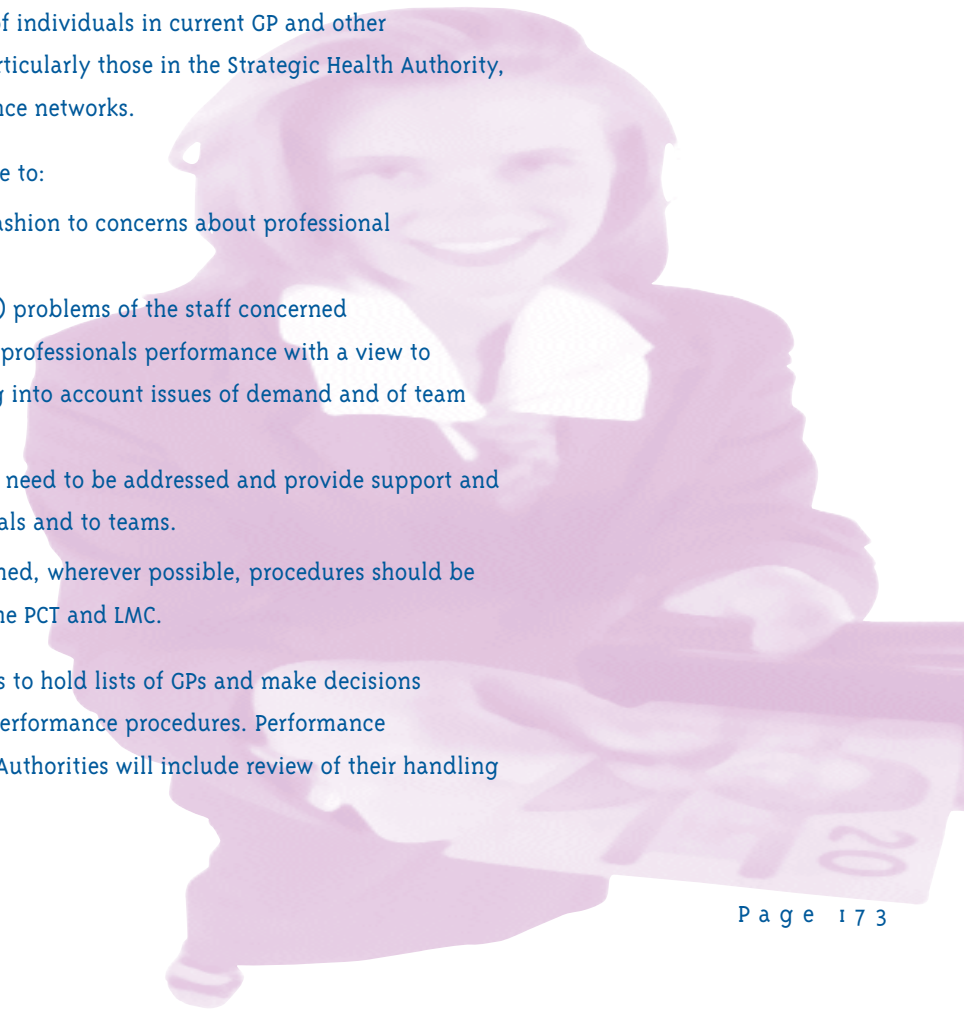
The detailed nature of the structures and membership of groups for handling concerns about professional performance will need to be determined locally, taking into account existing structures and the involvement of individuals in current GP and other professional performance procedures, particularly those in the Strategic Health Authority, LMCs, GP education and clinical governance networks.

The objectives of local procedures must be to:

- respond in a timely and appropriate fashion to concerns about professional performance
- identify any health (or other pertinent) problems of the staff concerned
- undertake an initial assessment of the professionals performance with a view to identify areas for improvement (taking into account issues of demand and of team performance and support)
- devise a plan to address the areas that need to be addressed and provide support and follow up as required both to individuals and to teams.

So far as general practitioners are concerned, wherever possible, procedures should be agreed locally and jointly promoted by the PCT and LMC.

From April 2003 PCTs have had full powers to hold lists of GPs and make decisions regarding complaints, disciplinary and performance procedures. Performance management of PCTs by Strategic Health Authorities will include review of their handling



of concerns about GP performance procedures. Similar clarity and supportive arrangements need to be developed in relation to pharmacists, dentists and optometrists.

In addressing GP related concerns PCTs can call upon the expertise and support of the NCAA.

NCAA is a special health authority established as one of the central elements of the NHS' work on quality. It began work in April 2001 aiming to provide support service to HA, PCTS, Hospital and Community trusts who are faced with concerns over the performance of individual doctors.

The NCAA aims to:

- provide expert advice, both at local handing of cases and effective local procedures
- undertake assessments of GPs where local procedures have not worked or where they are inappropriate
- make practicable recommendations for addressing the difficulties identified.

It is not safe to assume that under-performance occurs merely at the level of the individual clinician. Teams can under-perform for a complex array of reasons that include issues of

- resource/demand
- leadership
- management
- tribalism
- collaboration
- clarity of focus.

These issues need to be investigated with the same rigour as the root cause analysis of clinical risk – and with a parallel emphasis upon problem resolution as opposed to blame.

REFLECTION

What evidence exists to show that the PCT has taken steps to identify the accountability arrangements and processes in relation to all services it has commissioned on behalf of its patient community?

Clinical accountability and services commissioned by the PCT

The duty of quality extends to all services a PCT commissions as well as those that it delivers. The PCT must enquire into the systems of clinical accountability that are in place to regulate the treatment it commissions on behalf of its patient population. In the absence of such inquiries (and, where necessary, collaborative investment in developing appropriate systems of clinical accountability), a PCT may run the risk of unwittingly becoming embroiled in another major investigation such as that which occurred at BRI (this theme is explored more fully in Section 18).

Satisfying the demand for accountable care

The issue of clinical accountability – and how this is best addressed and discharged in relation to all professional groups working in primary care – extends beyond the remit of any one PCT. National and regional NHS communities need to wrestle with this issue.

Anglia Polytechnic University Clinical Supervision – Prompt for Supervisors

1 Monitor
   - volume
   - process (in the context of the system)
   - outcome.

2 Identify positives as well as concerns.

3 Prompt reflective analysis.

4 Combat 'rushing to judgement'.

5 Counteract 'the tyranny of habit' – 'the unique situation is understood through the attempt to change it – and changed through the attempt to understand it.' Donald Schön

6 Support staff affectively – 'for the skilled professional emotions, our own as well as those of our clients or patients are an obstacle, an object of scrutiny and a resource'. Salzburg-Wittenburger

In the meantime PCTs must ensure that they have taken all reasonable steps to ensure the accountability, and thus the safety, of the care they provide by identifying and managing overt clinical risks.

'Clinical supervision is not a cost, it is an investment.'

French, 1996

Priorities for action

Now that you have finished reading through this section, please identify three priorities for the PCT in relation to clinical accountability and then relate these steps to those identified in checklist below.

1

2

3

Checklist: Clinical Accountability and Support

In order to be certain that they have taken all reasonable steps to ensure the accountability and support of clinical practice PCTs should:

Audit what is happening across all professional groups.
Establish professional group specific systems to ensure that care is accountable.
Wherever possible, blend professional and organisational processes of accountability.
Ensure that all such processes will identify and differentiate 'excellent'; 'safe'; 'sub-optimal' and 'unsafe' performance.
Establish systems to deal immediately with unsafe and promptly with sub-optimal practice.
Establish systems to share best practice.
Provide practical support and professional guidance to the PCT' s clinical staff community.
Provide affective support to the PCT staff community.
Invest in the development and evaluation of accountability and support systems.

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Cooley, 1996. *Clinical Supervision*

Department of Health 1999. *Supporting Doctors, Protecting Patients, a consultation paper on preventing, recognising and dealing with poor performance of doctors in the NHS in England*, London: DoH

French, 1996. *Clinical supervision*

Sir Donald Irvine 1997 The Performance of Doctors *British Medical Journal*, May 1997

Resources

GPs with a Special Interest – A report shows that GPs with a special interest can help local health economies to meet some of the key NHS objectives such as improving patient access, reducing waiting times, improving the patient journey and promoting links between primary and secondary care.
www.doh.gov.uk/pricare/gp-specialinterests

For specific information about GPs with a special interest in ENT, visit
www.gpwsi.org

The Modernisation Agency is a valuable source of information. You can access the different strands of the Agency through the website at:
www.modern.nhs.uk

The National Primary and Care Trust Development Programme – the NatPaCT team helps PCTs with organisational development.
www.natpact.nhs.uk

The NHS Appraisal Toolkit will help doctors prepare for appraisal meetings in the context of local and other priorities. It will also help to develop an accurate picture of local learning needs that can help education providers and facilitators as they plan their programmes. The NHS Appraisal Toolkit can be accessed via its own website at
www.appraisals.nhs.uk
or via the joint Appraisal and Revalidation website at
www.appraisaluk.info or www.revalidationuk.info

Rating the PCT's current stage of development

Please rate the PCT's current stage of development in relation to the following questions.

Remember to use the Response Sheet provided for your answers.

11.1 To what extent has the PCT put in place clinical accountability and support arrangements for GPs in the constituent practices?

11.2 To what extent has the PCT put in place clinical accountability and support arrangements in relation to community nurses, health visitors and other health professionals?

11.3 To what extent has the PCT put in place clinical accountability and support arrangements in relation to community dentists, pharmacists and optometrists?

11.4 To what extent does the PCT have a strategy for maximizing 'quality gains' through the new GMS contract arrangements?