SECTION FOUR

FOSTERING OWNERSHIP OF CLINICAL GOVERNANCE

This section considers:

- the need for a common understanding of and commitment to clinical governance throughout the PCT staff community
- the need for staff to feel respected, valued and cared for by the PCT.

Introduction

If clinical governance is to become a reality that permeates all aspects of a PCT's activities, the Board and PEC must develop a strategy and vigorously pursue an action plan to foster a common understanding of and commitment to clinical governance across the entire PCT staff and patient community.

There should also be clear delegation of responsibility for taking forward all of these actions. The Clinical Governance Lead and the Clinical Governance committee must keep these actions and their outcomes under review and periodically present evidence of progress (or of problems) to the PEC and the Board.

The PCT must also pay due regard to the rights and entitlements of staff.

Key learning from the pilot programme

When they completed the questionnaire in May/June 2003, many PCTs still struggled to overcome the after-shocks of merger, the complexity of their relationships with 'independent contractors' and the professionally and geographically dispersed nature of the staff community. Though some were taking systematic and persistent action to foster a sense of ownership of quality across all professional and other staff groups, a number had not developed robust strategies to address and resolve this key issue.

Across all the PCTs in the pilot programme, the section on Fostering Ownership was scored at 5.3 on the progress scale (range 3.2 to 6.8).

Predictably, the more recently-formed PCTs were likely to find this a more challenging issue than those that had a longer time to address it. The 25 PCTs that were under a year old when they completed the questions scored an average of 5 whilst the remainder scored an average of 5.6.

A number of factors beyond the control of PCTs themselves compounded the difficulty of 'fostering ownership'. This was particularly true for PCTs that:

- had inherited staff from previously troubled predecessor organisations
- were functionally complex (e.g. had to run community hospitals or mental health services alongside their core provision)
- had inherited acute staff shortages in key clinical or managerial posts.

In addition almost all PCTs recognised that they faced a major challenge in fostering ownership across all members of the dental, pharmaceutical and optical communities for whom they had recently assumed responsibility – though a number had made commendable progress within a very short time.

Internal factors that determined the success that PCTs had in fostering ownership across the PCT staff community included:

- the overall calibre of leadership provided by the Board and the PEC
- the clarity and effectiveness of leadership of the constituent professional groups – not least general practitioners
- the development of a clear strategy, an action plan and time table for pro-active staff engagement (see the checklist at the end of this section).

Ensuring understanding of and commitment to clinical governance

Clinical governance is a relatively new concept and its meaning is not always clear to all staff. It did not exist as a unifying principle when the vast majority of NHS staff received their basic professional training; nor was it built in to their sense of professional identity.

New policies alone do not change practice. In complex organisations such as PCTs, where staff are dispersed across a variety of practice sites, have different employers and belong to different professional or employment groups, the communication and ownership of key values and principles need to be engineered, not assumed.

'My experience is that, in general, staff have a strong instinctive desire to improve the quality of the care they provide – this is one of their main motivations. They often believe the system is preventing them from fulfilling this desire.'

Shelly, 2002

PCTs must provide evidence to their staff that they too have a 'strong desire' to improve quality. The Board and PEC need to initiate active steps to ensure that their own sense of ownership of the clinical governance agenda is communicated to and actively fostered throughout the PCT community.

'Ownership of the plans needs to be generated not just at board level but right down the organisation in each individual team.'

Halligan and Donaldson, 2001

Taking the organisation's pulse

Fostering ownership of clinical governance needs to be seen as a process – not an event. In other words, it cannot be done once and for all and then forgotten.

It is important, periodically, to 'take the pulse' of the organisation via properly constructed staff questionnaires or 'slice groups', containing representatives of staff from every discipline, function and level within the organisation.

Together with evidence from the annual Staff Opinion Survey, it is possible to gain an accurate picture of staff views in relation both to their understanding of and active engagement with clinical governance – and to use this information to inform the organisational development and training agendas.

'To implement clinical governance in primary care, a common understanding must be reached by all members of the health-care team.

For clinical governance to have a positive impact it must be accepted as 'part and parcel' of the job and not an add-on.

Lack of resources (time, administration, information technology) remain the main barriers to the implementation of clinical governance in primary care.

In order to facilitate an emotional commitment to clinical governance, these barriers should be overcome.'

Clinical Governance Bulletin, May 2002

REFLECTION

How much attention has the Board/PEC paid to ensuring that there is common understanding and ownership of clinical governance across the PCT staff community?

What evidence is there of progress – or of obstacles to progress?

Fostering ownership across the entire PCT staff community

The clinical care provided by GPs, dentists, pharmacists, nurses, optometrists and other professional staff is vitally important. However, the overall quality of the patient experience is fundamentally influenced by the approach and actions of all staff within the PCT community – both those who interact directly with patients (e.g. reception staff) and those who support these interactions (e.g. administrators and managers).

'Clinical governance would not happen without ownership by the staff at the grass roots.'

Clinical Governance Bulletin, April 2001

The term 'clinical governance' can seem to imply that it is the exclusive concern or responsibility of doctors and other clinical staff – but this is not the case. Because it is a means to assuring and improving the overall safety and quality of the patient experience, clinical governance is the business of every member of staff of the PCT and of its constituent GP practices.

'Quality must be everybody's business.'

Department of Health, 2000

One mark of a PCT's commitment to and active investment in quality care is the extent to which it communicates this message clearly, effectively and consistently to all staff. This cannot be carried out once and for all, but must be an ongoing process – not least when

new staff groups (such as dentists, pharmacists and optometrists) join an existing community.

'At local level, NHS organisations will be expected to appoint a staff involvement leader to report to a nominated non-executive director and prepare a staff involvement plan.'

Department of Health, 2001

In a dispersed and professionally complex PCT community, this process will require persistent attention over time. The more recently-created PCTs — or those that have undergone some form of merger or association with other PCTs — need to give particular priority to promoting within their 'involvement plan' a shared understanding of and commitment to clinical governance. More established PCTs need to ensure that it remains a live issue within the staff community so that each individual and each team is encouraged and supported to make concrete and on-going improvements in quality.

'Until new behaviours are rooted in social norms and shared values, they are subject to degradation as soon as the pressure for change is removed.'

Kotter, 1995

Clinical governance must (somehow) be transformed from a set of broad rhetorical aspirations into a living and breathing, day-to-day reality that helps patients and embeds its principles into the culture of the PCT.

In order to achieve this, the best health care organisations encourage:

- active debate between all staff about those concrete things that promote or prevent the delivery of high quality care, and
- a multitude of discreet but aligned actions to improve safety and to redesign existing patterns and forms of care.

'This culture needs to be creative, challenging and supportive. It needs to embrace modern ways of working through teams and networks rather than through hierarchies and formal systems. It needs to recognise the complexity of the environment and the work we do. It also needs to be underpinned by shared values.'

Department of Health, 2002

Fostering ownership within and across professional staff groups

Professional bodies and others have attempted to foster commitment to the clinical governance agenda in general practitioners, nurses and AHPs.

'Nothing changes if you don't involve clinicians.'

Kennedy, 2002

The aim is that all professional groups should:

- see clinical governance not as a threat or an imposition, but rather as a powerful ally in their efforts to secure the best possible quality of care for individual patients and patient populations
- work together in pursuit of these goals.

'A multidisciplinary approach needs to be encouraged from the outset to ensure every profession contributes to the implementation of clinical governance.'

Clinical Governance Bulletin, April 2001

This requires explicit and effective leadership for each of the different professional groups within the overall PCT community. It is important that such commitment is not taken for granted. In the face of frequent structural and organisational changes within primary care, alongside a plethora of new initiatives and responsibilities, staff can feel detached from clinical governance if they see it merely as a new form of 'management speak', detached from the realities of practice.

'Almost all chairs said that professional support was important to success, but only 61% felt that a majority of their local GPs positively supported the organisation.'

National Primary Care Research and Development Centre, 2002

Fostering a sense of belonging and of common identity has proved to be particularly challenging for PCTs which have recently come together via a merger of previously discreet PCGs, or for those which have absorbed nursing and other staff previously employed by community trusts or other NHS bodies.

In these circumstances, it is important to manage the sense of dislocation and uncertainty that staff can feel. Board level strategies must be underpinned by targeted and well-planned activities and by clearly defined leadership responsibilities for each professional group. This is essential in order to foster a sense of shared identity and to enable staff to feel part of a new and supportive 'community of practice'.

PCTs who pursue such actions purposefully and persistently, and commit adequately resourced professional and managerial leadership, demonstrate significant and tangible progress from their work.

'PCG/Ts have demonstrated significant achievements in clinical governance, particularly in the areas covered by the NSFs. They have promoted a culture of quality improvement that is underpinned by the collection and sharing of information on the quality of the services provided. However, inadequate resources, a rapidly growing agenda and continuing organisational change were felt to be obstacles to progress.'

Wilkin et al, 2002

REFLECTION

What progress has been made in fostering ownership of clinical governance across all professional groups?

Is the work of the PCT clinical governance lead supported by a named individual within each professional group?

Fostering ownership amongst all levels of support staff

The actions of every member of a PCT community have an impact (either directly or indirectly) upon the quality of the clinical care that it provides. This may not be immediately obvious to staff.

'Some team members felt that clinical governance was 'about doctors, nurses and accountants' and that administrative and support staff had little involvement or interest in the process.'

Clinical Governance Bulletin, May 2002

In reality, the provision of high-quality clinical services is fundamentally dependent upon the actions of all staff within the PCT community. Every member of staff, from receptionists to Finance Directors and CEOs, supports frontline clinical staff and patients. Many non-clinical staff work directly with patients. Unless they understand and put the precepts of clinical governance into action, real problems can occur for patients.

'Nearly one in ten (9%) patients said that someone at the surgery had made it difficult for them to see the GP for something urgent in the last 12 months.'

National Primary Care Development Team, 2002

It is vital to ensure that all staff share a common understanding of and commitment to the patient-centred care that clinical governance represents. This should become an integral part of induction programmes and help to shape the education and training agenda for support, as well as for clinical, staff.

REFLECTION

What evidence exists of a strategy to foster a sense of ownership of and commitment to clinical governance amongst management, administrative and other support staff?

Staff at the grass roots often have powerful insights into system-wide problems and difficulties that get in the way of service improvement. Often they do not feel that they have the right or the opportunity to voice their concerns or make use of their initiative; their energy and enthusiasm need to be encouraged and harnessed.

This will ensure that:

- they have a real voice in shaping and improving provision
- their contribution to the safety and quality of current services is recognised.

'Networking makes a huge difference because it gives people a better understanding of everyone else's contribution to the organisation, helping them to liaise with one another and refer patients on to provide more seamless care.'

Mary Clarke, Director of nursing and quality improvement at City and Hackney PCT

Empowering staff to make clinical governance a reality

The Board and PEC have a vital influence upon the culture of their PCT. Their actions and their concerns exemplify the organisation's priorities and its values. If staff feel empowered and supported within the culture established by the Board and PEC, they will build on this foundation by taking the initiative and assuming responsibility for improvement.

REFLECTION

What support is being given to emerging leaders from clinical services to help them take on these new roles and responsibilities?

What evidence is there that the culture of the PCT fosters staff initiative and empowerment?

'A real shift in the balance of power will not occur unless staff are empowered to make the necessary change. The cultural shift needed will, in many ways, be more crucial to the success of the project than new management structures.'

Department of Health, 2001

This cultural shift implies a system-wide movement away from top-down, command styles of organisational management to more incorporative styles that place authority as well as responsibility in the hands of key front line staff.

'PCTs, NHS Trusts and Strategic Health Authorities will need to develop new ways of working that involve clinicians in all levels of decision making.'

Department of Health, 2001

Only where this is genuinely the case within the culture and practices of a PCT will it be possible to secure concrete and sustainable improvements in the quality of care that patients receive.

'Empowerment comes when staff own the policies and are able to bring about real change.'

Department of Health, 2001

Fostering ownership of clinical governance within the patient population and in the local community

Patient and public involvement in all aspects of service planning and delivery is a core principle of clinical governance. Patients and local communities will only be able to play a full and active part in these processes if they understand clinical governance – and the rights, entitlements and responsibilities that flow from it.

Boards and PECS must develop strategies to promote a wider understanding of these rights and responsibilities. There must also be clear delegation of responsibility to ensure that these strategies are implemented.

At the micro-level, patients (and their carers) must be active and informed partners in their own care. At the macro level, the Board and PEC must ensure that the new mechanisms of consultation and participation make a significant, sustained and evidenced impact upon patterns and quality of care.

'Giving front-line staff and patients the opportunity to think and work differently to solve old problems in new ways is the only way to deliver the improvements set out in the NHS Plan.'

Department of Health, 2001

REFLECTION

What evidence is there of active steps to foster an understanding of clinical governance rights, entitlements and responsibilities with patients and the local community?

Caring for the carers

The staff group of almost every health care organisation is both its most costly and its most precious resource. Just as it would be folly for a business to fail to service and care for costly machinery, so it is folly for any organisation which depends upon people (many with scarce expertise) to fail to care for and invest in them.

'The commitment and the dedication of staff in the NHS must be valued and acknowledged: those caring for patients must themselves be supported and cared for.'

Bristol Royal Infirmary Inquiry, 2001

The Board of a PCT must recognise and act upon its 'duty of care' for the safety and well-being of its staff, and of the staff of its sub-contracting practices (albeit this is a joint responsibility shared with those practices that directly employ staff).

'[Boards must ensure] that staff feel valued, that they share in the policy discussions about developing clinical governance, and that management is seen to be trying to tackle their problems and concerns as well as seeking their ideas for improvement and innovation.'

Halligan and Donaldson, 2001

This 'duty of care' is enshrined in employment and health and safety law and extends to all employers, whether in the public or the private sector. 'HR in the NHS Plan' and the new 'Work Life Balance' initiative include powerful messages which need to be recognised and acted upon by NHS organisations. This fact is underlined by the enforcement orders imposed in recent months by the Health and Safety Executive on two NHSTs that had failed to monitor or adequately manage the impact of work-related stress upon their staff populations.

PCT Boards must actively review the impact upon staff of the tasks that make up their work. By its nature and as a consequence of its context, caring imposes strains and stresses upon those who provide care.

'**Stress inducing factors in the clinical world:**

- Workload
- Organisational change and organisational culture
- Dealing with patients' suffering
- Fallibility, uncertainty, and the impact of mistakes and litigation
- Personality and customs'

BMA Health and Policy Economic Research Unit, 2000

Boards and PECs convey powerful practical messages to staff about a PCT's commitment to quality in the way that the organisation pro-actively takes steps to safeguard and promote emotional as well as physical well-being among staff.

This is more than just an expression of the humanity that should characterise all behaviours in the NHS. It is a pragmatic and necessary safeguard of 'sustainable quality'. Caring for others who are often in extreme physical, psychological and emotional/spiritual need can, over time, impose a cumulative strain upon those who provide care. Unless they are themselves valued and supported, their capacity to provide a consistent and high level of service will be inexorably eroded.

'Too long a sacrifice

can make a stone of the heart'

Yeats, 1920

To retain staff, and to enable them to give of their best, PCTs must be sensitive to the pressures under which staff operate and the likely consequences if steps are not taken to alleviate problems.

'A recent survey of general practitioner retirement (n=650) found that a quarter of respondents planned to retire before age 60. The main reasons for early retirement were 'changes in the NHS' given by 53% and 'patient demand' given by 45%. Other reasons were 'health, including stress' (36%) and 'dissatisfaction with role' (24%). .... In a study that employed the Hospital Anxiety and Depression scale psychiatric distress was found in 48% of general practitioners.'

Health and Social Care Quality Centre, 2002

Though most PCTs had responded positively to the Improving Working Lives initiative so far as their own employed staff were concerned, this will need to feature in the ways that they approach new GMS (nGMS) implementation. Many PCTs also need to give serious attention to the burden carried by their senior executives and by those clinicians who are taking active PEC and clinical governance leadership roles. Non-Executives have a particular responsibility for monitoring and managing this burden of demand.

REFLECTION

What evidence exists to show that active steps have been taken to ensure that appropriate emotional as well as physical care and support is provided for staff within the PCT community?

Priorities for action

Now that you have finished reading through this section, please identify three key priorities for action that would help to foster ownership of clinical governance across the PCT community and then compare your list with the checklist below.

1

2

3

Checklist: Fostering ownership of clinical governance

Please highlight or tick each issue when it has been considered.

Is there a 'benchmark' against which progress can be measured?

Is there a clear strategy for fostering understanding of and commitment to clinical governance across ALL of the staff groups within the PCT community?

- Do all members of the Board and PEC know about it?

Is the process of implementation of this strategy 'project managed'?

- Is there clear delegation of responsibility and authority?
- Is the strategy adequately resourced?
- Are there clear and realistic action plans?
- Is there an indicative timetable?

Is the project and its impact kept under regular and active review?

Are outcomes, emergent issues or major obstacles to implementation reported back to the Clinical Governance Committee and through them to the Board and PEC?

References

BMA Health Policy and Economic Research Unit 2000. *Work Related Stress Among Senior Doctors – a Review of the Research*, London: BMA.

Bristol Royal Infirmary Inquiry 2001. *Learning from Bristol:The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995*, BRI Inquiry Final Report, Bristol: BRI Inquiry

Clinical Governance Bulletin, April 2001. vol 2, no 1.

Clinical Governance Bulletin, May 2002. vol 3, no 1.

Department of Health 2000. *An Organisation with a Memory: report of an expert group on learning from adverse events in the NHS*, London: Stationery Office

Department of Health 2001. *Shifting the Balance of Power within the NHS: Securing delivery*, London: DH

Department of Health 2002. *Managing for Excellence in the NHS*, London: DH

Halligan, A. and Donaldson, L. 2001. Implementing Clinical Governance: turning vision into reality (Education and Debate), *British Medical Journal*, 322, 1413-1417

Health and Social Care Quality Centre 2002. *Dysfunctional Clinicians: The clinical governance challenge*, Workshop in London

Kennedy, R. 2002. Quoted in Raising the game in primary care. *Health Service Journal*. Supplement 14 November

Kotter, J. P. 1995. Leading Change: Why Transformation Efforts Fail, *Harvard Business Review*, Mar/Apr

Martin Shelly, Clinical Governance Lead, North West Leeds PCT

Modernisation Agency Guide to Organisational Culture. Work in progress – due to be published early Summer 2003 email Jay.Bevington@ncgst.nhs.uk

National Primary Care Research and Development Centre 2002. *National Tracker Survey of Primary Care Groups and Trusts 2001/2002: Taking Responsibility?* Manchester: NPCRDC

National Primary Care Development Team 2002. *The National Primary Care Collaborative: The First Two Years*, Manchester: NPCDT

Mary Clarke, Director of nursing and quality improvement at City and Hackney PCT.

W.B. Yeats 'Easter 1916'

Resources

Commission for Health Improvement (CHI) aims to improve the quality of patient care in the NHS
www.chi.nhs.uk

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

Doctors.net.uk is a peer-led organisation created to improve health care through modernising medical communication throughout the UK, ensuring all doctors have access to the best medical knowledge, and reducing costs for medical organisation wishing to use the Internet to disseminate information.
www.doctors.net.uk

HR in the NHS Plan – a quarterly briefing bulletin is available at:
www.doh.gov.uk/hrbulletin/nhs-qrt-plan-nov.pdf

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

National Clinical Governance Support Team (CGST) runs a series of programmes to support the implementation of clinical governance 'on the ground'.
www.doh.gov.uk/clinicalgovernance/cgst

National Institute of Clinical Excellence (NICE) – the site contains details on the Institute, its ongoing work programmes, the methodology and processes it uses, the guidance it has issued to date, copies of all press releases and the minutes and papers from its Board meetings.
www.nice.org.uk

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

National Primary Care Research and Development Centre is funded by the Department of Health for health services research and development in primary care. The Centre is leading research on the development of PCTs and includes the National Tracker Survey of PCGs and PCTs (now complete); National Database of PCGs and PCTs; and a number of focused studies including clinical governance and topics covered by this programme.
www.npcrdc.man.ac.uk
Publications line: 0161 275 0611

The National Primary Care Development Team – the NPDT team helps to address access and service improvements for patients.
www.npdt.org.uk

National Staff Opinion Survey – guidance for NHS Trusts and PCTs on carrying out the National Staff Opinion Survey: NHS staff survey 2002-2003 is available on
www.doh.gov.uk/hrinthenhs/staffsurvey.htm

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.

4.1 To what extent does the Board and PEC have an explicit strategy for embedding ownership of clinical governance across all sections of the PCT community?

4.2 To what extent do all members of the PCT community currently have a common understanding of clinical governance?

4.3 To what extent is there clear responsibility for leadership of clinical governance within all professional groups within the PCT?

4.4 To what extent does the current culture empower all staff to take initiatives aimed at quality improvement?