Improving Quality And Safety: Progress In Implementing Clinical Governance In Primary Care

Amongst GPs and Primary care nurses in England

Report produced for The National Audit Office by Medix

Main Report

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1 SUMMARY OF FINDINGS

- The average annual spend on clinical governance among GP respondents who could answer was £2,214.
- Only 2% of the GPs sampled were aware that their practice had undertaken a cost benefit analysis of the impact of clinical governance.
- More than a third of the GP respondents (35%) and almost two thirds of nurses (61%) felt they received appropriate induction training on joining their practice.
- The majority of the GPs (90%) and nurses (82%) surveyed have had their CPD requirements identified.
- Almost all the GP respondents (96%) received an annual (NHS) peer appraisal and 85% of nurse respondents do so.
- 28% of GPs and 46% of nurses said that their practice had been visited by their local Patient and Public Involvement Forum.
- Three quarters of nurse respondents (76%) believed that their practice or organisation had adequate leadership in place to implement clinical governance.
- A third of the nurse respondents (67%) considered that their practice or organisation had arrangements in place for addressing poor performance.
- The majority of GP respondents felt their practice's performance appraisal process for staff to be effective, with 23% considering this to be extremely effective.
- Virtually all respondents practice's (GPs, 99% and nurses, 100%) had a complaints process in place.
- The majority of the nurses sampled (85%) believed that there were processes in place for learning from patient complaints.
- Almost three-quarters of the nurse respondents (72%) had been informed of the outcome of complaints.
- About half of the GP respondents (53%) were routinely informed of the outcome of complaints received by the PCT.
- The majority of respondents practice's (GPs and nurses, 80%) had a risk management policy in place
- Almost all of respondents practice's had an incident reporting system (GPs, 94% and nurses 96%).
- 63% of GP respondents and 69% of nurse respondents had previously reported an incident.

- Among respondents who had previously reported an incident, the mean number reported in the last twelve months was 2.8 for GPs and 2.9 among nurses.
- Approximately one third of the GP respondents (32%) and just over a half of nurse respondents (56%) routinely reported adverse incidents to their PCT.
- A minority of GP respondents (4%) routinely reported adverse incidents to the NPSA and 19% of the nurses surveyed do so.
- The majority of respondents (GPs, 84% and nurses, 89%) had a clinical audit programme in place.
- 50% of the GP respondents who had a clinical audit programme included one multi-disciplinary audit agreed by the PCT and 60% had participated in clinical audit activity to benchmark performance.
- Approximately one third of the GP respondents (32%) said their practice encouraged patient involvement through a patient panel.
- A small proportion of the GP respondents (15%) felt clinical governance had helped them to deliver efficiency benefits.
- Five aspects were rated on an effectiveness scale by the GP respondents. Support provided by PCTs to help implement clinical governance in practices rated the lowest among the respondents.
- The effectiveness of GP practice's for taking action to address serious clinical risks and also for learning lessons from patient safety incidents, rated the highest.
- Also given a high rating by GPs was their practice's evaluation of complaints to improve the safety and quality of care.
- The systems and processes for engaging with patients and public in the GP respondents' practices faired reasonably well but not as effective as the previous three aspects.
- Among the GP respondents the main elements of clinical governance that have improved the quality and safety of care included the reporting of incidents, communication, and also the guidelines associated with clinical governance.
- The nurses surveyed responded in a similar way, also citing meetings and other support.
- Among both GPs and nurses the lack of time is considered to be the main barrier to implementing clinical governance. Also considered were the lack of finances, resources and the lack of expertise.
- The need for time was highlighted by the majority of GPs as the key factor required in developing clinical governance in their practice. Financial aspects and guidance or leadership from PCTs also ranked high.

- The need for training and education ranked the highest for nurse respondents. The need for support from management and also time were ranked high.

- Examples of how clinical governance has made a difference and other comments about clinical governance are included verbatim in the appendix.

2 INTRODUCTION

The introduction of clinical governance in 1998 was designed to introduce a systematic approach to the delivery of high quality health care. A duty of quality was placed on NHS organisations in the 1999 NHS Act. This introduced corporate accountability for clinical quality and performance. Clinical Governance is a 'whole system' process which has a number of features.

- Patient centred care needs are at the heart of every NHS organisation. This means that patients are kept well informed and are given the opportunity to participate in their care.
- Good information about the quality of services is available to those providing the services as well as to patients and the public.
- Variations in the process, outcomes and in 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 for their patients.
- Risks and hazards to patients are reduced to as low a level as possible, creating a safety culture throughout the NHS.
- Good practice and research evidence is systematically adopted.

The importance of the philosophy - patient centred, safety conscious, multi-disciplinary in delivery, is emphasised along with the methods to be used such as continuous improvement at a number of organisational levels tackling variation and using evidence.

By definition, a system is an 'entity that maintains its existence and functions as a whole through the interaction of its parts' (O'Connor and McDermott, 1997). Systems awareness and thinking looks at the whole process, as well as the parts, of healthcare delivery, and the relationships between them.

(O'Neill, S., Clinical Governance in Action part 8: Systems Awareness. Professional Nurse, February 2001, 16(5): 1074-1075.)

A widely used definition of clinical governance is the following:

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."

(G Scally and L J Donaldson, 'Clinical governance and the drive for quality improvement in the new NHS in England' BMJ (4 July 1998): 61-65)

3 RESEARCH OBJECTIVES AND METHODOLOGY

The objective of the survey was to assist the NAO in their comprehensive assessment of what has been achieved through implementing the clinical governance initiative in PCTs. The survey was designed to determine what lessons have been learned and what more needs to be done. In particular to research whether the NHS is achieving improvements in patient care.

The survey covered four main areas:

1. About the respondent and their practice
2. Ensuring the quality and safety of care to patients
3. Ensuring the quality and safety of their practice
4. Respondent experiences and other comments

The survey was conducted online between the 29th of November and 10th December 2005. All members of Medix who are GPs and Primary care nurses in England were invited to participate. The survey was closed when 503 GP and 54 Practice nurse responses had been gathered.

4 RESULTS

The main findings from the 503 GPs and 54 Practice nurses are detailed in this section.

4.1 ABOUT THE RESPONDENT AND THEIR PRACTICE

4.1.1 Sample demographics

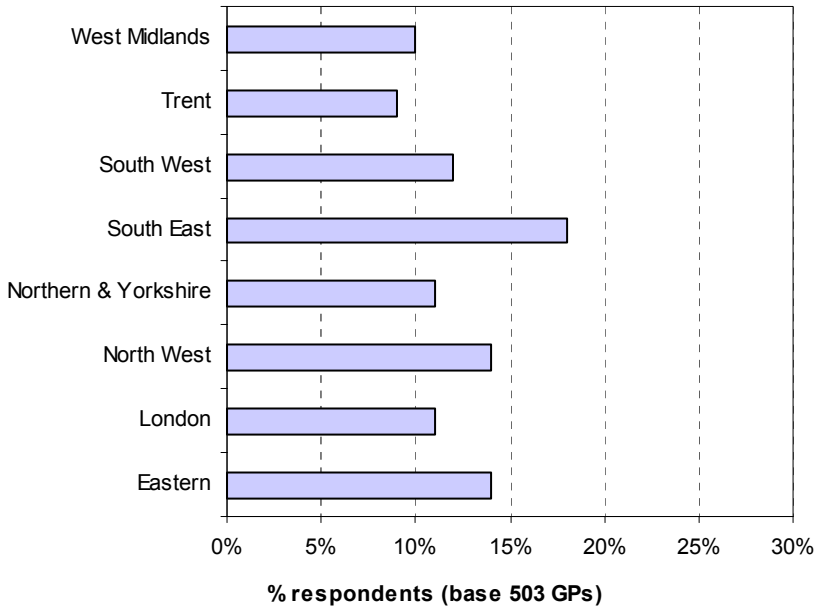
The majority of the GP respondents were Partners; 83% fell into this category. The remainder included Salaried doctor, Registrar and Locum grade. Seventy-eight percent of participants were full-time, 11% work three-quarters of the time, 7% half-time, and the remaining 4% less than half-time.

Twenty-two of the Primary care nurses (41%) were Practice nurses, a total of eight were either Nurse Practitioners (15%) or District nurses (15%). The remaining sixteen nurse respondents included Community nurses (9%) and PCT Nursing Staff Members (6%).

In terms of region, Figure 1 indicates the division of GP respondents across the NHS regions. Each region of England was represented in the survey. For the purposes of analysis, respondents also placed themselves into one of four regions and the split for these was as follows; 27% in the North, 31% in the Midlands and Eastern, 31% in the South, and 11% in London.

For the Primary care nurses the split was as follows for the four regions: 20% in the North, 33% in the Midlands and Eastern, 35% in the South, and 11% in London.

Figure 1: GPs - NHS region in which organisation / practice is located



The majority of the GP respondents primarily work in Practices, with 98% falling into this category. Fifty-nine percent of respondents qualified as a doctor more than 20 years ago, 27% between 11-20 years ago, and 14% in the last 10 years.

Over half of the nurse respondents (56%) primarily work in GP Practices and 37% in the Primary Care Trust.

Respondents were asked how long they have worked in their current practice or organisation. For the GP respondents, 26% have done so for more than 20 years, 35% between 11-20 years ago, and 39% in the last 10 years.

Seven percent of the nurse respondents have worked in their current organisation for more than 20 years, 20% between 11-20 years, 28% between 6-10 years, and 44% in the last 5 years.

Approximately three-quarters of the nurse respondents (76%) indicated that their practice had allocated specific responsibility for clinical governance to a named individual. Respondents were asked to specify the position held by this particular individual. Eleven out of the forty-one who could respond (27%) said it was the GP. Other positions included Clinical Governance Lead (12%) and Practice Manager (7%). Many positions were included in the other category and included variations on the term Clinical Governance, for example Head of, Director, Facilitator and Manger.

Just four of the nurse respondents (7%) said there was no named individual responsibility for clinical governance and nine (17%) did not know.

4.1.2 Annual spend on clinical governance

Eighteen percent of the GP respondents could not answer or did not know how much their practice spends annually in providing clinical governance processes and arrangements. The results to this must be interpreted carefully. Of the 411 respondents who answered, 23% indicated that nothing was spent. The average spend among the 411 respondents was £2,214. Nineteen percent of respondents have an annual spend of one-thousand pounds (this being the most frequent response) and 7% spend ten-thousand pounds or more annually. The highest spend was thirty-thousand pounds, this figure indicated by two respondents.

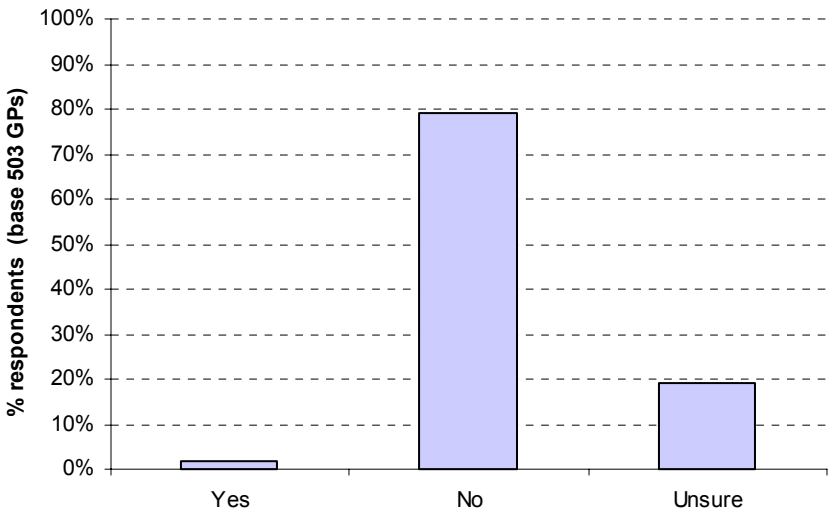
There were regional differences in the annual spend on clinical governance and also differences with regard to when the respondents qualified as a doctor. The figure for the average annual spend among GP respondents in the Midlands and Eastern was the highest with £2,456, and for those located in the North the annual spend was the least with £2,004. Only 13% percent of GPs who qualified in the 1970s did not know how much was spent, compared to 22% who qualified in the 1960s and 39% who have qualified since 2000. The annual spend figure was much lower for the latter groups, namely £1,382 (qualified in the 1960s) and £1,839 (2000s) compared to £2,488 (1970s) and £2,349 (1980s).

4.1.3 Cost benefit analysis of the impact of clinical governance

The majority of GP respondents, 79%, indicated that their practice has done no cost benefit analysis of the impact of clinical governance. A quarter of respondents were unsure and a small number, just eight (2%) had indeed done a cost benefit analysis.

There were no meaningful regional differences in the result. In regards to the decade qualified, respondents who qualified in the 1970 and 1980s were more certain that no cost benefit analysis had been undertaken, i.e. 84% and 88% respectively, whereas respondents who qualified in the 1960s or 2000s had a tendency to be more unsure, i.e. 44% and 61% respectively.

Figure 2: GPs - Awareness of a cost benefit analysis of the impact of clinical governance



The eight respondents who had undertaken a cost benefit analysis were asked the results of the analysis. The responses varied with seven of the eight being positive; just one respondent mentioned an '*Insignificant benefit*'. Examples of the positive responses include:

- Better practice
- Generally was improved by changes implemented. Some however [e.g. statin prescribing] difficult to assess long term cost benefits at a practice level
- The money is spent on essentials; the governance issues we are told (sic) by the PCT to address are rarely, if ever, funded

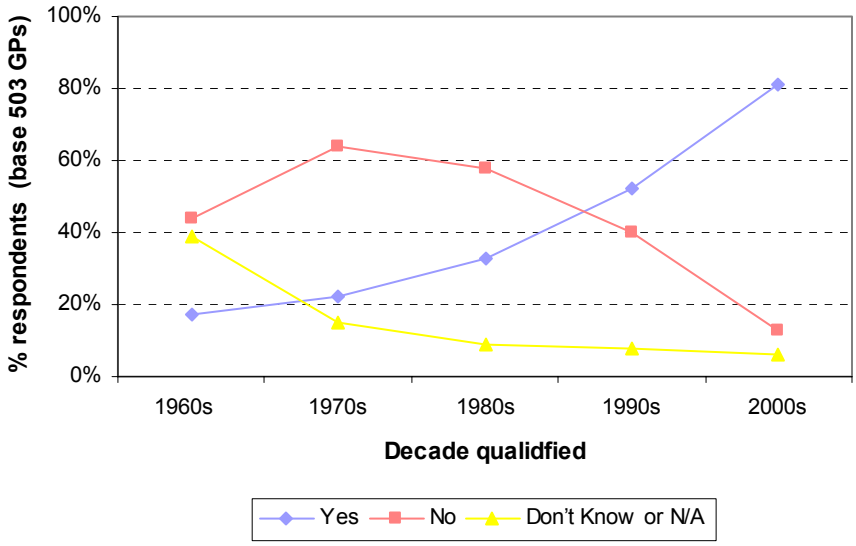
Among such a small number it is impossible to draw any further conclusions from regional or decade qualified analysis.

4.2 ENSURING THE QUALITY AND SAFETY OF CARE TO PATIENTS

4.2.1 Training and appraisals

Just over one third of the GP respondents (35%) received appropriate induction training on joining their practice. The results were broadly similar across the regions. From the GPs who qualified in the 1960s all the way through to the most recently qualified GPs there was a continual increase in the number who have received appropriate induction training on joining their practice.

Figure 3: GPs - Appropriate induction training by decade qualified

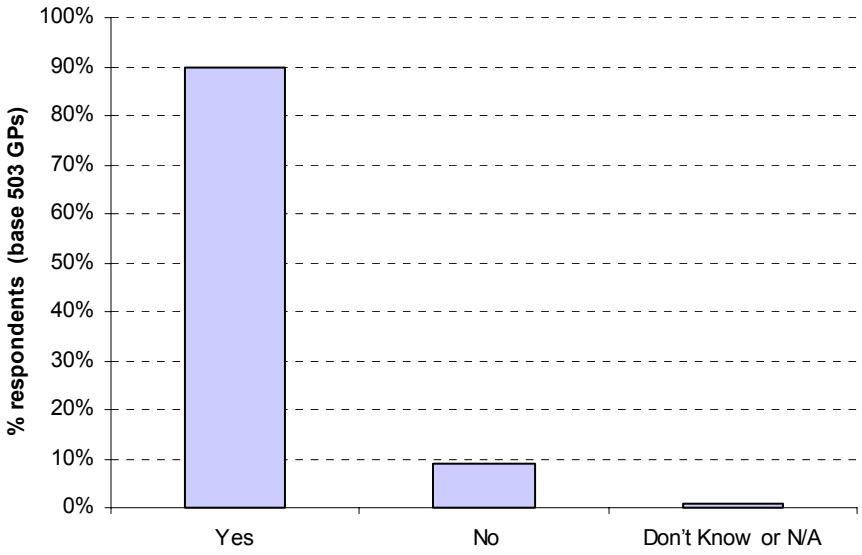


The majority of nurse respondents (61%) felt they have received appropriate induction training. A third (33%) considered they had not and 6% did not know.

Seventy-eight of the nurse respondents were provided with protected time to attend training courses, compared with 17% who were not. Forty-eight of the fifty-four nurse respondents (89%) felt they received appropriate training in respect of the roles they are asked to perform. Nine percent felt they do not receive appropriate training.

The vast majority of the GP respondents (90%) have had their Continuing Professional Development (CPD) requirements identified. There was little variance in the regional or decade qualified analysis.

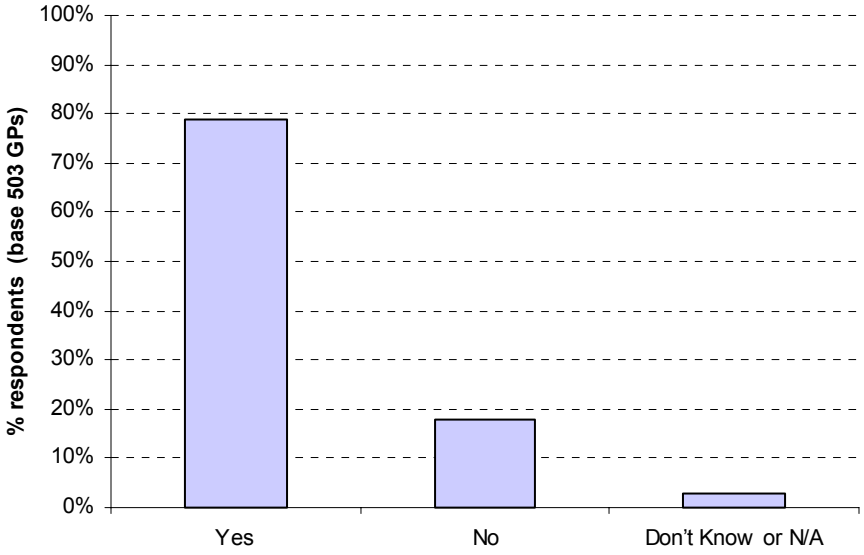
Figure 4: GPs - CPD requirements been identified



A lower but not wholly different percentage of the nurse respondents (81%) felt they have had their CPD requirements identified.

Seventy-nine percent of GP respondents felt there were arrangements in place to meet their CPD requirements; however 18% felt there were no arrangements in place. There was little variance in the regional or decade qualified analysis.

Figure 5: GPs - Arrangements in place to meet your CPD requirements

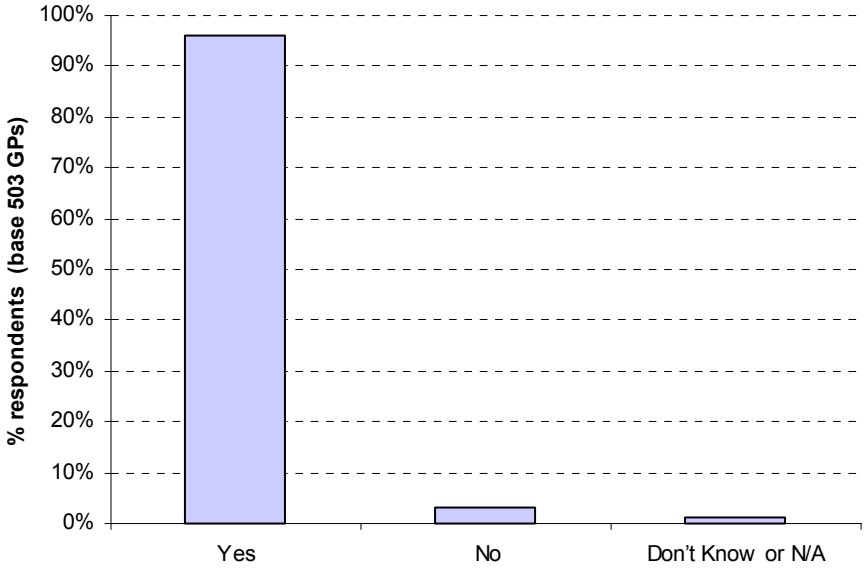


The nurse respondents were similar to the GP respondents for this category, with 76% indicating arrangements were in place to meet their CPD requirements, whilst 20% advised that no arrangements were in place.

The nurse respondents were asked if they had received specific clinical governance training. Fifty-two percent indicated they had not, compared to 44% who indicated they had. Four percent did not know.

Almost all the GP respondents (96%) receive an annual (NHS) peer appraisal. The results were very similar across the regions. Of note, all the GPs who qualified in the 1960s receive an annual appraisal which contrasts with only three-quarters of respondents qualified in the 2000s. However, this may be because a higher number of those who have qualified in the 2000s have not as yet experienced an annual (NHS) peer appraisal.

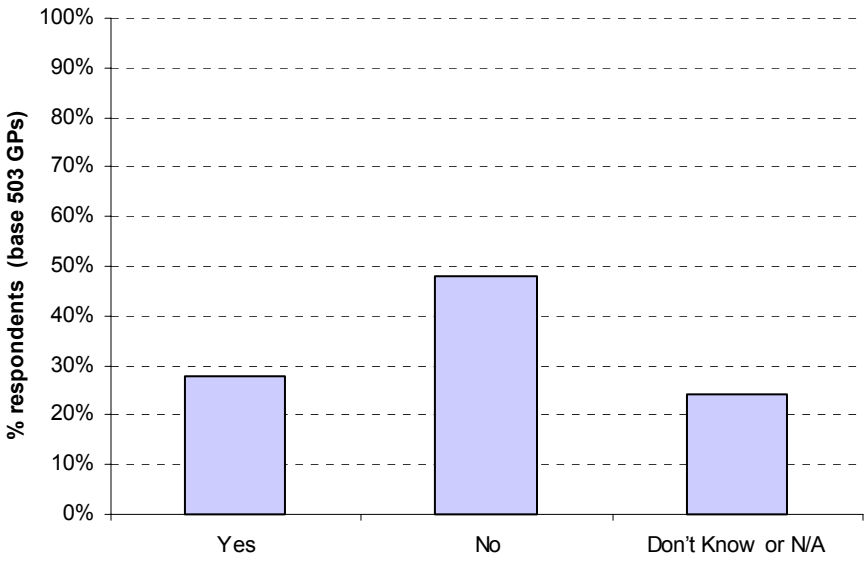
Figure 6: GPs - Receive annual (NHS) peer appraisal



The nurse respondents were asked if they receive a performance appraisal at least on an annual basis. The majority (85%) indicated they do receive such an appraisal and the remaining 15% do not.

Just over a quarter (28%) of the GP respondents thought their practice had been visited by their local Patient and Public Involvement Forum. Almost half of the respondents (48%) believed they had not and around a quarter (24%) did not know. There was very little variance in the regional or decade qualified analysis.

Figure 7: GPs - Practice visited by your local Patient and Public Involvement Forum



A larger number of the nurse respondents (46%) were aware that their practice or organisation had been visited by their local Patient and Public Involvement Forum. Nine-percent said there had been no visit and 44% did not know. Half of the nurse respondents also said that their practice or organisation had other formal interaction with patients and the public. Of the remaining in half, 30% said they did not and 20% did not know.

Forty-one of the fifty-four nurses surveyed (76%) felt their practice or organisation had adequate leadership in place to implement clinical governance. Eight respondents (15%) felt they do not and 9% do not know.

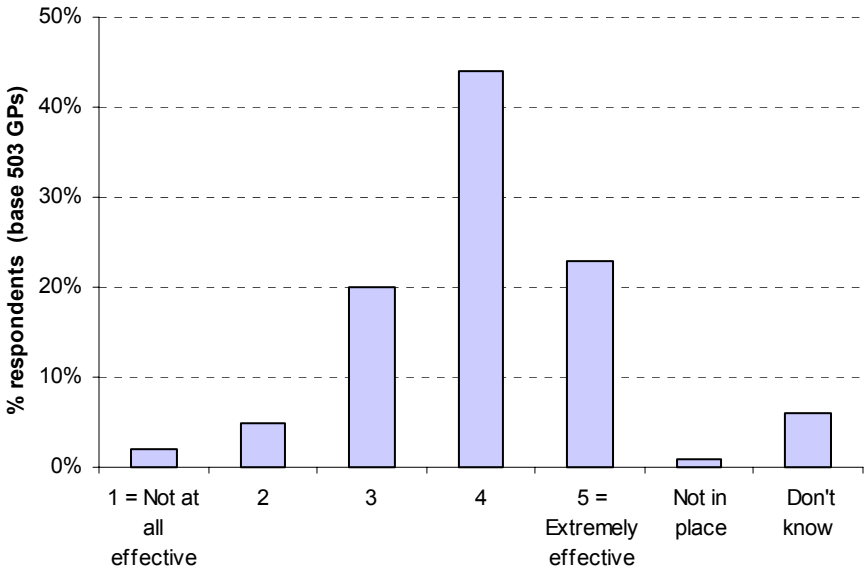
Approximately one third of the nurse respondents (67%) considered that their practice or organisation had arrangements in place for addressing poor performance, 11% did not feel they had whilst almost a quarter (22%) did not know. Almost all of the nurse respondents (98%) believed their practice or organisation to have a clean and safe environment in which to provide patient care.

4.2.2 Effectiveness of the performance appraisal process for staff

The majority of the GP respondents acknowledged that their practice's performance appraisal process for staff was effective, with 67% answering either 4 or 5. Figure 8 shows the responses for this question among all the GP respondents.

Regional differences were relatively small. However, GPs in London appeared to rate the effectives of their performance appraisal process for staff slightly lower than the other regions, with 61% giving a rating of either 4 or 5. The other regional percentages for those rating 4 or 5 were; North 65%, and Midlands and Eastern 69%, and South 68%.

Figure 8: GPs - Practice's performance appraisal process for staff



The nurse respondents considered their practice's performance appraisal process as less effective than their GP colleagues. Seven percent of GPs selected 1 or 2, whereas three times this number of nurse respondents (22%) did so. The nurse respondents who selected either 4 or 5 accounted for 59%, compared to 67% for GP respondents.

4.3 ENSURING THE QUALITY AND SAFETY OF YOUR PRACTICE

4.3.1 Complaints process, risk management and incident reporting

The respondents were asked a number of questions related to the quality and safety of their practice.

Nearly all the GP respondents' practices (99%) had a complaints process in place; just three respondents did not know. Similarly, almost all the respondents' practices (97%) investigate complaints to help identify safety and quality issues.

All the nurse respondents believe that their practice or organisation has a complaints process in place. Forty-six of the fifty-four nurses questioned (85%) also think that there are process in place for learning from patient complaints. Thirteen percent of the nurses did not know.

Approximately three-quarters of the nurse respondents (72%) had been informed of the outcome of complaints and a quarter (24%) had not. In the last year, 80% of nurse respondents' practices or organisations had undertaken a patient satisfaction survey.

Over half of the GP respondents (53%) are routinely informed of the outcome of complaints that are received by the PCT. A quarter of respondents (25%) are not routinely informed and a quarter of respondents (23%) don't know. There were regional differences in response to this question. Sixty percent of GP respondents in the North are routinely informed by the PCT, compared to 55% in the South, 49% in the Midlands and Eastern region and 39% in London.

When analysing the results by decade qualified it appeared that the longer ago a respondent qualified the more likely they are to be routinely informed of the outcome of complaints that are received by the PCT. The percentage of GPs responding *yes* decreased continuously from the 1960s to 2000s, i.e. 72%, 54%, 53%, 50% and 39% respectively. The highest percent answering don't know (39%) were for GPs who had qualified in the 2000s. As mentioned previously, the reason for GPs in the 2000s not knowing is due to having not experienced this yet.

The majority of the GP respondents' practices (80%) have a risk management policy in place and the remainder of the respondents are divided evenly; 9% do not have such a policy in place and 11% do not know either way. Any variation between regions and decade qualified were insignificant.

Almost all the respondents' practices (94%) had an incident reporting system in place. The other respondents are split; 3% don't have an incident reporting system and 4% do not know either way.

With regard to a risk management policy and incident reporting system, the nurses responded in almost the same way to their GP colleagues. Forty-three respondents (80%) had a risk management policy in their practice or organisation and fifty-two (96%) had an incident reporting system in place.

4.3.2 Incident reporting

The GP respondents were asked if they had ever reported an incident. Sixty-three percent had and 34% had not. A small number (2%) did not know. GPs in London are the least likely to have ever reported an incident (50%) and GPs in the Midlands and Eastern are the most likely to have done so (68%). Unsurprisingly, respondents qualifying most recently, in the 2000s, include the highest percent for GPs who have never reported an incident. GPs qualifying in the 1980s are most likely to have done so (72%). Figure 10 presents the results by decade qualified.

Figure 9: GPs - Ever reported an incident

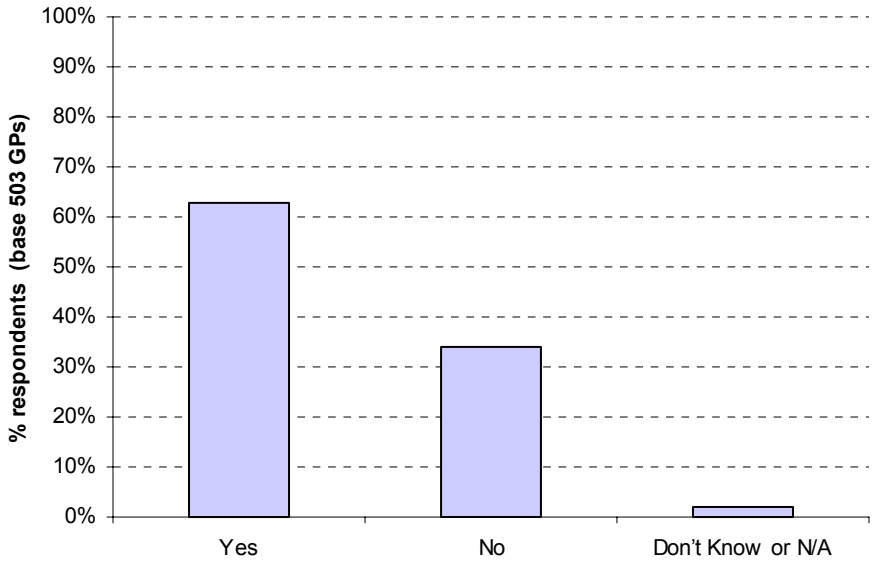
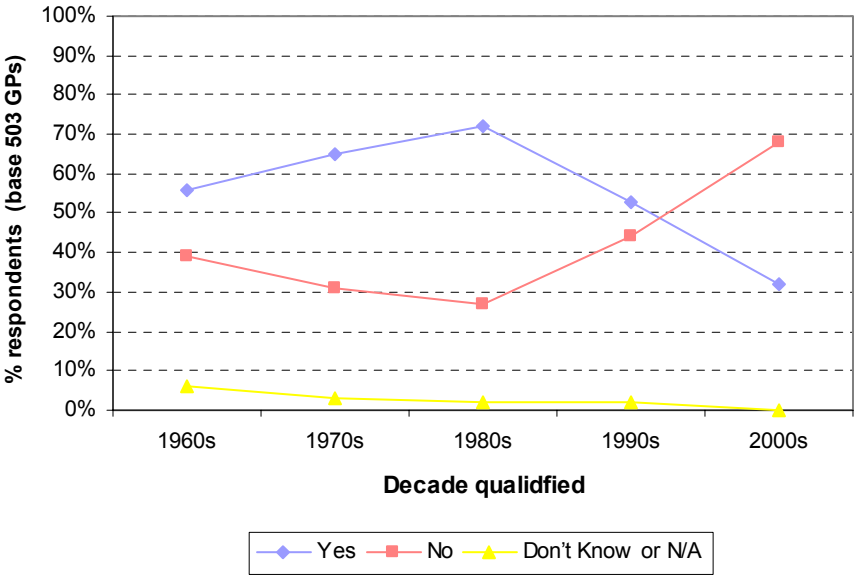


Figure 10: GPs - Ever reported an incident



Of the 318 GP respondents who had ever reported an incident, 10% had not personally done so in the last twelve months. The mean number of incidents personally reported in the last twelve months was 2.8. Twenty-seven percent of the respondents had done so once, 26% had reported an incident twice and 15% three times. Four percent of this group had reported an incident on ten or more occasions in the last twelve months, and the highest two figures were 25 and 30 incidents reported, each by one respondent.

The tables below summarise the mean number of incidents personally reported in the last twelve months across the regions and by decade qualified.

Figure 11: GPs - Mean number of incidents personally reported in the last twelve months

	All	Region			
		North	Midlands and Eastern	South	London
Sample base	318	89	105	97	27
% of total GP sample	63%	65%	68%	62%	50%
Mean number of incidents reported in the last 12 months	2.8	2.9	2.7	2.9	2.1

Figure 12: GPs - Mean number of incidents personally reported in the last twelve months

	All	Decade Qualified				
		1960s	1970s	1980s	1990s	2000s
Sample base	318	10	96	154	48	10
% of total GP sample	63%	56%	65%	72%	53%	32%
Mean number of incidents reported in the last 12 months	2.8	3.4	2.8	2.8	2.7	1.8

The 318 GP respondents were also asked if anything had changed in their clinical practice as a result of reporting incidents. Respondents were able to respond to this question in an open-ended way. Many respondents answered ‘yes’ or ‘no’ and did not elaborate or explain further. Through analysing the open responses it was found that for 80% of the sample (254 of the 318 respondents), clinical practice has changed as a result of reporting incidents. The ‘changes’ that had occurred were wide-ranging. The highest change, accounting for 15% of the 254 responses, included ‘new protocols, procedures or processes’.

Five percent of the respondents who have seen changes in clinical practice observed, more precisely, changes in ‘reviews or audits of Critical Incidents / SEAs (Significant Event Audits). Four percent noted changes in ‘internal reports or audits’. The majority of responses to this question proved difficult to classify. Examples of other responses to this question include:

- Increased awareness
- Better record keeping
- Improvements in handling test results
- Monitoring prescriptions and repeat prescriptions
- Avoiding preventable mistakes
- Internal meetings
- Staff training

- Closer monitoring of referrals
- Changes in administrative procedures
- Positioning of sharps boxes

Seventeen percent of the respondents indicated that there had been no changes in their clinical practice as a result of reporting incidents.

The nurse respondents were asked the same questions about incident reporting and on the whole responded in a very similar fashion to their GP colleagues. A slightly higher percent of nurses have ever reported an incident, i.e. 69% compared with 63% for GPs. Of the thirty-seven nurse respondents who had ever reported an incident, three (10%) had not personally done so in the last twelve months. The mean number of incidents personally reported in the last twelve months was 2.9, just 0.1 higher that the GP respondents. Thirty-two percent of the nurse respondents had done so once, 27% had reported an incident twice and 8% three times. The highest two figures were 12 and 15 incidents reported.

Twenty-six of the thirty-seven nurse respondents (70%) reported changes in clinical practice as a result of reporting incidents, compared to 80% of GPs. Nineteen respondents included details of the changes and again due to the variety, the responses prove difficult to classify. The following represent a selection of the changes noted.

- Have changed the type of venepuncture device to reduce potential for needlestick injury from contaminated sharps
- Have monthly critical incident meetings and change practice accordingly
- Record keeping improved
- Staff safety measures put in place as a result of incident
- Training for staff in drug errors
- Written questionnaire now used prior to travel consultations

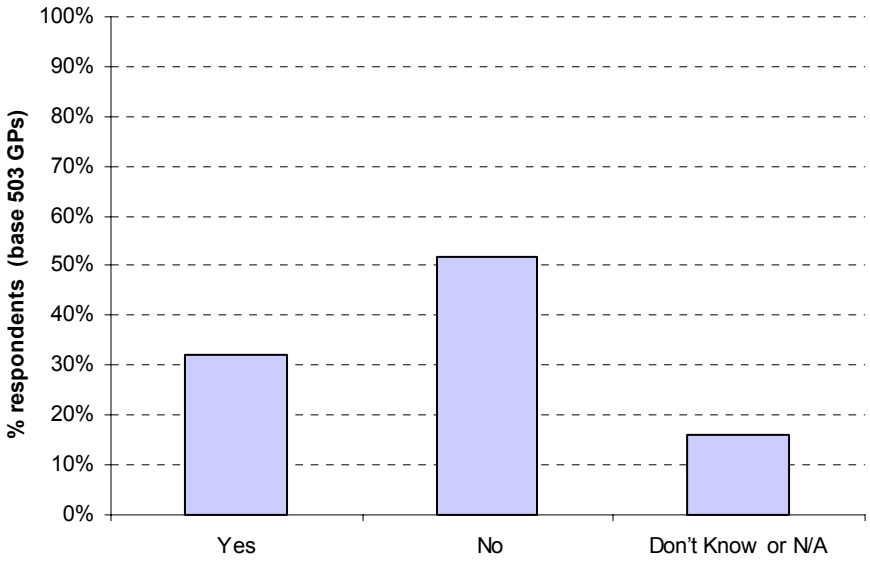
4.3.3 Adverse incidents and audit activity

Respondents were asked a number of questions about the reporting of adverse incidents, the existence and activity of various audit programmes and patient involvement.

Just under a third (32%) of the GP respondents routinely reported adverse incidents to their Primary Care Trust (PCT) and 52% did not. Respondents in London and the South were less likely to report incidents to their PCT, whilst 24% and 27% respectively, routinely do so. Comparing respondents in the North, Midlands and Eastern region the research found that 34% and 40% respectively, routinely reported incidents to their PCT. The variations between decades qualified are small. However, the percent for GPs qualified in the 2000s was considerably less (19%) than the percent who do routinely report incidents overall (32%). In addition, among GPs qualified in the 2000s the *don't know* percent was also much higher (39%) in comparison to the whole GP sample (16%).

The reason for the response from GPs qualified in the 2000s has been explained in previous sections i.e. their overall lack of experience and exposure to such matters is less in comparison to other GPs

Figure 13: GPs - Routinely report adverse incidents to your PCT



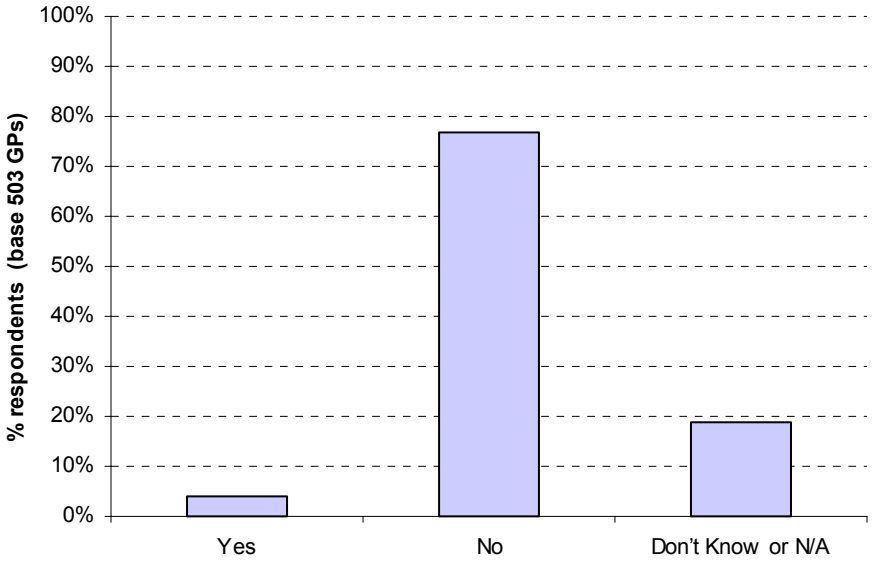
The nurse respondents are considerably different to their GP colleagues in this area. More than half of the fifty-four asked (56%) routinely reported adverse incidents to their PCT, whereas just over a quarter (26%) did not whilst the remaining minority did not know. This higher percent among nurses could be explained by the fact that 37%

of the nurse sample work primarily for the PCT and thus routinely reporting adverse incidents to the PCT would not be uncommon.

Considerably less GP respondents routinely reported adverse incidents to the National Patient Safety Agency (NPSA), with just 4% falling into this category. More than three quarters (77%) did not report such incidents and 19% of the respondents did not know.

Variations between regions and decades qualified were small. However, GPs qualified in the 2000s are much more likely to report incidents to the NPSA (13%) but are also more likely to not know, with 42% falling into this category in comparison to 19% for all the GP respondents.

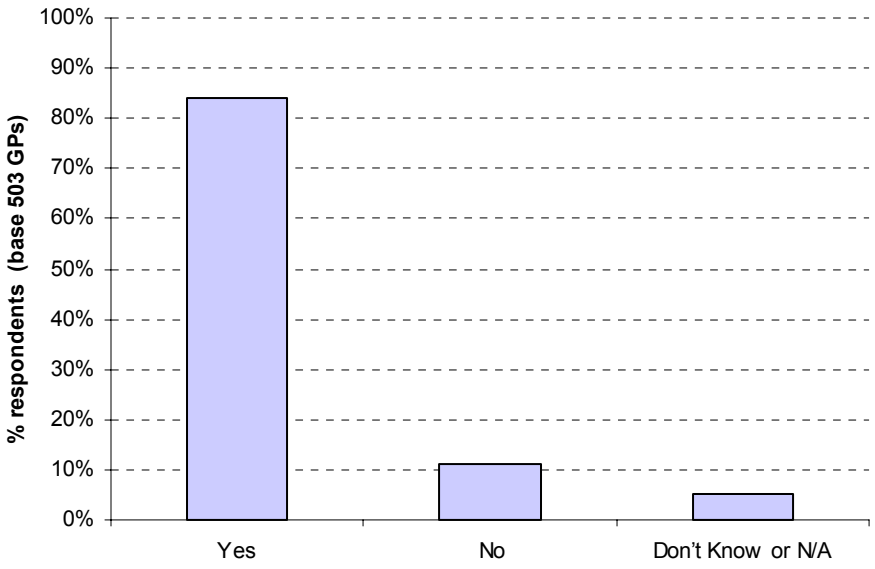
Figure 14: GPs - Routinely report adverse incidents to the NPSA



Almost five times more nurses (19%) routinely reported adverse incidents to the NPSA. Twenty-nine of the fifty-four respondents (54%) did not and more than a quarter (28%) did not know either way.

Eighty-four percent of the GP respondents had a clinical audit programme in place, 11% did not and the remaining 5% did not know. Once again, the variations between regions and decades qualified are small. Similar to the previous responses in this section the GPs qualified in the 2000s were more likely not to know (10%) in comparison to the other respondents.

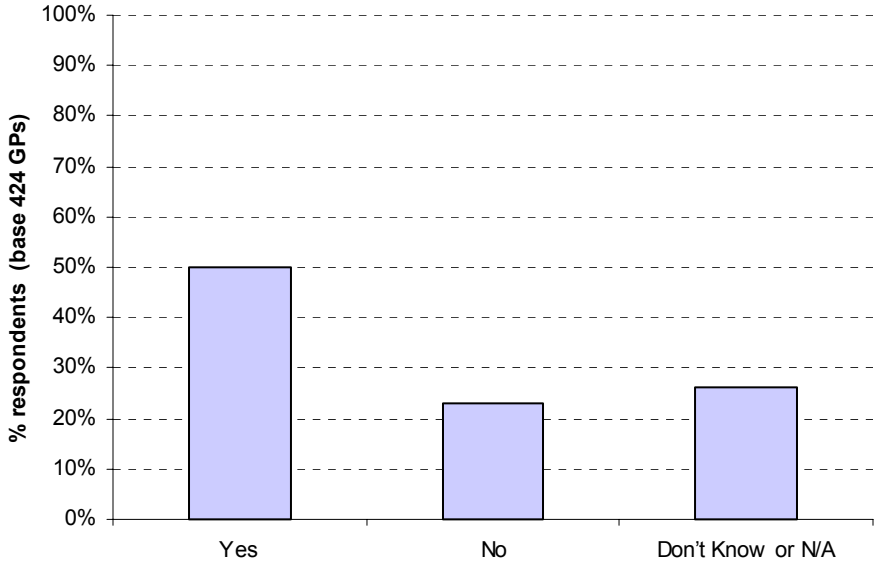
Figure 15: GPs - Clinical audit programme in place



A similar number of nurse respondents (89%) had a clinical audit programme in place, 9% did not whilst the remaining 2% did not know.

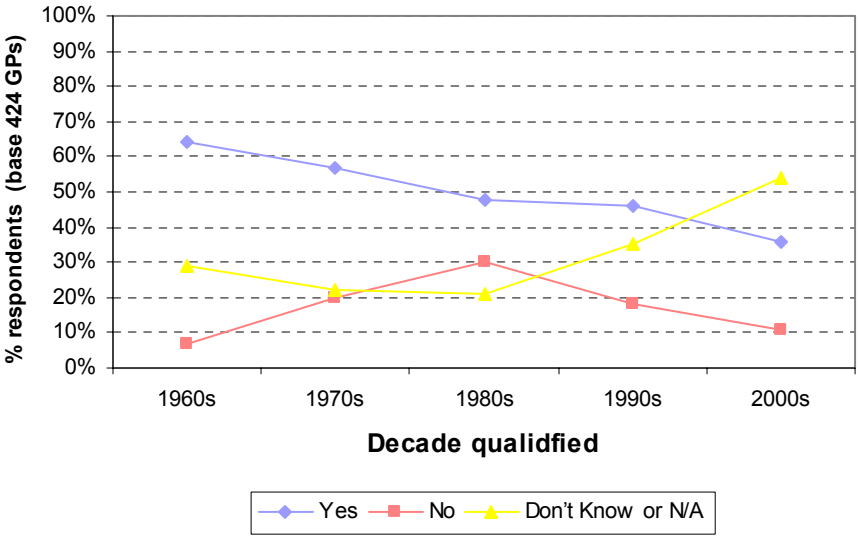
The GP respondents who know of the existence of a clinical audit programme in their practice were asked if it included one multi-disciplinary audit agreed by the PCT. Of the 424 GP respondents who were eligible to respond, half were aware that the programme does include this. A quarter of the sample (23%) indicated that this was not included and a quarter (26%) did not know.

Figure 16: GPs - Clinical audit programme include one multi-disciplinary audit agreed by the PCT



Examining the results by region indicated minor differences. Variations between decades qualified were more clear. Respondents qualifying in the 1960s and 1970s considered that their clinical audit programme included one multi-disciplinary audit agreed by the PCT to a larger extent than those qualified in the 1980s, 1990s and 2000s. Figure 17 indicates these variations.

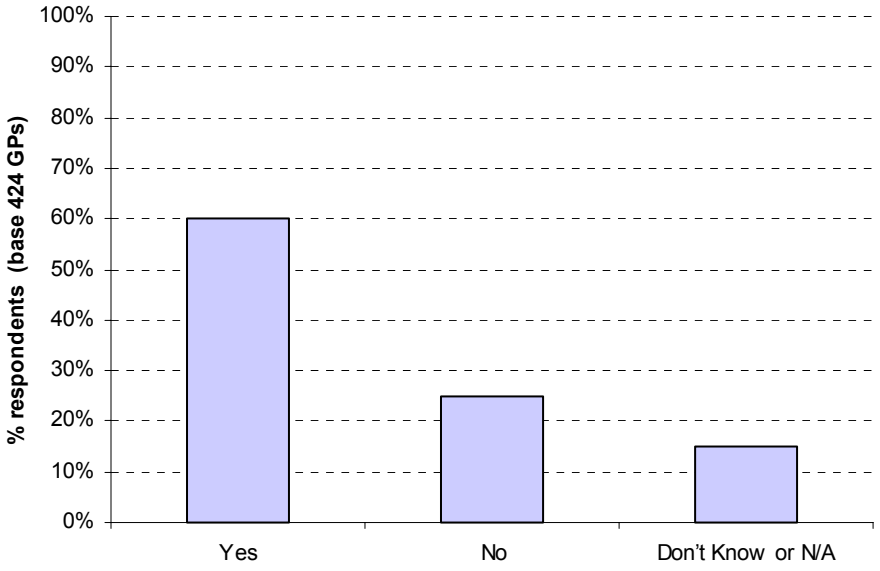
Figure 17: GPs - Clinical audit programme include one multi-disciplinary audit agreed by the PCT



The same 424 GP respondents were asked if they had ever participated in clinical audit activity to benchmark performance. The majority had (60%), a quarter had not, and the remaining 15% did not know.

More GPs in London (67%) have participated in clinical audit activity to benchmark performance, compared to 61% in both the North, Midlands and Eastern regions. GPs in the South had participated the least (56%). Analysing the results by decade qualified shows that GPs qualifying in the 1960s and 2000s are more likely to have participated in such an activity (71% and 68%, respectively) in comparison to the decades in between which varied between 56% and 60% for this category.

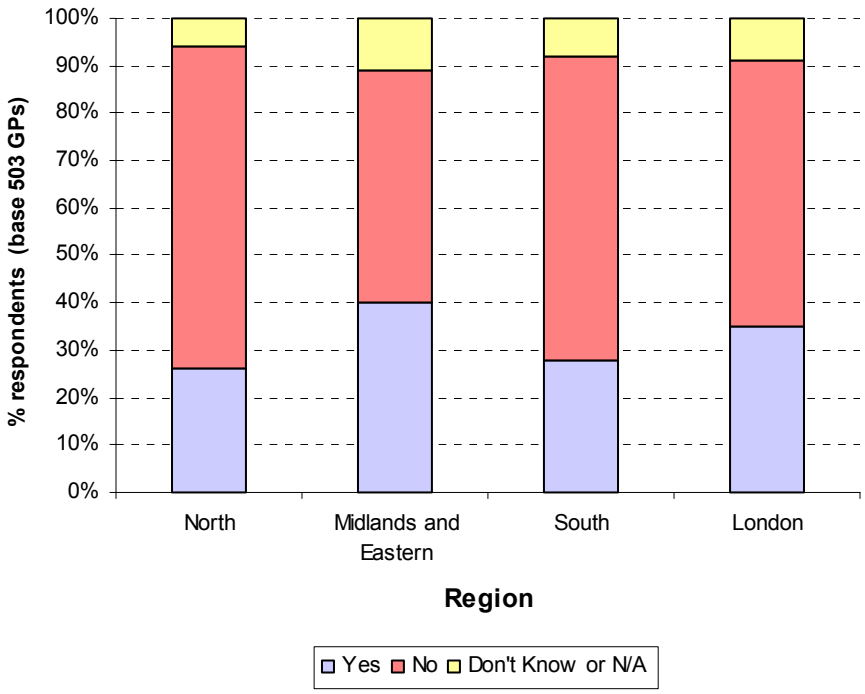
Figure 18: GPs - Participated in any clinical audit activity to benchmark performance



The question regarding patient involvement was open to all the GP respondents. A third of the respondents (32%) said their practice encouraged patient involvement through a patient panel; more than half (60%) indicated that such a panel did not exist, whilst 9% did not know.

A higher number of GPs in the Midlands and Eastern regions (40%) and London 35% encouraged patient involvement through a panel. The percentages for the North and South were 26% and 28%, respectively. The results across decade qualified were more consistent, though GPs qualifying in the 2000s were the exception. Nineteen percent of this group mentioned their practice encouraged patient involvement through a patient panel and 26% did not know.

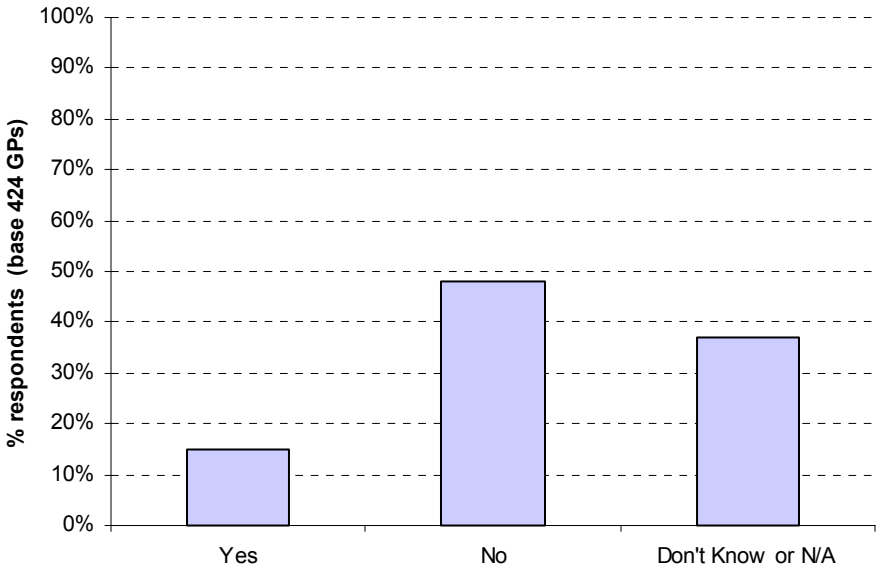
Figure 19: GPs - Practice encourage patient involvement through a patient panel



4.3.4 Efficiency benefits

A small proportion (15%) of the GP respondents felt clinical governance had helped them to deliver efficiency benefits. Almost half (48%) did not feel clinical governance had helped in this way and 37% did not know either way.

Figure 20: GPs - Clinical governance helped to deliver any efficiency benefits



Variations in the responses across regions were small. The differences between decades qualified were more substantial. The relationship between decade qualified and the responses are illustrated by the following table.

Figure 21: GPs - Clinical governance helped to deliver any efficiency benefits (decade qualified)

	All	Decade Qualified				
		1960s	1960s	1960s	1960s	1960s
Yes	15%	22%	14%	15%	18%	13%
No	48%	50%	54%	52%	40%	16%
Don't Know or N/A	37%	28%	32%	33%	42%	71%

The respondents who felt clinical governance had helped them to deliver efficiency benefits were asked what benefits they have experienced. The majority of the benefits noted made reference to improvements in patient care, but the content of the responses varied widely.

The following represents a selection of the benefits mentioned:

- Audit has improved our management of various clinical conditions
- Improve reception organisation and treatment room facilities
- Improved access and patient information

- Offer longer appt. time to patients; regular practice newsletters for patient's benefit
- More nurse involvement in patient care
- Prescribing audits leading to cost savings
- Significant event analysis has reduced risk to staff and patients. Revising clinical guidelines to improve patient well being responding to evidence

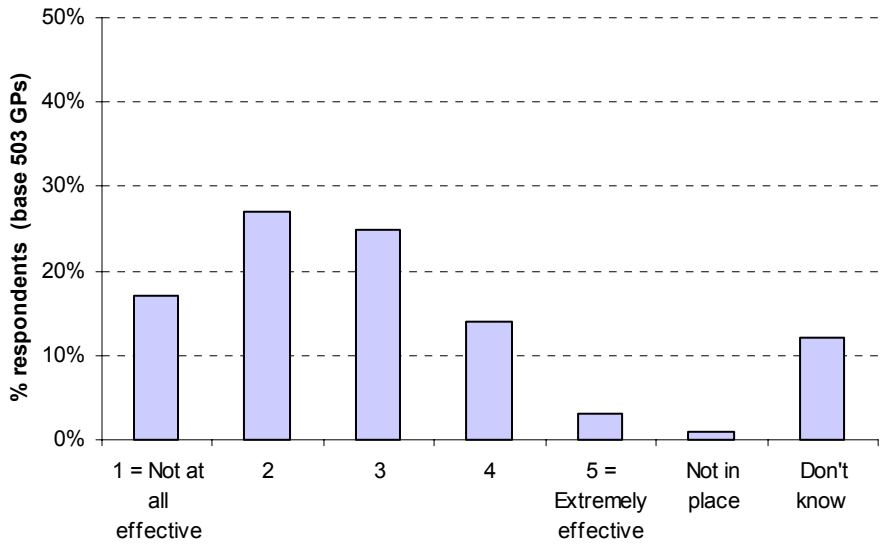
4.3.5 Effectiveness of practice's in providing clinical governance

The GP respondents were asked to rate the effectiveness of their PCT and their own practice towards several features ranging from implementing clinical governance to learning lessons from patient safety incidents. Effectiveness was rated on a five point scale, 1 indicating 'not effective at all' and 5 indicating 'extremely effective'. Respondents could also choose 'not in place' or 'don't know'.

Support provided by PCTs to help implement clinical governance in practices rated the lowest among the GP respondents, with an effectiveness score of 3.1. Forty-four percent of the respondents selected either 1 or 2 for this question further evidence of the low rating. Twelve percent responded don't know.

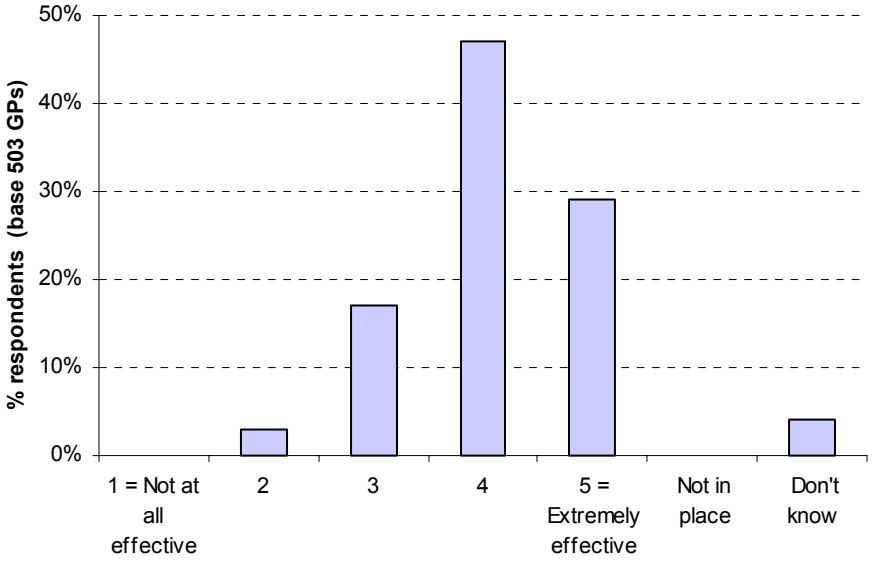
Examining the results by region and decade qualified showed only small differences.

Figure 22: GPs - Support provided by PCTs to help implement clinical governance



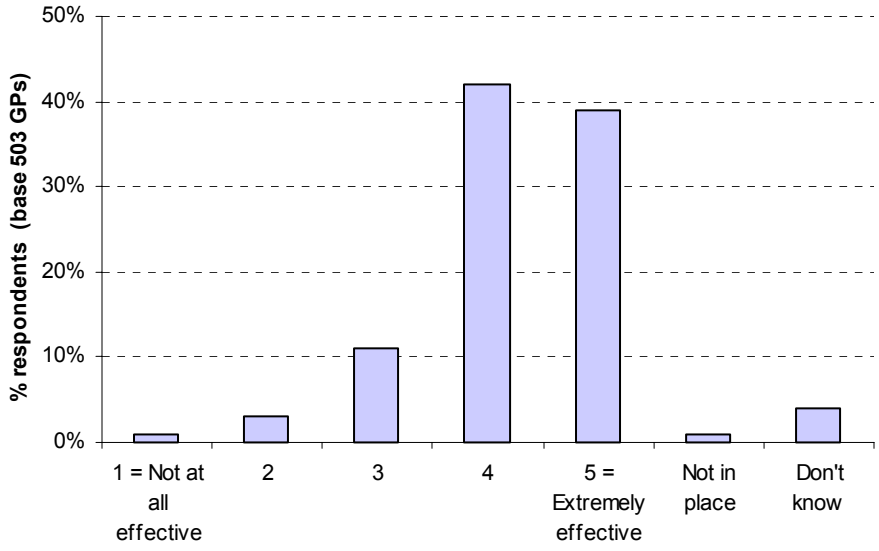
Three-quarters (75%) of the respondents asked, rated their practice in evaluating complaints to improve the safety and quality of care as either a 4 or 5. The overall rating score was a 4.2.

Figure 23: GPs - Practice in evaluating complaints to improve the safety and quality of care



When rating their practice's arrangements for taking action to address serious clinical risks, the mean score among the respondents was 4.3. Eighty-one percent selected either 4 or 5 in this category.

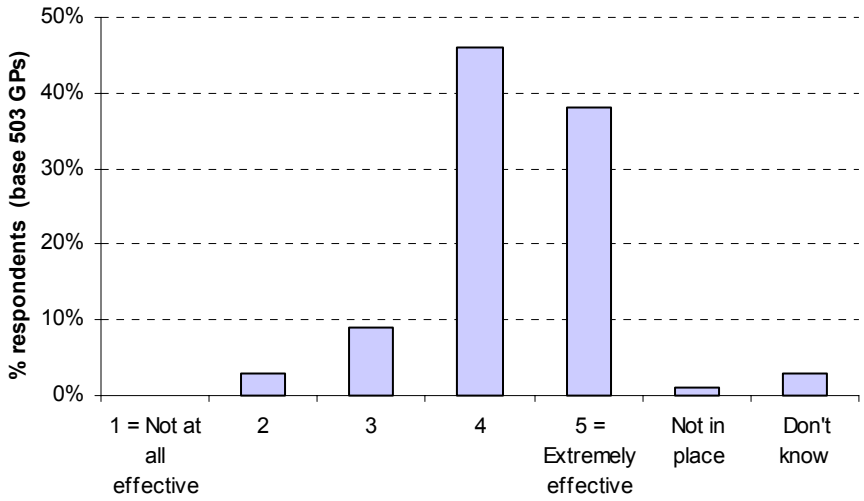
Figure 24: GPs - Practice's arrangements for taking action to address serious clinical risks



The nurse respondents were less enthusiastic about their practice's or organisation's arrangements for taking action to address clinical risks. Sixty-three percent selected either 4 or 5 in this category; the mean score was 3.9. Thirteen percent of the nurse respondents selected *not in place* or *don't know*.

Among the GP respondents assessing how effective they believe their practice to be at learning lessons from patient safety incidents, the mean score was also 4.3. For this response, 84% selected either 4 or 5.

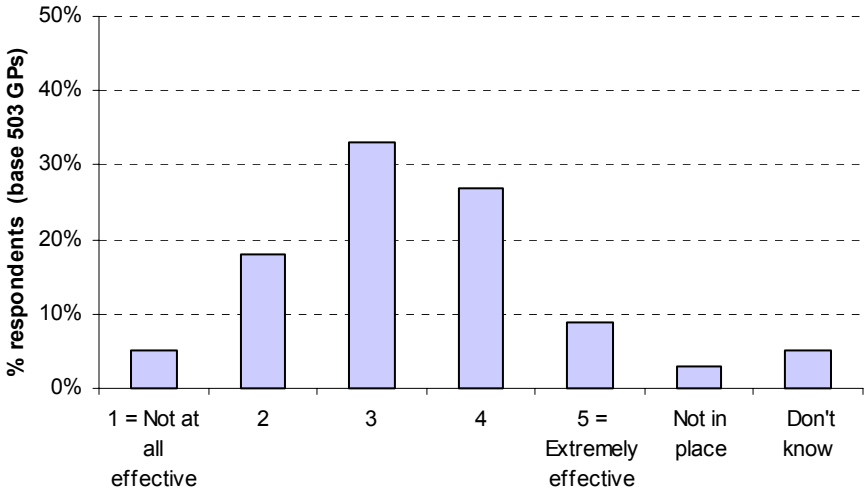
Figure 25: GPs - Practice at learning lessons from patient safety incidents



Among the nurse respondents the mean score was 4.0 and the percent selecting either 4 or 5 was 70%. Eleven percent of respondents selected *not in place* or *don't know.*

The GP respondents were further asked how effective the systems and processes for engaging with patients and public are in their practice. The responses were more spread across the five response options, with 33% choosing 3 and 27% choosing 4. The mean score was 3.5.

Figure 26: GPs - Practice systems and processes for engaging with patients and public



Variations between regions and also the decades qualified for all the questions in this section were particularly small. In common with other areas researched within this study, GPs qualifying in the 2000s tended to have a much higher response of ‘don’t know’, usually between four or five times higher than that for the whole sample.

4.4 RESPONDENT EXPERIENCE AND OTHER COMMENTS

4.4.1 Elements that have improved the quality and safety of care

The GP respondents were asked to consider the three main elements of clinical governance in their practice that had improved the quality and safety of care.

Thirty-seven percent of the respondents did not respond at all, although it is not clear whether they either feel there have been no improvements at all or that they don't know the elements that have improved the quality and safety of care.

The reporting and procedures of incidents was the element of clinical governance that GP respondents considered to have had the largest impact, as mentioned by 35% of GPs researched. Twenty percent cited improvements in communication, for example sharing information, teamwork and feedback. The third most frequently mentioned improvement (17%) related to the guidelines, polices and protocols associated with clinical governance.

Additional elements suggested included multidisciplinary, clinical or significant event meetings (16%) with the same proportion suggesting audits (type not specified by respondents). Further GP responses included: disease or medicines management (10%) training courses, including CME, CPD or protected learning time (8%), complaints procedure (8%), clinical audit (7%) and appraisals or staff appraisals (7%).

There were regional differences in relation to the elements of clinical governance that have improved the quality and safety of care the most. Figure 27 summarises these differences.

Figure 27: GPs - Main elements of clinical governance that have improved the quality and safety of care

	All GPS	Region			
		North	Midlands and Eastern	South	London
Improved reporting / procedure of incidents / critical incidents / SEAs	35%	33%	34%	38%	38%
Improved communication / sharing information feedback / teamwork	20%	23%	15%	15%	42%
Improved guidelines / QOF/ policies / protocols	17%	18%	16%	18%	9%
Internal / Multidisciplinary / clinical / significant event meetings	16%	18%	14%	14%	22%
Audit (non specific)	16%	17%	16%	18%	9%

The nurse responses to this question were similar to those of the GPs. The reporting and procedures of incidents (35%) was the element that nurses considered to have improved the quality and safety of care the most. Improvements in training and

improvements in guidelines or policies were each noted by 31% of the sample. The improvement in support and meetings also ranked high, with 30% of responses mentioning this. Just over a quarter of the nurse respondents (26%) did not respond at all, compared to 37% of the GPs.

4.4.2 Main barriers to implementing clinical governance

Almost a third of GP respondents (31%) either could not think of any barriers or did not believe that any barriers exist for implementing clinical governance in their practice.

The majority of the respondents (63%) considered time, or more accurately the lack of time, as the main barrier to implementing clinical governance. A lack of finances and the costs associated with clinical governance also ranked high with 22% of the sample pointing this out. Several other barriers were mentioned by at least one in ten respondents: lack of resources or implementation difficulties (13%), lack of staff or staffing problems (12%) and 11% noted lack of interest or support (from which source was unclear).

Eight percent of the respondents considered lack of interest or support from external sources (e.g. PCT), and 8% also noted the ongoing changing demands from the government or Department of Health (e.g. changing targets, contract, systems and guidance) as a barrier to implementing clinical governance.

The responses by region are summarised in Figure 28. GPs who qualified in the 2000s were the most likely to either not think of any barriers or assume no barriers exist for implementing clinical governance in their practice, 65% fell into *none* or *no response* category, compared to 31% for the entire sample.

Figure 28: GPs - Main barriers to implementing clinical governance in your practice

	All	Region			
		North	Midlands and Eastern	South	London
Lack of time	63%	61%	65%	70%	45%
Lack of finances / costs	22%	24%	24%	20%	18%
Lack of resources / implementation difficulties	13%	10%	12%	16%	18%
Lack of staff	12%	12%	11%	12%	11%
Lack of interest / support (non-specific)	11%	14%	9%	10%	11%

Twenty-two percent of the nurse respondents could not think of any barriers or did not think that any barriers exist for implementing clinical governance. In a similar vein to the GP respondents the lack of time was considered to be the main barrier with 56% of the nurses surveyed indicating this. Lack of interest and lack of staff were both suggested by 20% of the nurse respondents, and lack of finances and lack of expertise were noted by 17% each.

4.4.3 Help required in developing clinical governance

The GP respondents were asked what help is required in developing clinical governance in their practice. The responses followed a similar pattern to those mentioned in the previous section researching main barriers. Again, the respondents consider time to be of highest value as mentioned by 44% of the sample. Approximately a quarter of the respondents (23%) highlighted that help was needed from a financial, funding or budget aspect. Support, guidance or leadership from PCTs was suggested by 13% of the respondents and the same percent cited more staff resources or locums as a feature that could help.

Other areas of help included non specific resources (9%), non specific guidance, advice, support (8%), training or education (8%) and also less interference or bureaucracy from the government (6%).

A comparison of the results across regions is shown in Figure 29. The variations in results between decades qualified were minor.

Figure 29: GPs - Help required in developing clinical governance

	All	Region			
		North	Midlands and Eastern	South	London
Time / Protected Time	44%	45%	42%	46%	40%
Finances / funding / budget	23%	25%	22%	25%	15%
PCT support / lead / guidance	13%	12%	12%	11%	22%
More staff resources / locums	13%	13%	15%	10%	11%
Resources	9%	11%	8%	10%	4%

The nurses responded differently to the GPs when asked what help is required in developing clinical governance in their practice. The need for training and education was suggested by 30% of the respondents. The requirement of support from management was highlighted by 26% and time was noted by 22%. Nineteen percent of the nurse respondents noted teamwork or communication and 19% mentioned finances.

4.4.4 Examples of good practice

The respondents were asked to provide examples of good practice to illustrate how clinical governance has made a difference. Twelve percent of the GP respondents were able to provide examples. The responses varied greatly; the following are a representative selection of those received. All the verbatim responses are shown in the appendix section 5.2.1.

- Clinical management group meetings which are multi-disciplinary and involve all staff and specifically look at clinical issues and critical event analysis
- Instigate new telephone triage - new touch screens to register arrival in reception.
- Regular weekly meetings of the primary care group are a prime example - here the whole team gets an opportunity to discuss various clinical governance issues
- Regular staff meetings to improve communication
- Several of our nurses have been funded by the practice to train in minor illness / extended prescribing and triage. Some have since moved on to higher postings [e.g. community matron posts] but the benefit to patient care has been clearly shown.
- We had a risk management workshop to which all staff (Clinical and non-clinical) were invited, and asked to contribute a list of up to 5 risks. These were then prioritised using the standard Traffic-light system and action plans made for the bigger risks
- We use a non-blame near miss and critical incident plan where staff are asked to document everything - from abuse patient to drug errors. We then regularly look at these and develop policy from them. We also liaise with the parish councils in a patient forum to enable change

The nurse responses can be found in the appendix section 5.2.2.

4.4.5 Other comments about clinical governance

The GP and nurse respondents were finally asked if they had any other comments about clinical governance. The full list of responses can be found in the appendix section, 5.3.1 for GPs and 5.3.2 for nurses.

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5 APPENDIX

5.1 Questionnaires

5.1.1 GP Questionnaire

Introduction

NAO STUDY: Improving Quality And Safety - Progress In Implementing Clinical Governance In Primary Care

The National Audit Office is currently conducting a study of clinical governance in primary care in England. The main objective is to examine whether Primary Care Trusts (PCTs) are achieving improvements in patient care through better clinical governance.

Clinical governance means the systems and processes that provide assurance about the quality and safety of care.

The National Audit Office is completely independent of government and reports to Parliament on the economy, efficiency and effectiveness with which the Department of Health has used its resources. Its work saves the taxpayer at least £8 for every £1 spent running the Office. The output of its work will be a report to Parliament. This is your opportunity to influence Parliament with your views.

The methodology includes a census of Primary Care Trust Chief Executives, Clinical Governance Leads, and PEC and Board members. The NAO is also very keen to include as part of its study the experience of GPs and would be very grateful if you would spend a few minutes completing this questionnaire.

All responses will be anonymous and no information disclosed other than to present an analysis nationally. (If you prefer to e-mail the NAO separately about the study, you can do so at doctors@nao.gsi.gov.uk, or by contacting The NAO at: Clinical Governance Study Team, Room A579, 157-197 Buckingham Palace Road, London, SW1W 9SP)

For further details of the study see the Work in Progress section of the website at http://www.nao.org.uk/publications/workinprogress/primary_care.htm

A. ABOUT YOU AND YOUR PRACTICE

Q1 Are you a:
() GP Partner
() Salaried doctor
() GP registrar
() Sessional doctor
() Locum GP
() Other, please specify - - -

Q2 Do you work:
() Full time
() ¾ time
() ½ time
() Less than ½ time
() Other, please specify - - -

Q3 In which part of England is your organisation/ practice?
() North
() Midlands and Eastern
() South
() London

Q4 In which Primary Care Trust are you based?
- - -

Q5 At which of the following sites do you primarily work?
() GP Practice
() PCT walk-in centre
() PCT
() Community Hospital
() Other, please specify - - -

Q6 Please answer the following questions
| 0-5 years ago | 6-10 years ago | 11-20 years ago | more than 20 years |
() When did you first qualify as a doctor?
() When were you first accredited to work as a GP?
() How long have you worked in your current practice/ organisation?

Q7 How long do you imagine it will be before you retire?
() 0-5 years
() 6-10 years
() 11-20 years
() more than 20 years

Q8 How much does your practice spend annually in providing clinical governance processes and arrangements?
- - -

Q9a Has your practice done any cost benefit analysis of the impact of clinical governance?
() Yes
() No <gotoQ10>
() Unsure <gotoQ10>

Q9b What were the results of the cost benefit analysis?
- - -
- - -
- - -

B. ENSURING THE QUALITY AND SAFETY OF YOUR CARE TO PATIENTS

Q10 Please answer the following questions
| Yes | No | Don't know or N/A |
() On joining your practice did you receive appropriate induction training?
() Have your Continuing Professional Development (CPD) requirements been identified?
() Are arrangements in place to meet your CPD requirements?
() Do you receive an annual (NHS) peer appraisal?
() Has your practice/organisation had a visit by your local Patient and Public Involvement Forum?

Q11 How effective is your practice's/organisation's performance appraisal process for staff?
() 1 = Not at all effective
() 2
() 3
() 4
() 5 = Extremely effective
() Not in place
() Don't know

C. ENSURING THE QUALITY AND SAFETY OF YOUR PRACTICE

Q12 Please answer the following questions
| Yes | No | Don't know or N/A |
() Does your practice/organisation have a complaints process in place?
() Does your practice/organisation investigate its complaints to help identify safety and quality issues?
() Are you routinely informed of the outcome of complaints that are received by the PCT?
() Does your practice/organisation have a risk management policy?
() Do you have an incident reporting system in place?

Q13a Have you ever reported an incident?
() Yes
() No <gotoQ14>
() Don't know or N/A <gotoQ14>

Q13b How many incidents have you personally reported in the last 12 months?
- - -

Q13c Has anything changed in your clinical practice as a result of reporting incidents?
- - -

Q14 Do you routinely report adverse incidents to your Primary Care Trust?
() Yes
() No
() Don't know or N/A

Q15 Do you routinely report adverse incidents to the National Patient Safety Agency?
() Yes
() No
() Don't know or N/A

Q16 Do you have a clinical audit in place?
() Yes
() No
() Don't know or N/A

Q17 Does the programme include one multi-disciplinary audit agreed by the PCT?
() Yes
() No
() Don't know or N/A

Q18 Have you participated in any clinical audit activity to benchmark performance?
() Yes
() No
() Don't know or N/A

Q19 Does your practice encourage patient involvement through a patient panel?
() Yes
() No
() Don't know or N/A

Q20a Has clinical governance helped you to deliver any efficiency benefits?
() Yes
() No
() Don't know or N/A

Q20b What benefits?
- - -
- - -
- - -

Q21 Please answer the following questions
| 1 = Not at all effective | 2 | 3 | 4 | 5 = Extremely effective | Not in place | Don't know |
() How effective is the support provided by PCTs to help you implement clinical governance in your practice?
() How effective is your practice/organisation in evaluating complaints to improve the safety and quality of care?
() How effective are your practice's/organisation's arrangements for taking action to address serious clinical risks?
() How effective is your practice/organisation at learning lessons from patient safety incidents?
() How effective are the systems and processes for engaging with patients and public at your practice/organisation?

D. YOUR COMMENTS

Q22 What have been the three main clinical governance issues your have faced in your practice that have affected the quality and safety of care?
1 - - -
2 - - -
3 - - -

Q23 What are the main barriers to implementing clinical governance in your practice/organisation?
1 - - -
2 - - -
3 - - -

Q24 What help do you require in developing clinical governance in your practice/organisation?
1 - - -
2 - - -
3 - - -

Q25 The NAO is also hoping to identify examples of good practice illustrating how clinical governance has made a difference. If you have an example of good practice please tell us briefly about it.
- - -
- - -
- - -

Q26 If you are willing to be contacted by the NAO about the comments you have made above please include them here:
Name - - -
E-mail address - - -
Telephone - - -

Q27 If you have any other comments that you would like to make about clinical governance in General Practice please make them here.
- - -
- - -
- - -

5.1.2 Practice nurse Questionnaire

Introduction

NAO STUDY: Improving Quality And Safety - Progress In Implementing Clinical Governance In Primary Care

The National Audit Office is currently conducting a study of clinical governance in primary care in England. The main objective is to examine whether Primary Care Trusts (PCTs) are achieving improvements in patient care through better clinical governance.

Clinical governance means the systems and processes that provide assurance about the quality and safety of care

The National Audit Office is completely independent of government and reports to Parliament on the economy, efficiency and effectiveness with which the Department of Health has used its resources. Its work saves the taxpayer at least £8 for every £1 spent running the Office. The output of its work will be a report to Parliament. This is your opportunity to influence Parliament with your views.

The methodology includes a census of Primary Care Trust Chief Executives, Clinical Governance Leads, and PEC and Board members. The NAO is also very keen to include as part of its study the experience of GPs and would be very grateful if you would spend a few minutes completing this questionnaire.

All responses will be anonymous and no information disclosed other than to present an analysis nationally. (If you prefer to e-mail the NAO separately about the study, you can do so at nursing@nao.gsi.gov.uk, or by contacting The NAO at: Clinical Governance Study Team, Room A579, 157-197 Buckingham Palace Road, London, SW1W 9SP)

For further details of the study see the Work in Progress section of the website at http://www.nao.org.uk/publications/workinprogress/primary_care.htm.

A. ABOUT YOU AND YOUR PRACTICE

Q1 What is your principle role?
() Practice Nurse
() Nurse Practitioner
() District Nurse
() Health Visitor
() Community Nurse
() School Nurse
() Practice Manager
() PCT Nursing Staff Member
() Other, please specify - - -

Q2 In which part of England is your organisation/ practice?
() North
() Midlands and Eastern
() South
() London

Q3 In which Primary Care Trust are you based?
- - -

Q4 From which of the following do you primarily work?
() GP Practice
() Primary Care Trust
() District Hospital
() Other, please specify - - -

Q5 Please answer the following questions
| 0-5 years ago | 6-10 years ago | 11-20 years ago | more than 20 years |
() When did you first qualify as a nurse?
() How long have you worked in your current practice/ organisation?

B. YOUR PRACTICE/ORGANISATION

Q6a Has your practice/organisation allocated specific responsibility for clinical governance to a named individual in the practice/organisation?
() Yes
() No <gotoQ7>
() Don't Know or N/A <gotoQ7>

Q6b What is their position?
- - -

Q7 Please answer the following questions
| Yes | No | Don't Know or N/A |
() Does your practice/organisation have a complaints process in place?
() Does your practice/organisation have a process for learning from patient complaints?
() Have you been informed of the outcome of complaints?
() In the last year, has your practice/organisation undertaken a patient satisfaction survey?
() Has your practice/organisation had a visit by your local Patient and Public Involvement Forum?
() Does your practice/ organisation have other formal interaction with patients and the public?
() Does your practice/organisation have a risk management policy?
() Do you have an incident reporting system in place?

Q8a Have you ever reported an incident?
() Yes
() No <gotoQ9>
() Don't Know or N/A <gotoQ9>

Q8b How many incidents have you personally reported in the last 12 months?
- - -

Q8c Has anything changed in your clinical practice as a result of reporting incidents?
- - -

Q9 Please answer the following questions
| Yes | No | Don't Know or N/A |
() Do you routinely report adverse incidents to your Primary Care Trust?
() Do you routinely report adverse incidents to the National Patient Safety Agency?
() Have you participated in any clinical audit activity?
() Have you participated in any multi-disciplinary clinical audit activity?
() Did you receive appropriate induction training?
() Are you provided with protected time to attend training courses?
() Do you get appropriate training in respect of the roles you are asked to perform?
() Have your Continuing Professional Development (CPD) requirements been identified?
() Are arrangements in place to meet your CPD requirements?
() Have you received specific clinical governance training?
() Do you receive a performance appraisal at least annually?
() Do you think that your practice/ organisation has adequate leadership in place to implement clinical governance?
() Does your practice/organisation have arrangements for addressing poor performance?
() Is your practice/ organisation a clean and safe environment to provide patient care?

Q10 Please answer the following questions
| 1 = Not at all effective | 2 | 3 | 4 | 5 = Extremely effective | Not in place | Don't know |
() How effective are your practice's/organisation's arrangements for taking action to address clinical risks?
() How effective is your practice/organisation at learning lessons from patient safety incidents?
() How effective is your practice's/organisation's performance appraisal process?
() How effective are your practice's/organisation's arrangements for addressing poor performance?
() How effective is the training you receive in respect of the roles you are asked to perform?
() How effective is your practice/organisation at supporting your training?

C. YOUR COMMENTS

Q11 What have been the three main elements of clinical governance in your practice/organisation that have improved the quality and safety of care?
1 - - -
2 - - -
3 - - -

Q12 What are the main barriers to implementing clinical governance in your practice/organisation?
1 - - -
2 - - -
3 - - -

Q13 What help do you require in developing clinical governance in your practice/organisation?
1 - - -
2 - - -
3 - - -

Q14 The NAO is also hoping to identify examples of good practice illustrating how clinical governance has made a difference. If you have an example of good practice please tell us briefly about.
- - -
- - -
- - -

Q15 If you are willing to be contacted by the NAO about the comments you have made above please include them here:
Name - - -
E-mail address - - -
Telephone - - -

Q16 If you have any other comments you would like to make about clinical governance in General Practice please make them here.
- - -
- - -
- - -

5.2 Examples of good practice

5.2.1 GPs

Examples of good practice
A positive culture for ad hoc facilitated significant event meetings discussing individual events in depth in a 'fair blame' culture, using Gibbs' reflective cycle to capture positives and feelings as well as practical concerns and suggestions. Anyone can request an SEA meeting and a good proportion of the clinical team tend to attend. Bi-monthly Clinical supervision for the medical team has also had a similar positive impact on the standard of care we are able to provide.
All our clinical governance meetings audits etc are anonymous & minutes are available to the team
An audit last year looked at the co-prescription of gastro-protectant medication in palliative care patients, in whom a prescription for NSAIDs or steroids was being considered.
Annual Clinical Governance report which summarises all practice activities in this respect - approx 40 pages, produced yearly for past 3 years
Appraisals for GPs
Attention to new developments in diabetes, individual patient management plans, diabetic nurses empowered to lead on these
Chronic disease audits
Clinical management group meetings which are multi-disciplinary and involve all staff and specifically look at clinical issues and critical event analysis
Complaint or near miss this is reviewed and then the outcome of the review is reviewed to determine whether it has been put in place and whether it is effective
Diabetic audit and training have made a difference
Extended hours in practice already Until 21.00 on Tuesdays and from 07.30 on Thursday and Friday mornings all in place some three years
First rate Primary Care Clinical Governance Manager who is supportive of practices and tries to help with hands on activity - visits practices and tries to provide financial help for protected time
Flu vacc figures good year on year
Following a SEA we have designed a system to communicate with pharmacies changes in the prescription of medidoses. This has helped to prevent prescribing errors which have previously occurred.
Form with details of cancer patients looked after at home sent to all in the practice and the OOHs
I have won the clinical governance award from [my] PCT last year and this year-last year was an audit concerning palliative care and this year an audit concerning clopidogrel prescribing
Infection control audit is recommended (lead by [the] PCT and work based receptionist workshops)
INR monitoring, methotrexate monitoring
Instigate new telephone triage - new touch screens to register arrival in reception.

Examples of good practice
Introduction of in-house ENT and Ophthalmologic clinics and insulin initiation clinics for poorly controlled type 2 diabetics.
Involving all staff and pct in carrying out new contract
It was possible for someone on warfarin to be lost by our system if they failed to make an app for a test or cancelled an app and failed to remake one --- our system will not allow this to happen any more
Keeping a good record
Modesty and space forbids
My partners' diabetic clinic
Patient Specific Information book e.g. new cancer dxs accessible by all members of Practice Team [and separate from Sig Event Book]
PCT wide audits pre contract
Programmed the clinical system to display a strongly worded alert if patient is on Warfarin and has not had the requisite INR blood test within the previous 9 weeks. alert was triggered twice within a matter of weeks and generated appropriate response in staff.
QOF have caused a huge rise in the detection of hidden "illness"; whether this will save lives in the long term, remains to be seen
Recent review and change in repeat prescribing practices
Refusing to accept requests for prescriptions by patients over telephone all audits showed this is where mistakes occurred now must do in writing by post using repeat slips by fax or email
Regular clinical meeting to discuss various issues as identified by the team members/complaints/suggestions by the patients etc.
Regular medication reviews
Regular review and audit - nothing clever but requires time and focus
Regular staff meetings to improve communication
Regular weekly meetings of the primary care group are a prime example - here the whole team gets an opportunity to discuss various clinical governance issues
Reporting critical incidents to close the loop on missed appointments for Colposcopy /cancer referrals
SEAs, resultant clinical and admin protocols, etc.
SEAs excellent way to recognise and change practice to prevent same problems/raise standards, based on evidence (and revisited)
Self appraisals/investigation every incident of unsatisfactory/unexpected/untoward outcome to continually implement changes in personal practice
Several clinical incidents have modified behaviour and some organisational changes have taken place as well
Several of our nurses have been funded by the practice to train in minor illness / extended prescribing and triage. Some have since moved on to higher postings [e.g. community matron posts] but the benefit to patient care has been clearly shown.
Similar name patients, blood tests filed in wrong pt recording of side effects recording

Examples of good practice
of pt choice re vaccinations (e.g. single dose MMR) pt never told and misunderstanding for booster
Skill improvement - especially improved telephone consultation skills - better use of patients and clinicians time & access
Spreadsheet on the practice intranet which lists expiry date of all drugs in Doctor's bag, nurses room and emergency bag, enabling checking at any time for forthcoming expiry dates.
The best area is to bring any concerns, both of a negative nature, as well as positive feedback to our weekly meetings where discussions can be had in a full and open atmosphere
The PCT fund one session a month of GP partner time to engage in issues around prescribing governance
There aren't any
Use of conclusions of significant event analysis especially regarding prescribing, dispensing and vaccine administration
Very happy to speak to the NAO about what we achieved as a practice despite the best efforts by the PCT to ensure we fail
We audited our cervical cytology rates and noticed they were declining. We tasked our practice nurses identifying possible causes and solutions. This included opportunistic screening personal contact and identifying exclusions from the target population. Our smear targets are now acceptable
We had a risk management workshop to which all staff (Clinical and non-clinical) were invited, and asked to contribute a list of up to 5 risks. These were then prioritised using the standard Traffic-light system and action plans made for the bigger risks
We have a monthly clinical team meeting with doctors and practice nurses, and have a rolling audit programme for over 15 years, plus present significant events, review our protocols regularly, and also present interesting cases for discussion.
We have a system in place now of making sure GPs put alert system in place of at risk patient
We trail and audit all prescriptions
We use a non-blame near miss and critical incident plan where staff are asked to document everything - from abuse patient to drug errors. We then regularly look at these and develop policy from them. We also liaise with the parish councils in a patient forum to enable change
Weekly in house clinical meeting for all staff, Drs and nurses and ancillary staff if appropriate
Weekly review meeting of significant events
You become a teacher
Zoladex injections for ca prostate. How we follow up non-attendees for their injections clinical orientated read coded templates

5.2.2 Primary care nurses

Examples of good practice
As a result of survey changes were made to waiting room environment. Emergency equipment updated and improved, alongside better training for all staff.
District nurse referral service
Gold standard for cancer care developed locally in conjunction with regional areas to ensure that all people within the community in [the county] receive the same level of care with a lead professional trained in each practice.
High tech care team accept referrals and set up delivery etc for IV therapy/chemotherapy. Centralised group who act as filter for inappropriate referrals and ensure safe and up to date practice
Pilot site for Single Assessment Process throughout the Trust and partnership working with Social Services Dept.
Policies in place in PCT
Standard Mode of entry into client's home by community workers and what to do if access cannot be gained.
Training for all staff to attend clinical supervision awareness and training of supervisors and supervisees

5.3 Other comments about clinical governance

5.3.1 GPs

Other comments about clinical governance
A lot of time is wasted locally preparing CG protocols which could easily be done nationally. e.g. the giving of medicines at schools for the handicapped does not need a local committee to prepare such a protocol ; good practice is good practice and can be decided Centrally.
A very good thing
Although within the practice there are 8 partners, 1 assistant and 4 registrars I don't think have ever discussed exactly what clinical governance is and am fairly sure that no one understands fully what the concept is.
Another good idea that will fail because it is not properly resourced or staffed. We are too busy and too understaffed to do anything but QOF at the moment. We barely keep our heads above water.
Answer to cost of implementing clinical governance is purely guesswork as no formal assessment of costs has been made and clinical governance is frequently tied up / intertwined with other issues
As a salaried GP who occasionally does locum work I am out of the loop of communication - I receive directly or indirectly almost no information about local services, referral pathways etc - trickle down in GP practices is erratic. There is no simple path for requesting copies of the information I need to function safely and effectively despite contact with PCT and PEC members, mentioning it in my appraisals and helping to organise a conference on Sessional GPs at the RCGP in October. Is there anyone there???
As with too much these days there is slavish adherence to a slogan by those who have little or no no understanding of the underlying principles or the purpose of the process. For these reasons it is expensive and largely ineffective at improving standards of care. I suggest you address the question "How many hip replacements could we have done for the cost of this exercise?" to all the issues you address and then ask those on the waiting list how they would rather see the money and resources used.
At a recent meeting of doctors involved in a nationwide non-NHS medical activity, one delegate described clinical governance as "degree-level ****-****" - I was surprised that no-one spoke actively against this notion.
Best delivered by and to the PHCT.
Best talk to practice manager
Better than past
Biggest waste of time and money in the practice and in useless administrators creating jobs for themselves and diverting money way from patient care , hence NHS going bust
Clinical governance can be useful in improving safety and patient outcomes, but clinicians need constant reminders about it, as well as adequate resources to ensure that it is implemented properly
Clinical governance used just to be being professional I’m not sure risk management clinical effectiveness, and other buzz words mean anything different, the majority of

Other comments about clinical governance
clinical staff are self motivated and do not need the additional burden and bureaucracy The other issue is that the NHS "no blame culture" in reality means "blame, blame, blame" , always looking for a scape goat when the whole system is failing ,the current high levels of suspensions is indicative of this
Continues educational development
Controlling the balance between trusting clinical teams and the overuse of audit to scrutinise their activity diverting time from direct patient care
Doctors are well aware of what they are trained to do. Regrettably, the administrative and managerial staff in the NHS do not recognise that fact. The result is that there has developed a "them and us" situation in which good clinical care is reduced and dissatisfaction and complaining is increased.
Don't always feel that the PCT is really aware of how primary care works in general practice
Education is key to clinical governance that is welcomed and supportive versus the policing and punishing view taken by some (especially managers lacking any clinical background or understanding). The new GMS contract does not value education either directly or indirectly by recognising it or giving the time for it.
E.g. we have had a new comp system installed - this was delayed for 8 weeks so that relevant pct members could be around whilst this was installed. trying to get anyone now to help with problems that have arisen - virtually impossible !!!
Eugh! big brother is watching you. As my friend said 'they don't want you to think'. I hope I get out soon.
Everything that has been identified about clinical governance was being done in good GP practices long before the term 'clinical governance' was invented. I am very cynical with central government and DoH personnel who seem to want to reinvent the wheel every 5 years. At the coal face we just get on and continue to do 'what a doc's got to do'!
Facilities from PCT for staff training
Formalising an approach to quality of care in general practice has been a positive step.
Great idea in principle but the usual constraints of lack of time and money and poor provision of central guidance mean it is ineffectively organised
I am very enthusiastic about clinical governance but believe passionately that organisations and professionals must be given some scope to develop their own standards and methods of working. Outside imposition is often resented, becomes mechanical and does not always lead to changes - merely ticking the boxes and making the PCT go away will not prevent poor clinical care or I believe another Shipman
I believe that record keeping in primary care is key to the future especially with the new internet access of health workers to pt record. If practices are going to go paperless vast amounts of preparatory work need to be done with regard to data entering storage and accessibility. I do not think these preparations are being made or co-ordinated
I believe that the full scope of the definition of Clinical Governance is poorly

Other comments about clinical governance
understood in General Practice
I don't think we have time to worry about it.
I find it extremely difficult to quantify amount spent. Time is money and we have spent lots of time on this
I have never liked the term clinical governance. It covers far too wide an area and is easy to ignore because of the woolly nature of the term.
I have no idea what clinical governance costs us - have many been able to answer that with a straight face?
I think we have successfully moved from where people might have been afraid to report an error to a 'no-blame' situation where the error is analysed and steps put in place to reduce risk of recurrence.
I think we probably do it on an informal basis all the time - recording what we do and reflecting is the problem
If it did not exist no-one would notice
Increase the awareness and importance to report the incidents not just the mistakes but the right one to all the members.
It can be pretty unstructured due to our unique ways of working, PCTs/NHS managers do not appreciate this, this isn't time to "navel" gaze as they do and write a "book" on every incident.
It is a good idea, but badly implemented in our PCOs who have financial pressures so significant that they only slash services without consultation, under the thin veil of efficiency. In reality what is going on is dangerous, it affects the patients significantly (i.e. they are worse off as far as accessing services, or there are no more services available, and it will cost much more money to resurrect the services or find alternatives. Our PCT stopped practice assessment visits in order to save money (noble cause), but now only has paper exercise to go through the data and literature available to it from the practices in order to see how it is implemented.
It must be properly centrally funded (and the funds need to find their way to the practices, not the PCTs)
I'm never sure how effective clinical governance is for the average person. If pursued enthusiastically by someone with appropriate training and resources it can undoubtedly be beneficial but in an average busy general practice it seems to be just one more hoop to jump through, is done unwillingly with lots of time and resource pressure and results are variable at best.
Lack of locum availability to enable GP's to be able to be as involved in CG issues as desired.
Like every thing else - it is a very good principle but time/money /staffing constraints always threaten we are constantly asked /expected to implement new things without new resources- and this constantly whittles down our own salaries- especially since the new contract - which rather than being the heralded wage /morale boost - has been and constantly remains a serious threat to our quality of life and our take home pay!!!-
Mainly practice based as PCTs unable to afford time + lack of manpower to do this themselves
Manual / website of clinical governance examples or ideas

Other comments about clinical governance
NAO needs to ask effects of constant new directives from DoH has on important issues such as clinical governance as only so many hours in day and so many GPs/nurses working in "demand led" area
National templates and examples of good practice and local availability of protected time and training would help
Need to maintain flexibility so that practices can do it their own way. PCTs should look at outcome, not process
No-one seems to agree quite what governance is
Not sure to what extent patient involvement groups are likely to improve safety etc
Our local clinical governance gets involved in agreeing to different protocols for clinical researches in primary care. In my opinion that slows the process down tremendously; the protocols most of the time gets approved by the MRC and the local ethics committee.
PCT has been helpful in providing support for personal development
Peer professional review is helpful, care must be taken not to repeat the process too frequently, through the QOF for example.
Privatising the NHS is not going to guarantee equity of quality in GP in the future
Protected time needed but then less appointments so reduced access so always conflict of interests
Regarded locally as government interference in quality clinical care
See initial question 'how much do you spend annually on CG?' - I don't know but have had to enter £0
Still really don't know what the **** clinical governance is
Systems applied at local level are inevitably clouded by personal connections
The local GP Clinical Governance lead appears to have an agenda for making life as difficult as possible for other GPs and has an abrasive and antagonistic personality which is reflected in her dealings with GPs and in the attitude of the PCTs clinical governance department.
Very difficult to attach a financial cost to clinical governance. Process introduced several years ago by pct-(then PCG)
Very important subject -- comes into all we do in some way
Waste of time in present environment
We had a patient participation group in 1992-1994. Research shows that patient participation groups have a life of approx 2 years which is what happened to ours. Also I have been there and done that and I am now older and wiser and I am not spending my evenings and free time running such groups.
Whilst clinical governance is regarded as an add on and not part of normal day to day working practice it will continue to fail to delivery benefits for patients

5.3.2 Primary care nurses

Other comments about clinical governance
Child Protection needs a higher profile/priority in general practice
Difficult to balance demands of patients for instant attention with time and no of staff available
I don't feel that I know enough about Clinical Governance and therefore don't understand exactly what it means.
I would like to see ALL GPs as employers allow their nurses time out regularly to allow clinical supervision to take place.
In general practice, it has been slow to get going, and difficult in small surgeries. However my current role is as a PCT employed nurse and I would expect better from a PCT, but there seems to be a blind eye turned to the problems in providing the service.
Jargon causing more pressure at managerial level
Need to get an atmosphere culture of no blame to enable all clinicians to learn and go forward not always in place
Since the introduction of Clinical Governance visits by the PCT, it is seen as more important and valued- learning from experiences of others is just as valuable and can prevent repetition of mistakes
The quality and standards of care can be improve mainly through Clinical Governance
The will is there amongst management, but I feel staff apathy and lack of awareness of the relevance of CG are crucial factors which need to be addressed
With the current climate of QOF and contract points I feel that Clinical Governance has been ignored. Perhaps the GPs discuss clinical governance matters at their meetings but nothing is filtered back to the nurses. I know very little about clinical governance and what I do know is from my own reading on the issue.