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Clinical governance in action

# Forging links: evolving attitudes of clinical governance leads in general practice

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## ABSTRACT

**Background** Clinical governance was introduced by the British government in 1998 at the same time as the creation, in England, of organisations to deliver it in primary care – primary care groups. It was acknowledged, however, that individual general practices and primary care teams would actually deliver many of the requirements of clinical governance on the ground. Because of this, the opinions and attitudes of staff at practice level, particularly the clinical governance leads in the practices, are important for the delivery of the clinical governance agenda.

**Objective** To investigate the views of practice clinical governance leads on their role in relation to the delivery of clinical governance.

**Design** A qualitative study using two sets of semi-structured interviews, one year apart.

**Setting** Nineteen general practices from 19 primary care organisations (PCOs) within Trent Region.

**Participants** Key informants nominated by each of the participating practices as being their clinical governance lead. Sixteen practices nominated general practitioners (GPs) (in one of these, two GPs shared the role), one practice nominated a practice nurse co-ordinator, and another nominated both a practice nurse and practice manager to be interviewed. The remaining practice nominated a GP, practice manager and two practice nurses to be interviewed.

**Results** Attitudes of our informants to clinical governance are positive. There is an ongoing commitment to quality as clinical governance is being implemented at practice level. This is in spite of some initial reluctance by our informants to take on the role of clinical governance lead, and uncertainty about what the role would entail. In the first interviews there was a feeling that being clinical governance lead would involve a practice-centred approach, continuing existing practice quality initiatives such as clinical audit. One year later attitudes had evolved. Quality was still seen as important, but now more of our informants saw their role extending beyond the practice, in particular to a link role between themselves, their PCO and other practices.

**Conclusions** Clinical governance is being implemented in a positive climate in primary care, with an ongoing commitment to quality that predates the advent of clinical governance. The role of the practice clinical governance lead has evolved from a practice-centred approach to one that is more outward looking, as evidenced by a link role between practices and PCOs. We suggest that this role could facilitate many aspects of clinical governance, and as such it should be encouraged by PCOs, more specifically by enabling protected time for clinical governance work in practices.

**Keywords**: attitudes, clinical governance lead, interviews, role

# Introduction

Clinical governance was introduced by the British government in 1998, along with the creation in England of primary care groups (PCGs), which were made responsible for clinical governance in primary care.[1] This responsibility was transferred to the successor organisations, primary care trusts (PCTs). It was acknowledged, however, that individual general practices and primary care teams would actually deliver many of the requirements of clinical governance.[2] Because of this, the opinions and attitudes of staff at practice level, particularly the clinical governance leads in the practices, are important for the delivery of the clinical governance agenda.

The initial guidelines on clinical governance contained within *A First Class Service* were quite broad, but they were made more specific the following year.[1,3] In this context and at this time we set out to investigate the views of practice clinical governance leads on a range of issues related to this round of changes in the NHS. Since this was early in what was expected to be a lengthy process of change, we were particularly interested to see if views changed over time. Our study therefore included two sets of semi-structured interviews with practice clinical governance leads, one year apart. We report here on evolving attitudes to, and opinions on being, a clinical governance lead in general practice. Other findings from the interviews will be reported elsewhere.

# Methods

## Recruitment and ethical approval

In March 2000 we asked all 51 primary care organisations (PCOs) which then existed in the old Trent Region to produce a list of eligible general practices. Nineteen PCOs volunteered this information. We numbered each practice and randomly selected three practices per PCO using the random number function on SPSS. We invited these practices to join the study and the first one to reply from each group of three was recruited. If all three refused, we selected another three practices from the PCO. In total 65 practices were contacted, 24 volunteered and 19 were recruited. Each of the practices nominated the informants, their general practice clinical governance leads, to be interviewed. Sixteen practices nominated general practitioners (GPs; in one of these, two GPs shared the role), one practice nominated a practice nurse co-ordinator, and another nominated both a practice nurse and practice manager to be interviewed. The remaining practice nominated a GP, practice manager and two practice nurses to be interviewed. Ethical approval was obtained from the Multi-Centre and Local Research Ethics Committee in the Trent Region.

## Data collection

### First interviews

Semi-structured interviews were conducted by a qualitative researcher with a background in sociology (AW).[4] This researcher interviewed all the informants at their convenience in their practice using a semi-structured guide. The semi-structured guide was developed initially through discussions within the research team and was piloted in an interview with a GP based in a practice in the Trent Region that was not participating in the study. As a result of the pilot a few minor amendments were made to produce the final version (see Box 1).

**Box 1 Summary of key areas in the interview guide**

- General information, e.g. profession of key informant
- Knowledge of, and attitudes to the new structures, e.g. their PCO's priorities
- Current and planned activity for coronary heart disease, e.g. prevention, protocols
- Current and planned activity for data quality

The guide was structured around topic areas within which were open-ended questions and suggested probes. Each issue was probed in detail until it was felt it had been exhausted (see Box 2).

**Box 2 Sample section of interview guide**

**Knowledge and attitudes to the new structures**
Thinking about primary care in particular:

- Are your thoughts on changes in the health service? (positive/negative)
- Why do you feel this way?
- What impact do you think these changes will have?

Interviews were conducted with the informants from the participating practices between January and July 2000. Interviews lasted on average for one hour. All but two interviewees consented to their interview being audiotaped. Notes were taken during the remaining two interviews and written up immediately following the interview. All audiotaped interviews were fully transcribed and imported into the QSR N5 qualitative software package.

### Second interviews

One year after the first interviews, between May and July 2001, AW again contacted the informants and conducted interviews by telephone. One practice had withdrawn from the study since the first interviews. The interview guide was similar to that used in the first interviews, but included some new, specific questions about the experience of being clinical governance lead, based on the emergent themes from the first interviews, and the kinds of clinical governance-related activities that the informants had been involved in during the year. With the constant comparative method used in grounded theory, questions developed from the analysis and reflection on previous data are accepted as part of the process.[5] The second set of interviews were a continuation of the process started with the first set, and as such the first interviews informed the second set. This allowed us to compare the second set of interviews to the first and see if our original framework remained appropriate or whether significant changes emerged. Additionally the second set of interviews allowed us to explore new emerging areas.

## Data analysis

We developed a thematic framework through familiarisation of the transcripts, drawing on issues from the semi-structured guide and emergent themes and categories derived from within the data.[6] The framework was then systematically applied to each transcript and modified until no new categories were identified. We used the constant comparative method (developed by Strauss and Corbin) to check and refine categories.[7,8] This framework was transferred into the QSR N5 software package and transcripts were then indexed. The key themes associated were then charted.[6]

It has been noted that qualitative work has often been criticised for 'lacking scientific rigour'.[9] Although it can be more difficult to show, for example, reliability than it is in quantitative work, a systematic and thorough approach is similarly important in qualitative research.[10] In this study we aimed to minimise the effect of researcher bias and ensure reliability.[11] This was done by involving researchers from both within and outside the research team in the analysis process as summarised in Box 3. In addition to the benefits of such multiple coding in enhancing reliability, such an approach can also encourage a thoroughness of analysis, exploring and debating all possible explanations.[9,10] The use of computer-assisted qualitative data analysis further encourages systematic management of the data and facilitates team research and the development of consistent coding schemes.[12]

**Box 3 Reducing researcher bias**

- The whole research team discussed and agreed the initial framework.
- An experienced researcher independent of the project piloted the framework on a sample of transcripts. Following this, definitions were refined.
- RC and AM independently checked text against categories and agreed coding was appropriate.

# Results

Findings are presented according to the main themes that emerged from the responses to the questions in the first and second set of interviews. Not all themes emerged in every interview, but where informants gave similar responses, the number of informants is indicated.

## First interviews

### Becoming clinical governance lead: a reluctant choice

Our findings suggest reluctance on the part of the informants to take on the role of clinical governance lead.

A majority (seven) of the informants had become clinical governance lead for their practice because they were felt to be the most appropriate person to take on the role:

> 'Er, really because I've sort of been using the computer and searching its templates for clinical things like aspirin, asthma and ischaemic heart disease so it seemed to, from a clinical point of view that seemed to be my role so I understand you know audit, clinical governance covers all aspects of the practice, not just clinical aspects so, but anyway it's fallen upon me to do it.' (Informant 16)

Four informants said they were taking on the role, but not by choice:

> 'It's probably because I wasn't at the meeting when somebody was choosing the names.' (Informant 18)

And three more said that there was no other alternative in their practice:

> 'I'm the only one so, I'm the only GP. This is a single-handed practice and I'm the, you know, I'm it.' (Informant 15)

In four practices it had not been decided at the time of the interviews who should become clinical governance lead. Only one informant said that they had taken on the role because they were interested in it.

## The role of clinical governance lead: a practice-centred approach

In this early stage of clinical governance, the informants identified specific activities within the role that could be interpreted as a continuation of existing processes within their practice. Nine informants said that audit was part of the role:

> '. . . well, I suppose it's really sort of audit work and making sure that we're following guidelines and generally doing all that's required for audit.' (Informant 7)

Six informants identified maintaining or standardising quality as part of the role:

> 'Well, it's just trying to maintain a standard which we've set ourselves and to make sure that we keep on top of that.' (Informant 14)

And two thought that the role was just a title for work which was already being done in the practices.

However, three informants thought that the role would involve meeting requirements or targets set by their PCO:

> 'Really just, from my point of view really just to make sure that everything that is being sent down from the clinical governance boys we can try and actually then put it into practice and push it forward within the practice.' (Informant 2)

Two informants thought that being clinical governance lead would involve some sort of link role:

> '. . . mainly as a link between us and anybody else who needs to know information or wants to give us information.' (Informant 11)

In addition to these specific ideas about the role, six informants could envisage a broader remit:

> 'Oh, well there's the issue of under-performing doctors and so on, there's this whole wider remit as far as if you like whistle-blowing is concerned and there are health and safety issues which I have to say I haven't really considered or thought about so that there's lots of other different issues that are coming into it now.' (Informant 13)

In two further cases, the informants admitted that they did not know what the role would involve:

> 'Well, having read the document I'm still not much the wiser, it seems a really airy-fairy sort of a role, I mean I suppose what I really expected, what I wanted was that somebody from the PCG would come down and say ''right you do this, you do this, you do this'', and then we'll do it.' (Informant 3)

Seven of the informants went on to say that their new role was putting pressures on their time, and in two cases it was felt that they had received no guidance:

> 'I'd very much like the PCG to come along and tell me what they want me to do for coronary heart disease but 12 months down the line they haven't told me and I've got fed up of waiting so I've decided to get on with it.' (Informant 10)

These data suggest that the role of clinical governance lead was perceived mainly to be driven by issues within the practices, although there was some awareness that a broader role was likely to develop. Lack of time for the role was already seen as a problem at this early stage, along with a perceived lack of support from the PCO.

## Priorities: a satisfactory start

Priority setting was one of the earliest requirements of new PCOs, and so views on priorities are likely to serve as a good indicator of early attitudes to clinical governance. Six of our informants did not know what their PCO's priorities were, perhaps indicative of the level of engagement with clinical governance at this early stage. Of the remainder, ischaemic heart disease (12), teenage pregnancy (7), national priorities (5) and mental health (4) were the most frequently identified priorities. Nine of the informants thought that their PCO had chosen appropriate priorities; only two felt the priorities were not relevant to their practice:

> 'So I think you're influenced by your patients more than anything else and we were naturally developing a system that is very flexible that we think the population and our patients, you know, will help them here and I'm going to be more influenced by that than any sort of dictate or memo from on high. I think that's human nature really, it's an observation I think rather than a criticism' (Informant 6)

while one said that their practice had its own priorities. This apparent satisfaction is reflected in the observation by six informants that PCO members chose the priorities, although it was acknowledged that the government (three informants) or health authority (three informants) had influenced the choice. Our informants appeared generally happy with the way these priorities had been communicated, with meetings (12) and various written communications (15) being the most common methods.

## Follow-up interviews

All but one of the informants still identified themselves as clinical governance lead for the practice at the time of the second interviews. The remaining informant (11) was clinical governance lead for the PCG, but not the practice.

### Being clinical governance lead: lack of time and support

After a year of being the clinical governance lead in their respective practices, 12 of our informants commented that the role required extra work or time to fulfil:

> 'It's more work than I thought it was going to be.' (Informant 1)

Five of the respondents said that they had received guidance or support from their PCO:

> '. . . but the PCG have co-ordinated those and provided an emergency cover, doctor cover, so that the doctors are freed up from routine surgeries. That's got some advantages and disadvantages but the outcome of that is that there is an afternoon where the doctors can meet with the nurses and the managers and ancillary staff to have training.' (Informant 6)

But three said they had not received guidance or support from the PCO.

### The role of clinical governance lead: outward looking, forging links

Since the first interviews, opinion about the role of clinical governance lead had changed. Now, eight informants saw the role as being about linking or co-ordinating, six thought that the role was about ensuring quality, while two still did not know what the role entailed. Compared to the first interviews, quality issues remained a perceived part of the role, but more informants identified a link role and none identified audit as part of their role. These findings were reflected in the activities in which the informants said they had engaged over the past year. Only five said they had done audits, but others identified activities relating to quality or being a link between practice and PCO. Examples included feeding back ideas (3), attending educational events (4), attending meetings (5), and working towards PCO targets (2). Only two informants now had protected time for their work as clinical governance lead. Opinion about clinical governance in general was positive in a majority of cases (13), with only one informant expressing a negative view. These findings suggest that the role of clinical governance lead was now perceived to be more concerned with an agenda driven from outside the practice than was the case in the first interviews.

### Priorities: continuing progress

Only three informants now did not know what their PCO's priorities were. This suggests that engagement with the process of clinical governance had increased both at practice and at PCO level.

## Discussion

Our data suggest that overall attitudes of our informants to clinical governance are positive. There is an ongoing commitment to quality as clinical governance is being implemented at practice level. This is in spite of some initial reluctance by our informants to take on the role of clinical governance lead, and uncertainty about what the role would entail. In the first interviews there was a feeling that being clinical governance lead would involve a practice-centred approach, continuing with existing practice quality initiatives such as clinical audit. One year later, attitudes had evolved. Quality was still seen as important, but now more of our informants saw their role extending beyond the practice, in particular to a link role between themselves, their PCO and other practices. These views are encouraging in the light of the perceived benefits of clinical governance detailed by the NHS Executive.[3] In particular, the link role identified by our informants is likely to facilitate cultural change, addressing inequalities, training, sharing good practice and dealing with poor performance. This positive impression is tempered, however, by two main barriers to our informants' work in clinical governance: these are a perceived lack of resources, particularly time, and a perceived lack of support from the PCO.

The findings presented in this paper complement those of Sweeney *et al*, who investigated primary care clinical governance in the south-west of England at about the same time.[13] Both studies identify similar positive attitudes to clinical governance, and also similar challenges to its implementation. By confirming the work of others, this paper is able to suggest that the findings common to both studies may be transferable, and not just the result of local phenomena. Our data add the observation that practice clinical governance leads perceive themselves after one year's experience to be fulfilling a link role beyond their own practice. We suggest that PCOs could enhance the implementation of clinical governance by encouraging this link role and increasing the support that is given to it. In particular we suggest that the practice clinical governance leads need protected time to carry out their important role.

## Limitations of the study

The way that we recruited our informants could have led to selection bias, and if so our informants might have more favourable attitudes than those who did not take part. We do not have any information on the clinical governance leads whose practices did not take part in the study, so the extent of this bias cannot be determined.

We believe that our conclusions emerged from the data, and were not influenced by existing literature. At the time that the study was being conducted and analysed there was very little relevant literature available, and the study by Sweeney *et al* was discovered after the analysis was completed.[13] However, we bring to analysis our previous knowledge, and this is acknowledged by Strauss and Corbin who stress: 'In fact, there is an interplay between induction and deduction (as in all science)', and state that this is why researchers should validate their interpretations by constantly comparing data to one another, which we believe we have done systematically within this piece of research.[14]

## Conclusions

Clinical governance is being implemented in a positive climate in primary care, with an ongoing commitment to quality that predates the advent of clinical governance. The role of practice clinical governance lead has evolved from a practice-centred approach to one that is more outward-looking, as evidenced by a link role between practices and PCOs. We suggest that this role could facilitate many aspects of clinical governance, and as such it should be encouraged by PCOs, more specifically by enabling protected time for clinical governance work in practices.

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### CONFLICTS OF INTEREST

None.

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