West Gloucestershire NHS
Primary Care Trust

A Clinical Governance Strategy – an interim report.

The future for Clinical Governance in the West Gloucestershire Primary Care Trust, 2002 and beyond.

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1. Introduction

The agenda for quality improvement set out in *A First Class Service* provided both an opportunity and a challenge for all health professionals and managers working in the NHS. At the heart of this agenda is a requirement for NHS organisations, such as the West Gloucestershire Primary Care Trust (WGPCT), to seek to improve and assure quality through a system of clinical governance, underpinned by modernised professional self-regulation and extended life-long learning. *A First Class Service* also set out a package of proposals to set and monitor national standards through mechanisms such as National Service Frameworks, the National Institute for Clinical Excellence and the Commission for Health Improvement.

The Application for the West Gloucestershire Primary Care Trust (WGPCT) outlined plans for the development of clinical governance and discussions took place between the Primary Care Group (PCG) clinical governance leads and the Director of Public Health about plans for the county and a paper was drafted in September 2001. This paper outlined key areas and the plans for development, they included:

- Responsibility and accountability
- Audit
- Evidence based practice
- Workforce planning and development
- Education and training
- Risk management
- Identifying and remedying poor performance
- Research governance

In order to address the clinical governance agenda, these outline proposals have been taken forward by the new Primary Care Trust (PCT) Clinical Governance Project Group, which was established in December 2001 to develop a clinical governance framework and consider means of implementation for the new WGPCT.

This report is the outcome of a series of four meetings with a multi-disciplinary group of professionals representing the WGPCT and consultation with relevant countywide groups. The project groups' shared objective was to develop a clinical governance framework for the WGPCT in collaboration with primary and community service providers, included hosted services.

The following report should be considered as an interim position statement with recommendations for the next steps and the future. The report outlines structure, reporting mechanisms and communication arrangements. It also sets out recommendations for process to deliver the clinical governance agenda and the resources required.

The clinical governance framework will need to be developed in liaison with the new Professional Executive Committee (PEC) member with a lead for clinical governance, the proposed Clinical Governance Steering Group and locality representatives. Those responsible for clinical governance for the new Trust will also need to establish links with the countywide groups that are likely to continue – Research Governance, Clinical Audit, Support Group, Primary Care Clinical Governance Group and the Clinical Governance Forum.

The strategy and framework for the WGPCT will also need to account for national clinical governance arrangements, proposals and reporting requirements.

2. Executive Summary

Progress with clinical governance is currently necessarily variable within predecessor organisations of the Trust, both across professions and localities; this indicates that a framework that health care professionals and managers can sign up to is required for the future to ensure that all health care professionals are engaged and able to take forward the clinical governance agenda. Clinical leadership that will champion the new clinical governance framework for the WGPCT will be essential, appropriately supported by an experienced manager with administrative support systems and adequate funding (for the management, implementation and essential support from clinical staff).

In order to achieve a coherent approach to quality improvement and the championing of good practice and performance there needs to be an agreed strategy for the new West Gloucestershire PCT. This strategy needs to be negotiated and agreed with key clinical staff and embraced by health care practitioners that deliver health care services in west Gloucestershire.

Clinical governance should give health professionals the lead in planning how to provide the best care they can. It is an opportunity for health care professionals to take charge of the quality agenda while at the same time providing the accountability that is now expected of them. Practitioners have a responsibility to demonstrate improvement; some of which are clinically measurable, but often changes are less tangible or can be measured in other ways.

The Project Group identified that the key issues for the PCT are:

- To recognise that clinical governance is not only about doctors, but that it is imperative that the full range of health community workers within the PCT are engaged and supported. For health care workers to see clinical governance as an essential part of everyday good quality practice.
- To significantly invest in clinical governance in order to meet the challenges and take forward this important agenda. The level of investment will almost certainly determine the quality of and speed at which progress occurs.
- To establish a new, multidisciplinary Clinical Governance Steering Committee with strong clinical leadership, with appropriate managerial and administrative support.
- For patient centred care needs to be at the heart of the organisation and that patients are well informed and participate in their care.
- To engage and support the clinical governance lead professionals and provide appropriate support and training to all staff as required.
- To ensure there are clear lines of accountability for clinical quality systems with effective processes for identifying and managing risk and addressing poor performance.
- For good practice and research evidence to be systematically adopted and for success and good practice to be celebrated
- To ensure that clinical governance has systematic, education based qualitative, measurable improvements in clinical practice and that the implications for data collection, processes and systems to support the framework need to be recognised.
- To ensure that clinical governance issues are embedded in new policy development and in commissioning and contractual arrangements with service providers.
- To be adequately prepared for internal and external assessment such as The Commission for Health Improvement review (CHI).
- To agree to continue with countywide arrangements such as audit and research governance.
- To review the current clinical governance meetings, activities and plans across the Trust and agree a coherent and corporate approach.

The Project Group categorised issues in order to take matters forward and recommend that development al areas are identified to reflect these areas of clinical governance as follows:

- Patient focus
- Quality standards and initiatives
- Communication
- Education, training and development
- Appraisal
- Audit and clinical effectiveness
- Research
- Risk management
- Uni-professional groups
- Locality working
- Countywide groups

Recommendations are made in the strategy for how each of these areas may be taken forward by the steering committee with a multi-disciplinary and cross county representation.

Clinical governance should be seen as fundamental to good quality service provision and integral to the vast range of activities that are undertaken by practices and health care professionals. Clinical governance priorities should also be incorporated into the new practice development plans. There is already a good deal of clinical governance activity that has been undertaken and this must be celebrated, but there is still scope for improvement and development and it is envisaged that the Steering Committee will provide direction, establish priorities, provide support and guidance and ensure that this strategy is implemented in close association with those that deliver care.

The implementation of the framework will require a good deal of investment, not only in terms of funding but also in terms of commitment and a willingness to change and embrace good practice. It is therefore reasonable that the PEC and Trust Board is kept informed of progress and outcomes from this investment and that a sound reporting mechanism is established.

Advancement with clinical governance will need to be planned carefully and incremental in nature, the speed of advancement will be related to the level of investment that is available and the drive for change. With limited capacity to deliver such a big agenda, there will be a need to set local priorities for achieving changes in line with clinical governance requirements. These priorities need to be established with appropriate consultation with grass roots staff to ensure that they remain committed and engaged.

The Steering Committee and those involved in delivering the clinical governance agenda will need to be realistic about the level of resources available and the competing demands for funds. They will need to consider means of implementing the clinical governance agenda within limited resources, prioritise demands and activity and be creative about how the clinical governance issues can be incorporated into everyday life for practitioners.

A good start has been made in creating an embryonic infrastructure for clinical governance and a range of activities have been initiated, but translating this into an enduring culture of quality improvement will require adequate resources and positive commitment from primary and community health care professionals and the PCT Board.

This paper sets out a proposed structure, a way forward and identifies a range of issues that need to be addressed in the coming year.

3. The PCT and the Clinical Governance Project Group

A great deal of discussion has taken place with a range of professionals within the new Trust to understand how clinical governance 'feels' for staff now, to consider how health care professionals can be engaged to take ownership of the clinical governance agenda, how managers can provide support and enable systems to support clinical governance, and to take account of the significant shift in culture required to embrace all that clinical governance entails.

One of the key messages is that clinical governance is not only about doctors, but that it is imperative that the full range of health community workers within the PCT are engaged and supported. The other principle implication is that of resource, the PCG/T has already committed resources to support clinical governance, but the proposed framework requires significant investment in order to meet the challenges and take forward this important agenda. The level of investment will almost certainly determine the quality of and speed at which progress occurs.

It should be recognised that health care professionals in west Gloucestershire have made significant steps with clinical governance. They have been undertaking clinical governance activities for some time although they may not necessarily have been tagged with the clinical governance 'label'. There has been a notable shift in culture and ethos in relation to clinical governance activity.

Since 1998 when clinical governance plans for the NHS were formalised, a range of activities have taken place, although advances vary between professional groups, practices and localities. The areas of development include:

- Protected Learning Time (PLT) funded with GP practices undertaking discussion groups and training sessions both at individual practice team level, and as a locality
- Countywide audit had been initiated in 1990, with strong links for some professions
- A formal baseline assessment (based on the Manchester Model) of the current position for clinical governance took place in Gloucester and Tewkesbury PCG. The approach for the Forest locality was less structured.
- Involvement in work associated with the launch of NSFs
- Some practice based risk assessments have been undertaken
- Countywide panel established to assist with managing poor performance for doctors
- Leadership training for clinical governance leads planned for February 2002
- Training and development 'away days' for practice staff
- Nexus Training and Education survey undertaken in 2001 in Gloucester
- Staff review and appraisal for some professional groups e.g. allied health professionals
- Accident and incident reporting for community nurses
- Training and professional development plans for some practitioners
- Complaint handling
- Health and safety assessments for some professionals
- Decontamination on procedures audit in NHS Trust and GP practice premises
- Significant event audit
- Dental practitioners accessing funds for continuing professional development and allocations provided for establishing a practice based quality assurance system (15 practices since June 2001). From May 2001 it was a requirement for all dentists to undertake 15 hours of clinical audit or peer review over a 3-year period, further work should be undertaken to audit progress and undertake baseline assessment.

Other work undertaken by the PCG/T has notable links with clinical governance. The Primary Care Collaborative work has been instrumental in changing and implementing good practice and in encouraging an environment in which good practice is shared and supported and in which practices work together and share experiences. Care pathways for a range of clinical issues, such as hip replacement and heart attacks, have encouraged liaison between primary and

secondary care, introduced best practice and made a difference to the quality of care we provide for our patients.

The WGPCT Clinical Governance Group was established in December 2001 and has met on four occasions to consider the framework and implementation plans for the Trust. The group is multi-disciplinary and representative of the range of practitioners working within the West Gloucestershire area.

The Clinical Governance Group had clear terms of reference; they considered the ethos of clinical governance, what it will encompass, how it might be implemented, what would be best practice and how the structure might work. The following report sets out the proposals from this group.

4. The national picture

It is important to take account of the national picture and how our local clinical governance arrangements can be integrated into national initiatives and to ensure that we are in a position to respond to information and review requirements. There are a range of NHS organisations that play a significant part in developing and driving forward the clinical governance agenda.

Professor Liam Donaldson, Chief Medical Officer, defines clinical governance as "A system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish."

National guidance indicates that clinical governance should be a 'whole system' process, which has a number of features:

- Patient centred care needs at the heart of the organisation. That means patients are well informed and participate in their care.
- Good information about the quality of services available to those providing the services as well as to patients and the public.
- Variations in the process, outcomes and access to health care are greatly reduced.
- NHS organisations and partners work together to provide quality assured services and drive forward continuous improvement.
- Doctors, nurses and other health professionals work in teams to a consistently high standard and identify ways to provide safer and even better care to their patients.
- Risks and hazards to patients are reduced to as low a level as possible, creating a safety culture.
- Good practice and research evidence is systematically adopted.
- Celebration of success and good practice

Above all, though, clinical governance is about the culture of NHS organisations. A culture where openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received. (*A First Class Service)*

The NHS clinical governance support team
The NHS clinical governance support team was established at the end of 1999 to support the implementation of clinical governance across the NHS. They are a multi-disciplinary team, with members drawn from every corner of the NHS, including primary care, nursing, research, communications, management, acute medicine, clinicians and education.

Their main aims are:

- To support the development of clinical governance in the NHS
- To raise the profile and provide information about clinical governance
- To create, capture and spread ideas and good practice in clinical governance

The support team advise that national guidance is expected to support PCTs in preparing clinical governance frameworks, unfortunately this guidance is not yet published and the time scale is uncertain.

The Commission for Health Improvement (CHI)
CHI defines clinical governance as the system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care, including a patient centred approach, an accountability for quality, ensuring high standards and safety and improvement in patient services and care.

In time the PCT will be subject to review by CHI. The CHI review looks at the effectiveness of the NHS organisation's clinical governance arrangements. NHS organisations are selected for a clinical governance review on a random basis and on recommendations from the Regional Offices in England and the National Assembly in Wales. They will look at:

- Trust strategies for clinical governance
- Clinical governance partnerships with, for example, university, primary care, other NHS trusts, social services
- Quality of service provided by the organisation
- Trust plans for clinical governance
- Professional and practice plans for clinical governance
- Consultation and patient involvement
- Clinical risk management
- Clinical audit
- Research and effectiveness
- Use of information
- Staffing
- Education, training and continuing personal and professional development
- Best practice
- Areas for improvement
- Management and structures for clinical governance

In CHI's first annual report, published in February 2002, they reinforce their statutory role to provide external and independent scrutiny of national standards delivered locally through clinical governance. In 2000/01 their review of health authorities and primary care identified inadequate computerised information systems, improvements needed in staffing and education issues related to training, variable arrangements for tackling poor performance and the need to recognise the challenges for staff in relation to organisational change.

The National Patient Safety Agency (NPSA)
Promoting patient safety by reducing error is becoming a key priority of major health services around the world. In the UK an expert group was formed on learning from error and adverse events in the NHS. The group published a report *Organisation with a Memory* in 2000 - the Government agreed to implement all recommendations made in the report.

At its core are plans to establish a new national reporting system to record adverse events and near misses in health care and ensure that lessons learnt in one part of the NHS are properly shared with the whole of the health service. A new independent body, the National Patient Safety Agency (NPSA), established as a Special Health Authority on 2 July 2001, will run the new reporting system.

The implementation document *Building a Safer NHS for Patients* sets out a blueprint for the national reporting system to be operated by the NPSA. The national system is being tested through selective pilots at limited sites across the country to reflect a health care community that reflects the range of organisations that work together and are geographically and organisationally tied.

Their targets include all NHS Trusts and a significant proportion of primary care to be providing information to the national system, and for levels of reporting to have doubled in the NHS, by December 2002.

The National Institute for Clinical Excellence (NICE)
The role for NICE is to set clear national standards of what patients can expect to receive from the NHS. NICE will help promote clinical and cost effectiveness through guidance and audit, to support front-line staff.

NICE will be responsible for looking at the setting, delivering and monitoring of standards in the Trust. They promote the links with clinical governance, patient and public involvement, lifelong learning, professional regulation and dependable local delivery of services. NICE works alongside CHI, National Service Frameworks and National Patient and User Surveys.

There are opportunities for grass root staff to feed back to NICE. The PCT should be encouraged to interact with and respond to NICE guidance and reviews.

The National Collaborating Centre for Primary Care
The National Collaborating Centre for Primary Care is based at the Royal College of General Practitioners, and involves the following partners:

- Royal College of General Practitioners
- Royal Pharmaceutical Society of Great Britain
- Community Practitioners and Health Visitors Association
- School of Health and Related Research, Sheffield University

Most notably in relation to clinical governance,

- Clinical Governance Research and Development Unit, Department of General Practice and Primary Health Care, University of Leicester.

The National Primary Care Research Centre (NPCRDC)
This is a Department of Health funded initiative based at the University of Manchester. The NPCRDC is a multi-disciplinary centre, which aims to promote high quality and cost-effective primary care by delivering high quality research, disseminating research findings and promoting service development based upon sound evidence.

The work of the centre is based on three themes:

- Variations in health and the provision of primary health care: a population based approach.
- Primary care organisations: governance, budgets, workforce and partnerships.
- Quality of primary care.

The King's Fund
The King's Fund is an independent health care charity. They carry out research, development and educational work in health and social care. Currently King's Fund have instigated a Primary Care Programme, the main focus of this programme is the development of PCG/Ts and the quality of provision in London. Work has been set in train both to assist and to assess PCG/Ts progress in the development of primary and community care, the effective commissioning of hospital services and improving the health of the populations they serve.

The National Clinical Assessment Authority (NCAA)
Set up by the government to support the assessment of poorly performing doctors, they have a framework in place to providing advice to local organizations and undertaking assessments where problems cannot be resolved locally. Our local Support Group has been established in recognition of the value of this resource.

Local implications
Although there are a number of national bodies as outlined above and a range of initiatives nationwide to address clinical governance in PCTs, there is little formal guidance on developing clinical governance frameworks in primary and community care. The National Clinical Governance Support Group have advised in January 2002 that formal guidance is expected from the Department of Health, however it is not yet available and the time scale for publication is not clear.

The WGPCT will clearly need to take account of the range of national initiative, new frameworks, likely reporting requirements and proposals for formal review in relation to clinical governance.

5. The clinical governance agenda – local interpretation

Considering the range of clinical governance activity that has already taken place and the national imperatives to take the clinical governance agenda forward, the clinical governance requirements for the Trust should not be underestimated, the range and complexity of issues are significant and include:

- Patient focused practice and initiatives
- Safeguarding and maintaining high standards
- Quality improvement
- Sharing best practice
- Communication (practitioners, staff, patients and carers)
- Involving patients and carers
- Patient advocacy
- Evidence based practice
- Education
- Audit
- Clinical Effectiveness
- Research Governance
- Research and Development
- Professional development
- Professional accreditation
- Performance review
- Appraisal
- Workforce and succession planning
- Managing risk (practicing safely)
- Significant events - review & audit
- Incident reporting
- Handling and learning from complaints
- Data collection, management, interpretation and reporting
- Responding to national initiatives, frameworks and directives

In practice it is anticipated that clinical governance activity will progress most effectively with a practice and locality based framework, although there will inevitably be projects that will be specific to professional groups across the PCT . Those with a lead role for clinical governance and their teams will require:

- Access to experts (individuals or groups)
- Access to relevant organisations
- Advice and support
- Management support

- Administrative support
- Access to the Steering Committee and key leads for topical areas.
- Links to other project groups e.g. Audit, R&D, and countywide groups.

The Project Group have categorised the above issues and recommend that development areas be identified to reflect these areas of clinical governance as follows:

5.1 Patient focus
5.2 Quality standards and initiatives
5.3 Communication
5.4 Education, training and development
5.5 Appraisal
5.6 Audit and clinical effectiveness
5.7 Research
5.8 Risk management
5.9 Uni-professional groups
5.10 Locality working
5.11 Countywide groups
5.12 Managerial support

Clinical Governance Steering Committee
The recommendation of the Clinical Governance Project Group is that a single Steering Committee is established to oversee, support, direct and monitor the above range of issues and to determine clinical governance priorities for the Trust. The membership and terms for the new committee are outlines in section 6.1.

The Steering Group will be large due to the necessary representation of all professional groups, but it is not an appropriate forum for taking the more detailed clinical governance agenda forward effectively. It is proposed that members of the Steering Committee would take on a lead/contact role for each of these areas; this may be on a shared basis.

The Steering Committee must have clinical leadership and will be chaired by the PEC lead for clinical governance, they will need to be supported by a full time clinical governance manager with administrative support. Other representatives, members of staff or expert professionals may be co-opted as required in order to address their particular needs.

Programmes for development may be delivered locally, in a wider group, by professional group or any other appropriate forum. Delivery may be managed within existing resources or may require external expertise.

The Developmental Areas:

5.1 The patient focus
The patient focused elements of clinical governance include patient advocacy, involving patients and carers and developing patient focused practice.

A patient and public involvement group has already been established for the WGPCT, chaired by one of our non-executive directors. This work should link in with the work of the CG Steering Committee. The development of local public involvement should enable the power to influence local priorities, consideration needs to be given to how this might be balanced with the conflicting priorities that may arise from meaningful public participation and Trust or national plans.

5.2 Quality standards and initiatives
This work will encompass safeguarding and maintaining high standards, sharing best practice, quality improvements and evidence based practice. Those involved will need to liase closely with colleagues working with National Service Frameworks (NSFs) and audit frameworks. Sharing of

good practice should be encouraged and PLT events and perhaps a website would enable practices and health care professionals to do this.

The methods by which standards are set and maintained will be influenced by local and national policy. The steering committee will need to consider how best to monitor and support standards of care.

5.3 Communication

This work will address the vital issues around communication for practitioners, staff, patients and carers. Communication with patients and carers will assist in developing public confidence in the NHS and listening to the views of local people. Communication with staff will reinforce the message that quality is everybody's business and emphasise team working across professions and organisations.

The WGPCT patient and public involvement initiative will be key to ensuring that the Trust embraces the views of our community, patients and carers. A link to clinical governance will be imperative.

Many staff have requested an intranet tool to enable good communication in relation to clinical governance – access to policies and procedures, Q&A page, publishing and celebrating good practice, sharing ideas etc. There are significant resource implications if it is to be effective and kept up to date.

5.4 Education, training and development

Education, training and development will focus on several areas, such as the future of protected learning time and many other issues such as professional development, accreditation, education and workforce planning.

It will be important to re-focus the format and funding for protected learning time to ensure that all health care professionals are included and supported. Training for those that take on these key lead roles will need to be adequately trained and supported.

Training will be required for a range of staff, not just clinical governance lead personnel. There is also an overarching educational issue with regard to 'grass roots' staff and the proposal to re-launch clinical governance – what it means to them, the communication and reporting mechanisms and the delivery of the new framework.

Workforce planning can also be linked to this work – identifying deficiencies, enhancing skills of existing staff and planned development of staff, providing a set of skills and competencies to fit the circumstances and deliver the quality agenda.

A business case is being prepared for a Clinical Academy in Gloucestershire. Although initially this was based upon a medical proposal to enhance educational facilities and services, the PCTs are particularly keen to ensure this facility is available to all health care workers/professionals.

5.5 Appraisal

The project group agree that appraisal should be a positive and developmental process for individual clinicians, aimed at supporting good patient care and high standards of clinical practice.

There is a wide-ranging difference between professionals within our locality on the progress with appraisal, from little or none at all to full systems of review, appraisal, personal and professional development plans. It will be beneficial if processes are established locally and nationally for sharing learning about effective appraisal. A local pilot for GP appraisal in Gloucestershire is planned for April 2002. The national scheme starts at this time too.

The resource implications for introducing and implementing a successful appraisal system across all professions needs to be debated and assessed – consideration needs to be given to the time required to undertake appraisals, be appraised and to implement agreed personal or professional development plans. The resource implications for GPs alone is significant as it is estimated that GPs will require between 4 – 6 hours for both appraiser and appraisee.

For performance related issues, there is a countywide Support Group that meets to support GPs that are subject to complaints and/or poor performance issues. The recommendations of the project group are for this to continue on countywide basis and that the PCTs consider means of extending this support to other professional groups.

5.6 Audit and clinical effectiveness

Audit programmes have been in place for many years and the approach has been largely educational, bottom up and reflective. The Primary Care Audit Group (PCAG) has been successful in taking forward a varied and successful audit agenda across a range of disciplines. They have been valuable in establishing benchmarks and generating new protocols. The audit programme has been increasingly influenced by central initiatives such as NSFs.

It is planned for a Gloucestershire wide audit forum to continue, it is likely that their programme will be increasingly influenced by the new PCTs. The Cheltenham and Tewkesbury PCT is 'hosting' clinical audit and the new audit group is currently reviewing their terms of reference, membership, etc. It is envisaged that the audit group will include practitioners and managers from across the county and that there will be a new structure with a local audit officer supporting each PCT. The group has agreed that there should be formal links with PCT clinical governance committees.

There will need to be a strong link between the countywide audit group and the clinical governance steering committee and it is hoped that audit will include collaborative, multi-disciplinary programmes.

The Trust will need to take account of the resource implications for supporting staff that can collect, understand, interpret and share data.

5.7 Research and development

The Department of Health Research Governance Framework for Health & Social Care published in March 2001 seeks to promote improvements in research quality and sets out the responsibilities and standards that must be applied to work managed within the formal research context. The Gloucestershire Research and Development Support Unit (RDSU) is currently providing a countywide service supporting and advising all local Trusts, particularly the developing Primary Care Trusts, on the implementation of this framework.

The new NHS organisation within Gloucestershire provides huge scope for increasing Research & Development activity, not only within the acute Trust, but within the Partnership and Primary Care Trusts. Whilst exciting new opportunities will undoubtedly arise, it is vital that this increased activity meets the standards set within the framework.

The Research Governance personnel based at the HA are currently leading a countywide research governance group including representatives from all Trusts, a paper is being prepared with recommendations for the local interpretation and implementation of the Research Governance Framework. They are also bidding to the Regional Office for a countywide Research Governance Manager and a Clinical Trials Unit.

The recommendation of the WCPCT Clinical Governance Group is that Research and Development should remain a separate countywide group that embraces acute and community care across geographical areas. Strong links need to be forged between the countywide group

and the WGPCT clinical governance steering group who should monitor and shape the implementation of the research governance framework for the Trust. The R&D lead for the PCT will need to be identified.

5.8 Risk management (clinical)

The project group feel that there is a significant amount of work to do in reviewing and developing clinical risk management plans and activities for the Trust –organisationally, practice wide, uni-professionally and individually.

It is understood that there is likely to be a separate Risk Management Committee for the Trust that will report into a WGPCT Governance Committee. This group will address such matters as health and safety, security, medical devices management, emergency planning, infection control and Caldicott Guardians.

The work with the Clinical Governance Steering Committee will focus on clinical risk management including incident reporting, reviewing procedures, implementing evidence based, practicing safely, adverse outcomes of care and addressing deficiencies in service provision.

Complaints

Complaints review and management is also likely to require a separate PCT committee, the relationship with the clinical governance steering committee will need to be clarified in due course. WGPCT are hosting complaints management.

Incident reporting

The introduction of clinical governance provides NHS organisations with a powerful imperative to focus on tackling adverse health care events. The report, *Organisation with a memory (2000)* sets out to review what we know about the scale and nature of serious failures in NHS health care, to examine the extent to which the NHS has the capacity to learn from such failures when they do occur and to recommend measures which could help to ensure that the likelihood of repeated failures is minimised in the future.

There is a range of issues for the PCT to consider with the plans for introducing robust arrangements for incident reporting:

- Creating a 'no blame' culture where staff and patients feel able to report incidents and positive steps are taken to address and respond to reports.
- As an element of the new clinical governance framework, link with plans for complaint reporting systems and risk management.
- As an employer, particularly with new and additional responsibilities related to the hosting of new services such as physiotherapy, speech therapy and occupational therapy.
- As a provider of health care services – need for good reporting systems, sharing and learning from incidents, robust management of systems, dealing with outcomes, training and embedding lessons into practice.
- As a commissioner of health care services – monitoring the adverse occurrences of the service providers
- In relation to developing incident reporting systems for the independent contractors, particularly GPs and the team of staff they employ and who work alongside other health care professionals and care providers in the community.
- Be in a position to respond to the demands of national bodies such as the Commission for health Improvement (CHI) and the National Patient Safety Agency (NPSA). For example, the NPSA has a target for all NHS Trusts and significant proportion of primary care to be providing information to the national system by December 2002.
- Take account of H&S, MDA, HSE and other statutory requirements and how the system can incorporate these.

5.9 Uni-professional groups and lead groups

There will undoubtedly be a requirement for uni-professional groups to be established to take forward clinical governance issues that are specific to a profession, for example addressing the recommendations in the recently published *Clinical Governance in Community Pharmacy.*

Professional bodies are developing their own systems for clinical governance; these will need to be dove-tailed into the Trust responsibilities and the work of the Clinical Governance Steering Committee.

In addition there will be a need to maintain the group for practice clinical governance leads, at present this is on a locality basis but should be adapted to become a Trustwide group.

5.10 Locality activities

The Steering Committee will need to consider the current locality activity that is in hand. Plans have already been made for 2002 for Forest and Gloucester localities separately. The recommendation of the Project Group at present is that the momentum for clinical governance activity should not be interrupted and plans in hand should be permitted to continue. However the activities in each locality should be reported back to the Steering Group and one of the objectives of the Steering Group must be to review this arrangement and make recommendations for the future.

5.11 Countywide clinical governance groups

In addition to the speciality countywide groups referred to above such as Audit and Research, there are two other countywide clinical governance groups:

- The Gloucestershire Primary Care Clinical Governance Group
- The Gloucestershire Clinical Governance Forum

The Primary Care Group meets quarterly and the members of this group met last on 19th February and are recommending that this group continue, along with the Forum, which includes representatives from across the health community in Gloucestershire. It is intended that this combined group will maintain continuity and ensure communication is effective across the county and all health care organisations. Sally Pearson has agreed to prepare a paper for Project Directors/Chief Executives in March to recommend a host PCT for these groups and outline terms of reference and membership of these groups.

Relationships within the health community will need to be nurtured in the new NHS structure and countywide groups that communicate, collaborate and share good practice should be encouraged.

5.12 Managerial and administrative support

The Clinical Governance Manager will need to support the Steering Committee and any short life working groups that may be required, in addition attendance at other countywide groups will be needed. Assistance will be required with PLT and taking forward the work described in this section. At the present time it is considered to be possible for a full time manager with full time administrative support to be able to provide the necessary support initially in 2002/03, this will only be possible with the assistance of lead clinical personnel from the Steering Committee and other clinical/operational staff within the PCT.

6. Responsibility and accountability

It will be essential to ensure that all employed and contracted staff (frontline to the Board) understand and engage in the clinical governance agenda and to feel that they have ownership of the new framework. They need to be aware of the important and valuable work that has taken place and that needs to be done. This will require consideration to be given to clinical governance being incorporated into job descriptions, performance reviews, and objectives.

The DoH have published a corporate governance framework and recommended that Trust Boards establish a range of committees, including the requirement for the Executive Committee to establish sub-committees for risk management and clinical governance

The clinical governance project group are of the firm view that the clinical governance steering committee has a direct reporting link to the Professional Executive Committee (PEC) in order to keep clinical governance high on the Trust's agenda and have direct contact, reporting and guidance from the clinicians and key executive directors.

The PEC will have the overview of Trust activity and priorities and will need to be responsible for managing the risk of 'policy overload', which can be a barrier to effective clinical governance.

6.1 The proposed Clinical Governance Steering Group

The membership and leadership of this group will be instrumental in the success of taking forward the clinical governance agenda for the Trust.

A clinician who is a champion of the clinical governance framework and should be a credible clinician with an ability to form opinions must provide leadership. The members of the Clinical Governance Steering Group should clearly understand the importance of their role in assisting with implementing the framework and representing their profession.

Although it is important to have 'grass roots' representation it is also important to ensure that the representative is able to influence and implement changes in practice. Excellent consultation and communication networks with their colleagues across the PCT will be imperative.

The Clinical Governance Steering Committee membership should be:

- PEC Clinical Governance Lead (Chair)
- General Practitioner
- Senior nurse/manager
- Practice Nurse
- District Nurse
- Health Visitor
- Hospital Practitioners (Doctor and Nurse)
- Pharmacist
- Dentist
- Optometrist
- Allied Health Professional
- Audit (co-opted as required)
- Public health Advisor
- Educationalist
- Practice Manager
- Clinical Governance Manager

The professional groups should nominate representatives and the term of membership may be limited, with optional rotation after two or three years. It is imperative that clinical governance knowledge, expertise and change management skills can be passed down so that the committee is self-sustaining and that changes in representation does not cause stalling of the agenda.

The Steering Committee needs to be chaired by the PEC lead for clinical governance, but there is likely to be a requirement to have a 'lead' for localities and for professional areas of development, this needs to be discussed further and recommendations made. The Steering Committee will need to be able to influence the PEC and the Trust Board. This committee is likely to need to meet monthly for about 3 months to clarify objectives and determine roles, responsibilities and priorities, and then continue to meet quarterly to direct and monitor activities and report to the PEC/Board.

Draft Terms of Reference for the new Steering Committee are attached at *Appendix 1.*
The proposed accountability and reporting structure is attached at A*ppendix 2*

The Steering Committee will need to consider the future of locality based clinical governance activity, which is already planned for 2002. There is a view that to run Trust wide events related to clinical governance would be less productive than the locality based events that have taken place to date. However, the project group are keen to promote integration of both localities and professional groups at least some of the time.

7. Moving Forward and Resource Implications

The progress with clinical governance is notable, although necessarily variable at present. And there is still much to be done! The recommendations of the project group are for the implementation on a clear framework and a move towards some standardisation across localities and professional/staff groups. A framework, priorities and targets should be agreed by the steering committee, but implementation will undoubtedly be variable

The implementation of the framework will require a good deal of investment, not only in terms of funding but in terms of commitment and a willingness to change and embrace good practice. It is therefore important that the PEC and Trust Board is kept informed of progress and outcomes from this investment and a sound reporting mechanism will need to be established.

Advancement with clinical governance will need to be planned carefully and incremental in nature, the speed of advancement will be related to the level of investment that is available and the drive for change. With limited capacity to deliver such a big agenda, there will be a need to set local priorities for achieving changes in line with the clinical governance requirements. These priorities need to be established in consultation with grass roots staff to ensure that they stay engaged.

The project group recommend that the new clinical governance framework is 'launched' within the PCT and that it is carefully communicated to all staff and practitioners within the health community. It is considered important to promote clinical governance with 'grass roots' staff, to explain what it is all about and where we are going to assist with developing a shared vision. Clinical Governance Leads across the new Trust should share a corporate identity.

The Steering Committee activities and priorities will need to be established and lead representatives for countywide groups agreed. The Steering Committee should be chaired by the PEC lead for clinical governance supported by a full time clinical governance manager with effective administrative support.

Baseline assessments

It is recommended that baseline assessments be undertaken for all practices and health care professional groups and community services. Implementation will need to be realistic and is likely to be incremental, but is essential to determine the status of all groups with progress with clinical governance in relation to professional, organisational, local or national requirements or standards.

There is a national framework for clinical governance baseline assessments for GP practices (The Manchester Model), this was adopted in the Gloucester locality, with the Forest locality using a less formal approach to baseline assessment. It is intended that this framework assist practices in making progress and work towards addressing any national requirements such as appraisal, revalidation and other such assessments.

It is not clear whether this baseline assessment framework is likely to be adopted and implemented nationally, but it is good practice to undertake such an assessment and this will be necessary for all practices, community services and professional groups and will require appropriate resources. For some the assessment will be a review rather than a initial assessment.

For example a community pharmacy baseline assessment for the county is imminent and likely to cost in the order of £10K, including the need to second/appoint a pharmacist to undertake the assessment. This countywide approach may be valid for other such assessments and may be more economical than undertaking such assessments on a PCT basis.

Once a baseline assessment is done, account needs to be taken of the need to address areas where improvements are required, maintaining and implementing good practice, meeting targets, training and development and so on.

Education and Protected Learning Time (PLT)

Investment will be required for educationalist input for GPs and other professions. This is currently not available for educational input into clinical governance, but without it the PCT would fail to deliver a high quality programme.

Funding will be needed to support primary care leads in co-ordinating and managing CG and PLT by providing training to CG Leads. For example, leadership training 2 day course for 10 GPs with Edgecumbe Consulting £4000 (Evaluation of this course to be undertaken March 2002).

PLT is currently 11 sessions/half days per annum, the recommendation is for 17 sessions per annum, but in the first instance any additional funds should be directed to those staff that currently do not have financial support for PLT.

Support and funding will be needed to develop the delivery of clinical governance in primary and community care teams. Once best practice and areas for improvement have been identified, there are often resource implications for instigating change and implementing best practice.

Resource and support is required for the programmes of primary care based PLT, at present this often only includes some practice staff and should be extended to include other health care professionals.

At present quarterly locality- wide/PCT wide events are held for both multi-disciplinary and uni-professional development. There is a need to extend the availability of PLT to all professional groups and this will require investment to release them from their patients/duties.

Appraisal and review
There is a national imperative and a local response to the need to implement GP appraisal. This has been instigated with a pilot to start to train GP appraisers at the end of April 2002. Funding will be required to implement support for appraisers and appraisees.

Appraisal also needs to include all professional groups, some are doing it well others have nothing at all. This inequity will need to be addressed. Account will need to be taken of the costs of appraisal time and then resource the outcomes of appraisals – personal learning plans and development plans.

As with many of the clinical governance issues the working groups will need to make recommendations about what proportion of activity should be absorbed in the practitioners' working time and what will require additional resources.

Audit
The countywide audit group is set to continue and is supported with central funding at present. PCTs are likely to have more influence over the audit programme and the cost implications of such programmes need to be accounted for. The starting budget for the Gloucestershire Group has been agreed for 2002/03.

Countywide groups
There are plans to continue the Primary Care CG Group and Countywide CG forum; this needs resource for attendance, which is proposed as 3 representatives from each Trust.

Research Governance
The countywide group is set to continue, representation form the Trust will be imperative and resources to implement the new national framework locally will need to be considered.

Risk management
Risk assessments have been undertaken, but the implementation is patchy and should be extended to all practices and professional groups.

Incident reporting will need resources for system management, data collection and managing outcomes, changes in practice ands so on. The Trust as an employer of existing and new staff will need to account for employer liabilities for induction, H&S etc.

The project group working to the Clinical Governance Steering Committee will focus on clinical risk management including incident reporting, reviewing procedures, implementing evidence based, practicing safely, adverse outcomes of care and addressing deficiencies in service provision. Implementing these systems and ensuring quality improvements will have resource implications. Complaints management will also need to be addressed, but this is not envisaged to be through clinical governance directly.

Managing poor performance
There is a national support agency and a countywide support panel established to assist with managing poor performance for doctors. Consideration needs to be given to the future of a countywide group (recommended) and extending this support network to other health care professionals. The meeting of this group and the outcomes such as mentoring and training or development plans will have resource implications.

National bodies
The Trust needs to be in a position to respond to the demands of national bodies such as the Commission for health Improvement (CHI) and the National Patient Safety Agency (NPSA). For example, the NPSA has a target for all NHS Trusts and significant proportion of primary care to be providing information to the national system by December 2002.

The Trust will also need to take account of H&S, MDA, HSE and other statutory requirements and how the system can incorporate and respond to their needs.

Other considerations:
There are a range of other issues that also need to be considered in relation to the clinical governance proposals:

- Appropriate attendance at CG related meetings to ensure that progress is made – resource to attend meetings and to carry out actions, monitor progress and report outcomes.
- Involvement in work associated with the launch of NSFs
- Clinical governance partnerships with, for example, university, primary care, other NHS trusts, social services
- Consultation and patient involvement and patient focused practice and initiatives
- Use of information – gathering, understanding, and interpreting and reporting data will be critical in progressing CG matters
- Good communication costs (practitioners, staff, patients and carers)
- Workforce and succession planning
- Caldicott Guardians – the recommendation is that this role lies within IM&T

Last year approximately £50K was spent on 'clinical governance' for Forest of Dean and Gloucester & Tewkesbury PCGs. Of this £14K was obtained from sponsorship. This expenditure does not include salaries, travel or training and is principally related to the protected learning time events, this expenditure does not account for the additional work undertaken by lead clinicians in their clinical governance role or for professional groups other than GPs. It is notable that companies are much less willing to sponsor events for multi-disciplinary groups and should be taken account of with financial planning for the coming year.

It has not been possible to estimate the actual resource implications for clinical governance, other than to recognise they are significant. Therefore, should the Board approve the strategy in principle then further financial assessments should be made.

8. Conclusions and recommendations

Recognising the resource implications:
The quality of and speed at which clinical governance can progress will be linked to the level of investment. However the Steering Committee and those involved in delivering the clinical governance agenda will need to be realistic about the level of resources available and the competing demands for funds. They will need to consider means of implementing the clinical governance agenda within existing resources, prioritise demands and activity and be creative about how the clinical governance issues can be incorporated into everyday life for practitioners.

The new West Gloucestershire Primary Care Trust will need to respond to the national guidance *Clinical Governance – Quality in the new NHS (reviewed March 2001)*.

This means that Primary Care Trusts will have responsibility for:

- Undertaking the four key implementation steps for clinical governance:
  - establishing leadership and accountability arrangements
  - baseline assessment
  - development plan
  - reporting arrangements
- Further developing the programme of clinical governance in accordance with the principles outlined in this guidance and taking account of further guidance which may be issued from time to time

- Ensuring that clinical governance principles are developed and applied which cover the full range of services they provide, and those that are delivered by other providers on their behalf
- Assuming joint accountability for clinical governance of services which are delivered on a multi-sector, multi-agency basis
- Establishing an open, learning relationship with bodies which may make judgements about the quality of their services or their programme of clinical governance (particularly the Commission for Health Improvement)
- Making sure that clinical governance principles are applied to services delivered by other providers on their behalf through Long Term Service Agreements and through contracts with non-NHS providers
- Supporting their member practitioners in applying clinical governance.

The preparation of a development plan/framework is embedded in this report, but the Clinical Governance Steering Committee will need to refine and develop the framework over time and in response to national guidance that is expected in 2002 from the DoH. The framework and plan will need to be prioritised; accountabilities agreed and activities and objectives made more specifically time related in order to measure progress.

Systems will need to be put in place to ensure that reporting and communication structures are functioning and to ensure that account can be made of progress. Data collection processes will need to be assessed and future requirements identified.

The interface with secondary care should continue, progress will be achieved with on-going NSF development, the Gloucestershire Clinical Governance Forum and through commissioning activity (which should incorporate clinical governance requirements of our provider organisations).

The clinical governance framework will need to be developed with full consultation with all health care practitioners. Consultation will need to include design and implementation to ensure that it is properly embedded and valued. Clinical leadership will be imperative, they should be a champion of clinical governance and an opinion-forming leader. This is required at Executive level, at the Steering Committee and at local level (clinical governance leads) to implement and embed initiatives and good practice.

There will need to be a shift in organisational culture, which is central to the success of clinical governance. The Board should consider the implications for this shift in culture and the organisational change required, bearing in mind the many organisational and policy changes that are inevitable with the emergence of the new PCT. Relationships should be forged with our partners working together to seek to improve and assure quality through a system of clinical governance

Clinical governance is requires systematic, qualitative, measurable improvements in clinical practice. The implications for data collection, processes and systems to support the framework need to be recognised. Robust reporting systems will be important to measure our success and to maintain new systems related to clinical governance.

Recommendations

The new organisation will need to recognise that in order for clinical governance to flourish there needs to be a positive approach to a gradual culture change, creating and supporting environments in which clinical governance can develop.

A clear clinical governance framework will need to be put in place, supported by the Board and the PEC, recognised and accepted by primary and community care staff and appropriately resourced in order to ensure that there is systematic quality improvement.

A good start has been made in creating an embryonic infrastructure for clinical governance and initiated a range of activities, but translating this into an enduring culture of quality improvement will require adequate resources and positive commitment from primary care professionals and the PCT Board.

The Board are asked to endorse the proposals set out in this paper, which outlines a framework for taking the clinical governance agenda forward. This report should be considered as an interim position and as the Clinical Governance Steering Committee becomes established and a range of issues such as priorities, accountabilities and reporting structures, are clarified a further position statement and recommendations put before the PEC and the Board.

The following page outlines the recommendations to the Board.

The Board are asked to:

1. Recognise that the Trust needs to appropriately and effectively invest in the clinical governance agenda and new framework in order to comply with national directives and to support the commitment to improve quality in health care.
2. Provide feedback to the Clinical Governance Steering Committee in relation to the level of investment anticipated for clinical governance, acknowledging that lack of investment will result in lack of progress and a consequential risk of a critical CHI assessment.
3. Approve the accountability and reporting structure proposed in Appendix 2
4. Endorse the recommendations of the project group to formally establish the Clinical Governance Steering Committee with the above representation and the PEC lead for clinical governance as Chair. Locality leads to support the PEC lead needs to be considered.
5. Agree that the countywide groups for Audit, Research & Development, Clinical Governance Forum and the Support Group will continue in 2002 with representation where appropriate from the WGPCT Clinical Governance Steering Committee. Host PCTs for these countywide groups is recommended and has already been agreed for the Audit Group.
6. Agree that in line with national guidance that baseline assessments and/or reviews should be undertaken as a priority. These baseline assessments need to be incremental, realistic and will require funding.
7. Agree that the half-day protected learning times should continue for 2002. The activities in each locality should be reported back to the Steering Group and one of the objectives of the Steering Group must be to review this arrangement and make recommendations for the future. The involvement of the full range of professional/staff groups must be progressed by the Steering Committee. At present funding for these protected times are for out of hours sessions for GPs only.
8. Consider the resource implications required for the programmes of primary care based PLT, at present this is different for each locality and often only includes some practice staff and should be extended to include other health care professionals. Arrangements for payment for PLT may need to be standardised.
9. Consider the data collection systems that will need to be put in place to ensure collation of information, reporting and communication structures are functioning and to ensure that account can be made of progress. E.g. incident reporting which is undertaken by Severn at present.
10. Accept papers from the Steering Committee and any other countywide groups in due course and consider recommendations for further development, action and resources.
11. Consider including a clinical governance section to all Board papers, so that clinical governance is integrated into all Trust policy.
12. Endorse the recommendation that the new clinical governance framework is ‘launched’ within the PCT and that it is carefully communicated in consultation with all staff and practitioners.
13. Endorse the development of the WGPCT website to enable improved communication and sharing of information around clinical governance activity.
14. Agree to make arrangements for clinical governance issues to be appropriately incorporated into objectives for all staff.
15. Ensure that clinical governance issues are incorporated into contractual arrangements with providers and other contractors.
16. Consider the arrangements for adverse incident reporting arrangements
17. Note that the PCT needs to be in a position to respond to the requirements of national bodies such as the Commission for health Improvement (CHI) and the National Patient Safety Agency (NPSA).
18. Agree that the Caldicott Guardian role should lie within the IM&T/finance directorate.

Appendix 1

Clinical Governance Steering Committee

Draft Terms of Reference

N.B. Updated in December 2002

1. Purpose

To develop and implement the Clinical Governance framework for the West Gloucestershire Primary Care Trust, in collaboration with primary and community service providers, including hosted services.

2. Terms of Reference

- To develop the values and purpose of clinical governance in the new organisation

- To develop and monitor the Clinical Governance Framework for the West Gloucestershire Primary Care Trust, which is consistent with the PCT's application. This will need to include:

    - Clear lines of Responsibility and Accountability
    - Comprehensive Programme of Quality Improvement
        - Clinical Audit
        - Supporting and Implementing Evidence Based Practice
        - Workforce Planning and Development
        - Developing quality standards and initiatives
    - Education and Training Plan
    - Risk Management
    - Appraisal systems
    - Identifying and Remedying Poor Performance
    - Research Governance
    - Baseline assessments

- To agree the framework for implementation for 2002/03 and beyond, to be launched in January 2003.

Notes:

- It should be explicit that Health & Safety is addressed as part of Risk Management and that there is a relationship to Complaints & Compliments.
- The work of identifying and remedying poor performance, refers to staff that are employed by the PCT and individual practitioners working within the PCT area.
- Arrangements should be in place to ensure that clinical governance is inherent in staff contracts and service level agreements with providers.

- Where services are purchased from non-NHS bodies Service Level Agreements must ensure that satisfactory Clinical Governance structures are in place within the provider organisation.
- Existing countywide groups – audit, research governance, support group and clinical governance forum – should continue in the medium term.
- Readiness and response to internal and external review and validation will be essential.

3. Membership

- PEC, Clinical Governance Lead (Chair)
- GP
- Public Health Advisor
- 2 nominations from Community Hospitals (1 nurse, 1 doctor)
- Practice Nurse
- District Nurse
- Health Visitor
- Senior Nurse/Manager
- AHP
- Local General Dental Practitioner
- Local Optometrist
- Local Pharmacist
- Educationalist
- Practice Manager
- Audit representative co-opted as required
- PCT Clinical Governance Manager

The first meeting will take placeby July 2002.

Appendix 2 of Appendix A
West Gloucestershire Primary Care Trust
Proposed Clinical Governance Structure and Reporting Framework