SECTION NINETEEN
INTER-ORGANISATIONAL ELEMENTS OF CLINICAL GOVERNANCE

This section considers:

- the need for truly seamless services as patients move between different forms of health and social care provision
- the need for full and active engagement with all the other key players in the local health economy
- the need for full and active engagement with all the other key players in the local social care economy.
- the development of patterns and forms of flexible partnership based clinical governance that reflect and manage entire patient journeys.

Working in partnership

Clinical governance is not just about the way that organisations conduct their own affairs. Because patient care is delivered, for the most part, through an inter-connected and inter-dependent network of organisations in the health care sector and beyond, the way that an organisation works in partnerships with others in the care 'network' will have a crucial impact on the overall quality of care that individual patients and patient communities receive.

'PCTs will need to involve patients and the public as well as their own practices and partners. They will need to develop capacity to manage the co-ordination of all the agencies that deliver local health care, taking the responsibility for creating strong local partnerships, addressing the broader determinants of health and truly representing the populations that they serve. In doing so they will also need to work collaboratively with other PCTs, Strategic Health Authorities (SHAs) and NHS Trusts as well as local authorities.'

Department of Health, 2002

Clinical governance provides the value base that should shape and inform the way that a PCT – and other partner organisations in health – approach and conduct their relationships. The values of respect and trust that underpin clinical governance should characterise the relationships within a local health economy. Although the particular language that is used may be different, these same values should inform the emergent relationships with partner organisations in the statutory and voluntary social care sectors and in the independent sector. Not least through the pioneering work of the Primary Care Collaboratives, opportunities have now been created for PCTs to participate in development activities that will influence the transformation of the NHs into a service that is truly attuned to the needs of the 21st century.

'By the end of 2002, practices in every PCT in England will have the opportunity to be involved in this, the largest single healthcare improvement programme worldwide.'

National Primary Care Development Team, 2002

The critical importance of the effective generation and management of collaborative partnerships across all aspects of the health system so that a holistic judgement can be made about the well-being of local communities is forcefully emphasised by the new Commission for Health Audit and Inspection.

'Nearly all patients, especially the most vulnerable ones, rely on more than one organisation for their overall care and well-being. Consequently, CHAI will seek both to work in real partnership with others, and to exercise its duty to coordinate other regulators in health. In this way, not only will we increase our sources of intelligent information but we will also be able to obtain a more comprehensive view of patients' overall experience of the care received than we would be able to do by ourselves.'

CHI, 2003

The Secretary of Sate has emphasised that, within the emergent twenty first century, NHS PCTs will have three essential roles.

'Improving the Health of the Community

Securing the Provision of High Quality Services

Integrating Health and Social Care'

Reid, 2003

Inter-alia, in support of these functions, he emphasis the importance of PCTs

'Taking the lead for the NHS in partnership working with Local Strategic Partnerships to ensure co-ordination with a wider government agenda ...

Improving the provision, development and integration of primary community, acute and specialised services through the engagement of local communities, patients and front line staff.

Working with local authorities to maximise opportunities for patients and clients.'

Reid, 2003

None of these aspirations can be translated into reality without persistent and imaginative partnership-based working within local communities and across local health and social care economies.

Key learning from the pilot programme

All PCTs in the pilot demonstrated a consensual willingness common to Boards and PECs to work collaboratively with local partners.

Most PCTs recognised that co-ordination and alignment of the services within a health (and social care) economy is a fundamental building block in the overall quality of the patient experience.

However, in view of the many competing short-term financial and target-driven pressures upon them, many were still to explore and exploit the longer term opportunities proceeding from the Health Act flexibilities and from their commissioning responsibilities and leverage.

The section on Inter-organisational Clinical Governance was scored in the middle of the section averages at 5.2 on the progress scale (range 3.8 to 7.0).

Predictably, in the face of the other pressures upon them, the more recently-formed PCTs had had less time and energy to devote to the creation of effective partnerships. The 25 PCTs that were under a year old when they completed the questions scored an average of 4.9 whilst the remainder scored an average of 5.5.

PCTs within the sample provided evidence of partnership-based working aimed at improvements in the quality of care that had arisen from characteristically different starting points.

Some improvement or transformation initiatives had been prompted by high-level dialogue between senior executives within a health economy. This was often supported by non-executives from different sectors who could take up a common cause in the interests of local communities or patient groups with, in some cases, facilitative help and support for the SHA. In these cases, the respective organisation had then needed to 'sell' change strategies to their clinical communities.

In other cases, the initial impetus for change had come through dialogue focussed upon a specific clinical topic or disease process between clinicians from the primary, secondary and (on occasions) tertiary sectors. Sometimes this initial dialogue was prompted by dialogue between primary care physicians and their own patients that had reinforced their concerns about the safety and co-ordination of care across a health community. In this case, organisational support had been grafted on to patient- or clinician-led initiatives.

In either case, passionate and persistent commitment to improvement from Boards and PECs and from front line staff, allied to collaborative partnerships with patients and their carers, provided the foundation for local integrated care pathways which generated evidence of service redesign and of sustainable quality improvement.

Managing the 'patient journey' – the importance of organisational partnership

Previous sections have looked at:

- the way a PCT assures the standards of care which it and its constituent practices and other primary care partners provide
- the ways in which it must seek to improve these standards and to work in partnership in order to do so, using the precepts of clinical governance.

This section concentrates on the issues arising from partnership-based working.

From the perspective of the individual patient, or of patient communities, the overall quality of care (and of life) is not dependent exclusively upon the quality of those services that General Practitioners and other professional primary carers provide. The patient journey often crosses and re-crosses the organisational boundaries within which health care organisations operate and are governed. Often, in addition, and not least for vulnerable older people and children, this journey crosses and re-crosses the frontiers of social care.

'PCTs will work as part of Local Strategic Partnerships to ensure co-ordination of planning and community engagement, integration of service delivery and input to the wider government agenda including Modernising Social Services, Sure Start, Community Safety, Quality Protects, Youth Offending Teams and Regeneration Initiatives.'

Department of Health, 2001

Weaknesses in any interdependent system are most likely to occur (from the perspective of the service user):

- at inter-faces (that is, system/functional interfaces within an organisation)
- at boundaries (that is, system interfaces between organisations within a sector)
- at frontiers (that is, system inter-faces which cross sectoral and territorial divides).

The extent to which these interfaces are managed, in order to produce, from the patient perspective, seamless rather than disjointed and fragmented care, is a major determinant of overall 'quality of care'.

Overall, almost 45% of patients report problems with transitions between health care providers. The work of Picker Europe demonstrates authoritatively that the UK fares poorly in this area when compared with other international systems of care.

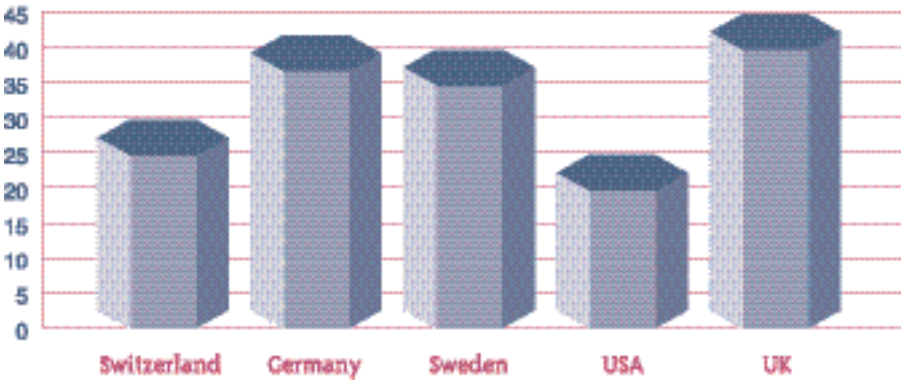

Figure 19.1 Percentage of patients reporting problems

PCTs, as a consequence of their commissioning powers and responsibilities, have a specific and particular responsibility for ensuring that they explicitly identify and manage (or commission the management of) all of these complex inter-faces for individual patients and local communities.

'When patients enter secondary care, they already have a relationship with primary care, and will return to primary care, once their visit or stay is completed. Primary care professionals have a unique perspective on, and involvement in, the patient journey.'

National Primary Care Development Team, 2002

This perspective may enable PCTs to re-conceptualise blockages and obstacles to effective care and address long standing system issues in new and imaginative ways.

'Traditionally, much of the work to reduce delays for patients waiting for routine secondary care services has taken place within secondary care itself. In developing a framework for this area of work, NPDT sought to consolidate knowledge and innovation around improving the patient journey and reducing delays from within primary care.'

National Primary Care Development Team, 2002

REFLECTION

Thinking about any care provided by the NHS to you or a member of your family, how well co-ordinated was that care?

How could this care have been better managed, better integrated and improved?

Promoting healthy alliances – assuring the quality of current provision

Just as organisational interfaces need to be recognised and managed, so do potential conflicts of interest between PCTs and/or between them and other health providers. Devoting management and clinical time to issues of integration, co-ordination and competition within a health economy represents an investment for the community, as well as a cost to the organisations concerned. In the interests of promoting a 'just' system, it is essential that SHAs are supported by PCTs in their efforts to ensure the best and most cost-effective outcomes for the whole regional community.

'PCTs need to behave in a mature and co-operative fashion, working closely with one another and health and social care organisations to deliver effective health care across populations wider than their own individual communities.'

Department of Health, 2001

Unhealthy aspects of organisational behaviour which were previously and perversely encouraged by the 'internal market' must not be allowed to re-emerge. An important acid test of the value added by 'Foundation Trusts' will be their willingness and their drive to work collaboratively in ways that foster and promote social enterprise rather than

narrowly defined organisational advantage. Apparent cost savings within one part of the system that are achieved merely by transferring cost to another part of the health (or social care) system do nothing to promote overall cost-effectiveness, indeed, they violate the core principles that should underpin 'public service'. Where they also have a damaging or disruptive impact upon what CHI calls the 'smooth flow of care', they also flout every precept of clinical governance.

A well-regulated health economy will recognise, manage and deter such behaviour. PCTs can use their commissioning leverage, Health Act flexibilities and their overall 'duty of quality', alongside the regulatory influence of SHAs, to promote genuinely healthy and health-promoting alliances.

'PCTs working with local authorities should maximise opportunities for patients and clients by the integration of health and social care through the use of the Health Act flexibilities and through the use of the Health and Social Care Act 2001 and the well-being power in the Local Government Act 2000.'

Department of Health, 2001

Promoting healthy alliances – transforming the nature and quality of future provision

Many patterns of care are determined by historical precedent. Whatever the nature of the need that gave rise to these particular service configurations in the past, a fluid and evolving society will have needs that test these systems and structures to the point of collapse. From the perspective of patients and users of services, many of the problems they encounter are structurally *iatrogenic* – that is, they are generated by the very organisational structures that are supposed to meet their needs.

The needs of communities have evolved and moved on far more quickly than have patterns and locations of provision.

'PCTs will be expected to work closely with other PCT and NHS Trusts locally to ensure that services are provided in support of patient need and across organisational boundaries.'

Department of Health, 2001

On the provider side of the equation, this is particularly true:

- where technological innovation has made practicable forms and types of care which were not possible when current patterns were first laid down
- where structural change (such as the closure of a dominant local industry and consequent depopulation) have led to major changes on the consumer side of the equation.

It is important to remember that clinical governance is a transformational principle which should drive the health service to become genuinely needs-led, rather than provision-led.

As the Secretary of Sate has pointed out,

'For over 40 years the public has experienced NHS reconfigurations that have moved more and more services away from them and their local place to centralised hospitals. This is a dangerous direction for the NHS to travel in and needs to be stopped. The NHS needs to deliver services where people are, not where they are not – otherwise it is not 'their' service.'

Reid, 2003

To that end, PCT Boards must 'think outside the box' in considering the appropriateness of current provision, the possible shape/flexible shapes of future provision and the extended partnership working that will be necessary to support community transformation.

'Fifty five percent of PCG/Ts were involved in partnership initiatives using Health Act flexibilities.... Two thirds (67%) were jointly providing intermediate care facilities with social services and 79% were jointly providing community rehabilitation for older people ... All PCG/Ts were working with community development/regeneration departments and most were working with leisure (80%), housing (77%), and education (76%).'

National Primary Care Resource and Development Centre, 2002

REFLECTION

What evidence is there to suggest that the PCT is forging new forms of local partnership?

The governance challenge posed by integrated care networks and NSFs

Integrated Care Networks and NSFs are both attempts to move the focus of clinical care beyond the boundaries of a particular organisation and onto the complex reality of the patient journey.

'NatPaCT wants to support the development of Integrated Care Networks, through which PCTs and their local partners in other parts of the NHS, local government, and in the community, voluntary and private sectors can work together to improve the quality of services to people needing health and social care.'

NHS Litigation Authority, 2002

Like NSFs, properly constructed and governed care pathways provide a vehicle to ensure

- greater engagement with local communities
- improvement of health and social well-being
- reshaping of care services
- reshaping of resource flows through increased use of integration opportunities.

Despite this opportunity, pressures of work, issues of management and clinical capacity have so far held back progress in many PCTs

'PCTs provide the opportunity for commissioning along care pathways, yet under 50% of PCTs are currently doing so and even a third of these doubt if they are doing so effectively.'

NHS Alliance National Survey, 2003

However, prompted by the impetus of national priorities a number of exemplars already exist. They provide excellent evidence both of progress and of the obstacles that are encountered in embedding new forms and patterns of care provision.

'It will be for local organisations, working together in a cancer network, to develop strategic plans and put them in place, to agree how best to use resources for cancer and to implement processes to monitor the quality of care through clinical governance.'

Department of Health, 2000

Much progress has been made in improving services to cancer patients. Nevertheless, leading representatives from the cancer networks identified (at their January 2002 national conference) the absence of clear governance of the network as a major barrier to overcoming obstacles to fundamental service transformation. The overwhelming majority indicated that, as yet, little or no progress had been made in establishing clear and effective governance of the care pathway at local level. The obstacles to progress that they identified (see Figure 19.2) are worthy of consideration in relation to other attempts to generate 'joined up care' a the level of the patient condition.

improvement

Notwithstanding these obstacles and difficulties, progress is most likely to occur where specific clinical conditions or priority topics are used as a focus for systematic analysis and engagement across organisational boundaries.

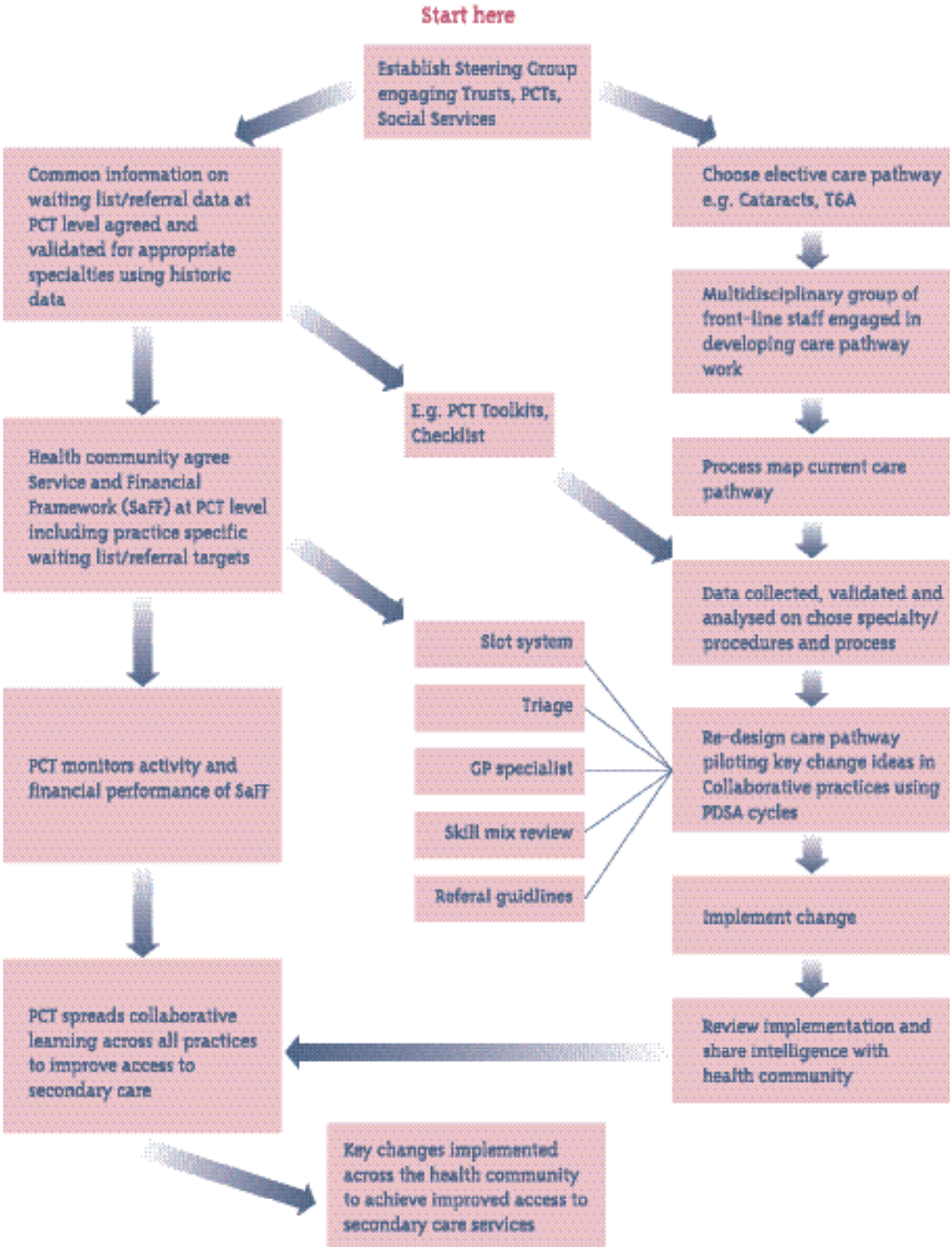

Figure 19.3 Route map for capacity and demand management

REFLECTION

Given the day-to-day pressures which characterise the experience of so many senior executives, managers and clinicians in health care organisations, how many opportunities are created within the health economy for them to meet together (with patients and with other community representatives) to reflect upon fundamentally different ways of responding to local needs?

Effective transformational leadership in primary care needs to be characterised by realistic attention to the present alongside clear-sighted commitment to a new future. Even when driven by the future needs of the community, creativity, imagination and vision need to be tempered by the recognition that real and sustainable change can only be achieved and justified if a health economy acts in unison.

However, improvements in capacity and demand management are not only important in producing more effective and timely care – they can also help to re-introduce into the system the 'down-time' that is necessary if clinical and management staff are to have the time and the space to stand back from every day pressures and reflect, alongside service users and representatives of local communities upon longer term innovation, reform and service transformation.

Priorities for action

Now that you have finished reading through this section, please identify three key priorities for action in relation to inter-organisational governance.

1

2

3

References

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Reid, J. 2003. *Localising the National Health Service: gaining greater equity through localism and diversity.* London: New Local Government Network.

Resources

Department of Health – access to all Department of Health information is through their website: www.doh.gov.uk

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

Help on the implementation of NSFs in primary care (*National Service Frameworks: A Practical Aid to Implementation in Primary Care*) is available from:

Department of Health Publications
PO Box 777
London SE1 6XH
Tel: 08701 555 455
Fax: 01623 724524
Email: doh@prolog.uk.com

By quoting 28270 National Service Frameworks

This document can also be found at the department's website at: www.doh.gov.uk

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

Picker Europe – Surveys and research into aspects of clinical governance and the health service
Email: Info@picker-europe.com
www.picker.org

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.

19.1 To what extent does the PCT have a strategy for developing its partnerships with all local stakeholders?

19.2 To what extent have the Board and PEC critically appraised the appropriateness and sustainability of inherited patterns of provision within the local health and social care economy?

19.3 To what extent does the PCT actively and imaginatively promote the creation of Integrated Care Pathways?

19.4 How effective are partnership arrangements with the local social care and voluntary sector communities?