Exploring the impact of clinical governance on the professional autonomy of general practitioners in a primary care trust in the North West of England

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Chapter Six

The Results

Clinical Governance and Professional Autonomy

'Sceptics dismiss individual experience as anecdotal, but when you are your own anecdote, it's hard not to be convinced.' (Rose Shepherd, the Observer Magazine, February 2004)

6.1 Introduction.

This chapter reports the results of my study and is presented in the form of a comparative summary of the responses of managerial and professional participants in the research. The chapter is structured around the three core themes of the study, these are, 'the nature of clinical governance in general practice', 'implementing clinical governance in general practice', and 'the impact of clinical governance on the work and role of GPs in practice and the role of GP medical advisers in the implementation of clinical governance.' The responses of the managerial and professional participants are analysed and summarised and then evidenced with key quotations from the interview and focus group transcripts. Quotations from the interview and focus group transcripts are referenced with the key informant's job title, the number of the interview transcript, and the page number and

paragraph letter from the transcripts. The job titles are mostly self-explanatory, however, 'CEO' refers to the Chief Executive Officer of the PCT; 'MA' and 'NA' refer to the GP and Practice Nurse Medical Advisers/Professional Representatives to the PCT; 'AHP' refers to the Allied Health Professional Adviser/Professional Representative to the PCT and 'GP Chair' refers to the GP Chair of the Professional Executive Committee (PEC) of the PCT. In some quotations the context has been added and placed in brackets to provide the sense of the point being made.

6.2 Theme One: Clinical Governance in General Practice.

6.2.1 What is Clinical Governance?

The Chief Executive Officer and functional directors of the PCT had clear perceptions of the nature of clinical governance describing it as a means to assure clinical quality and outcomes around seven areas of work of the PCT. The lay Chair of the PCT Board and the Non-executive Director participating in the study could not be so precise in their definitions. They were however aware that clinical governance is about quality improvement, risk management and increased accountability for healthcare services. For these individuals, clinical governance was more ambiguous as a concept.

> "I take clinical governance as being what's actually outlined as the seven pillars that we have to work with, public and service user involvement, risk management, clinical audit, clinical effectiveness, use of information, education and training and staff management. The overall basis is to have the means to assure clinical quality and clinical outcomes. In theory it is working on those seven different areas to make sure they are not working in silos, but across each other and underpinning everything we do.....It's making sure that all aspects of the organisation, be it a large or small organisation are working to ensure good clinical outcomes.....It's the same for individual practices as it is for the PCT" ***(CEO; Interview 1; Page 2; Paragraphs C and D).***

> "Are we talking here about control, risk management and all that sort of thing?" ***(Chairperson of the PCT Board)***

> "I find it extremely difficult to visualise what clinical governance is. I know it is an umbrella term incorporating quality issues and risk management and health and safety, and tightening up on accountability and things like that. I find it extremely difficult to get a picture of clinical governance. I think it is a phrase for a thousand different things really, but I think it is around maintaining quality control and accountability." ***(None-executive Director; Interview 9; Page 2; Paragraph E).***

The PCT directors and managers defined clinical governance as a quality assurance system to improve the quality, consistency and standardisation of healthcare services and access to those services across general practice. It was reported that this involves the setting of national standards via National Service Frameworks (NSFs) and National Institute of Clinical Excellence (NICE) guidance; the delivery of those standards by the application of evidence-based practice, reinforced by performance appraisal and the continuous professional development of healthcare professionals including GPs; and finally, the monitoring of those standards by national and local benchmarking, using Key Performance Indicators (KPI), user satisfaction surveys and external inspection by CHAI.

> "National Service Frameworks are part of clinical governance. They are an attempt to drive up standards and improve services around specific areas, and to provide some common standards nationally. They are an attempt to get away from postcode prescribing and to provide access to services whatever part of the country you are in". ***(Health Improvement Manager; Interview 11; Page 2; Paragraph E).***

> "The links between NSFs and clinical governance are very strong. NSFs are minimum national standards that practices are supposed to achieve .....NICE guidance links closely to the implementation of NSFs.....I think that by looking at generally improving services, by examining existing practices you get the opportunity to look at risk and to benchmark with other organisations and geographic areas. ***(Health Improvement Manager; Interview 11; Page 3; Paragraph H).***

> "I think for me it (clinical governance) is nothing more complicated than improving clinical care. Getting a common standard of approach and consistency across

> general practices.....The main feature (of clinical governance) is to bring general practice into a much more responsive mode of modern day medicines and practices through continuous professional development and benchmarking." ***(Director of Modernisation; Interview 4; Page 2; Paragraph C.***

The professional group, whilst recognising clinical governance as a quality assurance system defined it more in terms of their own professional attitudes and behaviour and patients perceptions, than in terms of policies, procedures and systems. The professional group recognised the need to provide high quality services, but focused more on the risk management element of clinical governance.

> "You can't have a consultation with a patient without looking at advantages and disadvantages of different options, and what the risks and benefits are. I guess clinical governance is about formalising those sorts of dilemmas. It's looking at the systems and structures to support improved healthcare quality. It's looking at the quality of the services you are providing and pulling it all together under one umbrella organisation." ***(GP Chair; Interview 14; Page 2; Paragraph E)***

> " (Clinical governance is) a way of standardising practice to improve the standard of care and access to services across the board locally and nationally, so there is no variation, so that patients get equality of care. It's also about sharing best practice, so that if a particular practice develops good practice, they are encouraged to share it with other practices. It also incorporates things like NSFs and risk management and significant event analysis and clinical supervision and all those sorts of things. GP appraisal is also a part of it." ***(Practice nurse focus groups 1 and 2; Page 1; Paragraphs A to D)***

> "I think it (clinical governance) is really summed up in doing your job properly. Nothing more,nothing less. It's about Professionalism, something which is on the wane!" ***(GP 12; Interview 18; Page 1; Paragraph A)***

> "Clinical governance centres around the quality of the services we provide and perhaps more importantly, the patient's perceptions of the quality of those services. Does the patient believe he's had good quality service?" ***(AHP; Interview 26; Page 1; Paragraph A)***

> "Clinical governance is about providing a safe environment for both patients and doctors to work in. Patients are to be given the best possible treatment in the safest way." ***(MA.1; Interview 16; Page 1; Paragraph A)***

Eight of the twelve GP participants perceived clinical governance to be a performance management system and a potential tool for controlling their work. Two of the twelve GPs believed clinical governance to be a covert system for rationing healthcare services. Clinical governance was also defined by the professional group as a time consuming bureaucratic process. The practice nurse advisers and all of the GPs, except one, stated that clinical governance aligns closely with the new GMS contract.

> "I'm not quite sure what people mean by clinical governance because it can mean different things to different people. I understand it to be a way of auditing and measuring and I would say 'controlling' what we do in general practice. I am deeply cynical about the reasons why things are measured. I think it is to produce statistics to prove that the NHS is getting better, or make sure that we are not over-spending, or to design covert rationing policies. ***(GP1; Interview 17; Page 1; Paragraph A)***

> "If you monitor all sorts of aspects of the way we (GPs) work, and you compare one GP with another, then there are going to be discrepancies and there are going to be economic considerations with those discrepancies, and you are going to say well why is it that GP X is doing this and it is costing the PCT loads of money and other GPs aren't. In that sort of context it will be used as a management tool, and I don't think we can do a right lot about it. I mean, we are being managed at the minute, but we are going to be managed more in the future, and you need to have the information to manage. This is just one bit of it." ***(M.A. 2; Interview 16; Page 3; Paragraph J)***

> "It seems to have become more bureaucratic, its being accountable isn't it, for things, proving what you are doing is right sort of thing, having to record everything, providing evidence." ***(Practice Manager of GP 11; Interview 24; Page 1; Paragraph C)*** ....."I think what she (the practice manager) is trying to say, and we agree with each other (GP and practice manager), we spend more time on management, doing all the computing and paperwork, than we do on patients!" ***(GP 11; Interview 24; Page 1; Paragraph B)***

6.2.2 The Requirements for the effective implementation of clinical governance in general practice.

For the effective implementation of clinical governance in general practice, the PCT directors and managers stressed the need for a clear framework of policies, procedures

and systems around seven areas of work; clinical effectiveness, clinical audit, risk management, education and training, service user involvement, use of information and staff management at the PCT and in the individual general practices. The need for education and training of the whole primary care team and a new more supportive learning culture in general practice where people feel safe to admit to mistakes and to learn from them was stressed. The directors and managers also highlighted the need for performance appraisal for medical professionals, strong leadership in the practices and a multi-professional team-based approach to service delivery. Practices would need to be more open and willing to share information and disseminate good practice. There will also need to be clear lines of communication within the practices and between the practices and the PCT, underpinned by an appropriate information system.

> "The best way to describe clinical governance is very much around the 7 pillars. If we look at what underpins that, there has to be a good communications strategy in terms of what is happening around the clinical governance and risk management agenda. Also, information technology systems to support the 7 pillars and their development." ***(Director of Clinical Services; Interview 2; Page 2; paragraph D).***

> "It is about improving quality across the whole spectrum of care. One of the more tangible features is around education and training, but it is also about the way people communicate, the way they organise themselves as a practice in terms of policies and procedures within general practice. The main feature is around training and development of the whole primary care team." ***(Director of Primary Care; Interview 3; Page 2; Paragraph C)***

> "Clinical governance is about delivering safe clinical care to patients. This requires competent practitioners with appropriate up to date skills. It requires the identification of errors and learning from experience to improve future quality. This implies not only performance appraisal and the continuous professional development of medical staff, but also the existence of an organisation culture where people feel able to do this. With the kind of services we are providing, sometimes things go wrong. There are cultural issues around encouraging people to identify their mistakes and learning from those mistakes in a continuous quality improvement process." ***(Director of Human Resources; Interview 5; page 2; Paragraph D.)***

The professional group similarly recognised the need for a framework of policies, procedures and systems and a more supportive, learning culture in general practice. There was however a greater focus on the *nature* of those systems and procedures, stressing that if they are to be effective and maintain credibility with GPs and practice teams they will need to be simple, relevant, realistic, practical and flexible. Clinical governance will also need to be adequately resourced. For clinical governance to be accepted and supported in general practice GPs and practice teams will need to fully understand it, and be convinced of its value, that it makes the practice more efficient and provides better services for patients. The professional group recognised that clinical governance had medical input at the design stage but believed this to have been contributed by 'academic' rather than 'practising' professionals and was therefore perceived not to be as useful and practical as it could have been.

> "Clinical governance is merely a system of quality assurance with certain minimum standards and hopefully allows practices to exceed these and continually drive standards higher. It needs to be relevant and realistic. The practice should have ownership to let them see that it is relevant, that it isn't just another tool to be used by managers for bashing you with. It's got to be possible to put it in place and not lose sight of it, rather than you pull it out of a cupboard once a year, it has got to become part of normal practice." ***(MA2; Interview 15; Pages 1 and 2; paragraphs D and E)***

> "It (clinical governance) has to be easily implemented within the workplace. It has to work, not make life difficult for either professionals or the public; it has to be easily applicable and seen to be useful. I think a lot of things that have been done in the past have been thought to be a waste of time, therefore implementation has been somewhat half hearted." ***(MA2; Interview 16; Page 1; Paragraph B)***

> "It (clinical governance) needs to be designed in collaboration with GPs, they (the government) may say that it has been, but they will be non-practicing, 'academic' GPs, they won't be the hard working 'dogs bodies' on the ground. It needs to be simple, it needs to be practical, it needs to be flexible and it needs to be realistic." ***(GP.1; Interview 30; Page 2; Paragraph B)***

> "One of the biggest issues around clinical governance is resources. Clinical governance, to be effective will be very resource intensive. It really depends how much work is dumped onto general practice by the health service, and specifically secondary care, together with the amount of work that is involved in performing under the new GMS contract. Clinical governance is all very well and good, but it's difficult to do it when sometimes even the basics of health services are difficult to achieve because of the enormous demands that are put onto something of a creaking system. The resources should be put into making sure the basics are right before you do the 'nice to haves.' ***(GP 12; Interview 18; Page 1; Paragraph B)***

> "We'll all have to be on board to make it work. The whole team will need to understand what we are trying to do and agree that the effort is worth it and justified." ***(GP 4; Interview 19; Page 5; Paragraph D)***

> "It will be necessary for GPs to want it (clinical governance) to work, and to understand the value of it. If you think it is going to make your practice run more efficiently, and you are going to give a better service to your patients, then it's worth doing isn't it?.....I think you can modify clinical governance, some of it you can throw out, but you have had to look at it first. If you look at it and decide something isn't right for your particular practice, I think that you can throw that bit out. I don't think there are many areas of clinical governance that are not valuable, but some can be a bit, well, stodgy! It can be very difficult to implement it in all its forms." ***(GP 6; Interview 21; Page 4; Paragraphs I and J)***

6.2.3 How is Clinical Governance Different from Previous Quality Initiatives?

The directors and managers of the PCT had a clear understanding of how clinical governance is different from previous quality initiatives. They identified it as a more rigorous, systematic, and holistic approach to quality assurance and continuous improvement of healthcare services. Clinical governance is also described as a more integrated approach, so that quality assurance and continuous improvement of healthcare services are no longer add-ons, but a part of everyone's responsibility across all sectors of the health service, and at the interface between primary, secondary and tertiary services.

> "Clinical governance is a much more holistic approach to general practice. We have learnt from what we have done before, and now we are trying to put it into one overarching agenda." ***(Director of Modernisation; Interview 4; Page 2; Paragraph D).***

> "Previous quality initiatives focussed on continuous improvement but not in such a rigorous and systematic way, and in relation to the patient experience.....It didn't necessarily encompass the seven pillars of clinical governance, or look at how these are integral to the patient experience." ***(Director of Clinical Services; Interview 2; Page 2; Paragraph E)***

> "Clinical Governance is a culture change for general practice in terms of always thinking about the patient experience, and the quality of service being provided and how all of this fits together." ***(Director of Clinical Services; Interview 2; Page 2; Paragraph F).***

> "The difference is that the intent is for it to be integrated. Previously, quality was very much an add-on. Somebody had the job of being a quality manager, or director, or whatever. My understanding of clinical governance is that it is to be part of everything we all do, and to integrate it into everything we do" ***(Human Resource Director; Interview 5; Pages 6 and 7; Paragraph M).***

> "Clinical governance requires colleagues to talk at a clinical level both within and between primary, secondary and tertiary care in a common format." ***(Director of Modernisation; Interview 4; Page 2; Paragraph E).***

Clinical governance was also perceived by the managerial participants to have more credibility and power than previous initiatives because it places a statutory accountability on Chief Executive Officers for the quality of healthcare services provided by their organisations. At the same time, it was recognised that everyone has a responsibility for quality.

> "There have been as many approaches to quality as there have been re-organisations to the NHS. Clinical governance is new in firmly attaching the responsibility for quality to the CEO. Its not just like an organisation thinking that it would like to focus on quality and perhaps select an appropriate quality model, it is in statute, so its not what we might feel like doing, its very definitely what we have to do!" ***(Assistant Director of Clinical Governance and Professional Development; Interview 8; Page 2; Paragraph D).***

> "I think previous quality initiatives tended to be a bit hit and miss, this time it's a definite must, we've got to achieve this. Whereas in a lot of previous initiatives, yes, some people did, some people didn't, but we've got to see it right across the board.

> We are not going to be able to deliver if a large part of the team isn't delivering. ***(Chair of the PCT Board; Interview 7; Page 3; Paragraph J).***

The managerial group recognised that clinical governance requires an evidence-base and has a greater focus on risk management than before. The focus on the patient experience was also stressed, and the increased involvement of service users. Clinical governance was perceived to require more resources than previous quality initiatives. It was observed that clinical governance represents a clear and overt attempt to 'manage' the performance of healthcare professionals, including GPs via performance appraisal and continuous professional development and will require a cultural change in general practice.

> "Clinical good practice has always been in place but has not been managed in such a structured and systematic way, and I think that all of the principles around corporate governance, risk management and clinical governance, are all about having systems and structures in place to manage and improve and ensure awareness of the principles you need to adopt, and what evidence you need to gather to be able to demonstrate that you are actually achieving what you set out to achieve." ***(Risk Manager; Interview 12; Page 4; Paragraph F).***

> "The focus on risk management within clinical governance is quite a new phenomenon. It is about being able to identify risk. Being able to assess the risk and being able to put control measures in place." ***(Risk Manager; Interview 12; Page 2/3; Paragraph E).***

> "I think there has always been a lot of lip service in terms of quality in the past. Clinical governance is different because it starts at the roots. In the past we have done superficial things, but clinical governance has got weight of power behind it to achieve things. We've had Bristol and Shipman, we can't survive with any more of those kinds of things. We've got to get it right. Oh yes, it's different this time." ***(Director of Finance – Acting; Interview 6; Page 5; Paragraph K.)***

The professional group were less consistent in their ability to identify the differences between clinical governance and previous initiatives. The GPs participating in the study found it particularly difficult to do this. The GP Chair of the Professional

Executive Committee (PEC) suggested that clinical governance is little more than a re-labelling of what has always been present in general practice, although she did go on to identify the new supportive, learning culture as a distinguishing characteristic. This new culture was also stressed by the Allied Health Professional participant. The GP Chair suggested that clinical governance represents a more structured means of dealing with the increasingly litigious environment in which medicine is now practiced. The GP participants suggested that clinical governance is a more formal system, requiring medical professionals to prove what they are doing by producing an evidence-base, and that there are more careful attempts to measure outputs, involving more detailed record keeping in the practices. Three of the twelve GPs recognised clinical governance as a vehicle to enable the government and NHS managers to more closely control the work of the medical profession. Close links with the GMS contract were identified as the means of achieving GP compliance with clinical governance.

> "I get the feeling it is just collecting together things that have always gone on and giving it a name. I don't think it is something new; it's just a re-labelling of what's already there. We work in an increasingly litigious atmosphere. You always feel that somewhere round the corner somebody is going to make a complaint against you. No matter how hard you try, you can be a complete perfectionist, do everything by the book, but things can still go wrong because we are only human. One of the ways of learning to live with this is to minimise risk and try to introduce a much more supportive environment, rather than a blame culture, and try to use things that do go wrong as a learning tool rather than as a battering ram. This is what clinical governance tries to achieve. I don't think we are there yet, we have a long way to go, but I believe there is a genuine wish out there (in general practice) to do so. People are still very suspicious though and think it is going to be used as a disciplinary tool.....I think ensuring that people can trust in a supportive environment, it's that trust that needs to be developed. We've got quite a long way to go yet." ***(GP Chair; Interview 14; Page 3; Paragraphs E, F and I)***

> "The greatest change seems to be moving away from looking at quality audits in term of finding the negatives and leaving it at that, to a learning style within an organisation and moving away from the fear factor of something not being right and therefore we couldn't admit to it. I think learning is the key feature of clinical

> governance, sharing knowledge and skills and learning from experience..... In the past, if we audited and found anything wrong we were encouraged to tick all of the boxes and say everything was fine even if it wasn't because we would be penalised by the Health Authority. Now, it's moved from, it's some person's fault to the system needs improving. This is a big shift" ***(AHP; Interview 26; Pages 1 and 2; Paragraphs A and B)***

> "Clinical governance has always been here, just because managers come up with a new name and think they have invented the wheel doesn't mean to say they are right. Good GPs have always exercised clinical governance, in that, if something goes wrong, (you have a buzz word now, you will call it significant event analysis, or near misses), pick up the notes, look what has happened, learn from this, what happens if it happens again? Who do I share it with, do I have to look at it myself in more detail, and do I have to look at the systems we are working with? We have always done it, but not in such a structured way and recorded it. It has maybe been done more personally, informally, just by word of mouth, but it has always happened." ***(MA 1; Interview 15; Page 8; Paragraph C1)***

> "I'm stuck because I am still trying to get my head around clinical governance. Obviously I understand what it is all about, but how its different.....We've always tried to provide good quality care and what seems to be happening now is that what we are doing is being measured and therefore we have to prove to be doing what we say we are doing. It requires a lot more detailed record keeping which is more time consuming. Also, clinical governance applies to all aspects of our work, whereas previous quality initiatives have been focused on specific areas like heart, diabetes, asthma. ***(GP 12; Interview 19; Page 3; Paragraph A)***

> "I don't know that there is anything different in substance than what went before. It is perhaps more structured and formalised and, dare I say, 'policed' than previous initiatives. I think previous initiatives were notable by their wooliness and lack of structure." ***(GP 12; Interview 18; Page 1; Paragraph A)***

The nurse professional advisers and practice nurse participants had clearer perceptions of the differences, and these were the same defining characteristics as those identified by the PCT directors and managers. The need for stronger leadership in the practices and the focus on the patient experience were also stressed.

> "It is broader than other quality initiatives that we have had. It takes in things like life-long learning, education, training and support. Another key feature is strong leadership, looking at what we are doing, how we are doing it, are there different

> ways of doing it to improve the patient experience, and another key feature is involving patients in the process. I think that is something we have not done effectively in the past. We have to look at things from the point of view of the patient.....It also looks at the boundaries as well. It is about interacting with other agencies outside of general practice far more. It is about improving the patient experience from their first contact with the health service, until they leave the health service after that particular episode of care. It involves so many people, from porters in hospitals to telephonists answering telephones, you know it is not just clinical care that they receive but the broader perspective is now built in to providing care." ***(NA 1; Interview 25; Page 3; Paragraphs A, B and C)***

> "I don't think we have formalised quality initiatives in such a cohesive way before, we have never co-ordinated the end point before, and I don't think we have ever listened to our clients before and taken their views into account. We haven't closed the loop from a user's perspective and learned from that experience. I don't think we have been very good at learning from mistakes on clinical issues, it wasn't open and transparent." ***(NA 2; Interview 27; page 2; Paragraph B and C)***

6.2.4 The Strengths and Weaknesses of Clinical Governance.

The PCT directors and managers tended to identify strengths and weaknesses of clinical governance in relation to its potential to achieve the political and managerial objectives for which it has been designed. The professional group, with the exception of the Professional Executive Committee representatives, tended not to perceive many strengths of clinical governance at all and to identify weaknesses in relation to the negative impact it might have on their working lives.

The PCT directors and managers identified the key strength of clinical governance to be its potential to provide a clear and consistent framework for quality improvement, covering not just clinical but organisational and managerial elements as well, and covering all sectors of the health service in an integrated way, including the interface between them. NSFs and NICE guidance were identified as an effective way of providing standardised and consistent access to and quality of health care services nationally and locally and a useful vehicle for linking healthcare services across the various health care sectors. Whilst flaws with respect to the crude measures used in some of the Key Performance Indicators was recognised,

KPIs were identified as an effective means of benchmarking against national standards and facilitating progressive performance management. The new supportive and 'learning' culture that clinical governance is designed to generate was perceived to be greatly needed in general practice. Clinical governance was seen to be an effective and systematic approach to the consistent development of best practice, with a greater possibility of this being more widely disseminated than it has ever been before.

> "Clinical governance provides a clear framework which includes not only clinical aspects but organisational and administrative aspects as well which should work together to improve the quality of care for patients." ***(CEO; Interview 1; Page 2; Paragraph F)***

> "I think the strength is the consistency of the model and of the method adopted right across the health service. Clinical colleagues have an opportunity to talk at clinical level, both within and between primary, secondary and tertiary care in a common format. So its strength is its universal approach in terms of the NHS in this country." ***(Director of Modernisation; Interview 4; Page 2; Paragraph E).***

> "National Service frameworks are good because it means you keep your eye on everything and you performance-manage progressively and continually." ***(Health Improvement Manager; Interview 11; Page 4; Paragraph J)***

> "Clinical governance is integral to the daily business of running a general practice and to patient care, not an add-on. I think this is something of a culture change for general practice in terms of always thinking about the patient experience, or about the quality of services being provided." ***(Director of Clinical Services; Interview 2; Page 2; Paragraph F)***

> "Its strengths are in ensuring that systems and procedures are in place. Instead of best practice being ad hoc, it's making the whole service operate within measurable levels of good practice, and thereby being able to improve on a continuous basis." ***(Risk Manager; Interview 12; Page 4; Paragraph G).***

By contrast, the professional group was less able to define strengths associated with clinical governance. Although not all of the GP participants were welcoming of NSFs and NICE guidance, and many weaknesses were identified with these, they mostly did acknowledge

them as a valuable reference point for GPs and a useful means of keeping up to date with recent evidence-based developments in medicine. Two of the twelve GPs also acknowledged that they welcomed the definition of service levels for specific medical conditions, taking the pressure off them having to justify their clinical decisions to their patients. The nurse participants suggested that a strength of clinical governance in general practice is that it focuses attention on the patient experience and quality, and forces GPs to consider this in their decision making, so as to make the most effective use of resources in general practice. The Allied Health Professional participant stressed the value of sharing good practice and learning from experience across the professions in primary care. It was observed that this may prove more challenging for GPs who have traditionally behaved more independently than other primary healthcare professionals. It was perceived that GPs may feel threatened by this aspect of the new culture.

> "I think they (NSFs and guidance) are good practice, and if we had the time and resources to implement them, I think they would improve the health of the population, but I don't think we are quite in that situation yet." ***(GP Chair; Interview 14; Page 4; Paragraph M)***

> "The strength has got to be the evidence-base, especially around the NSFs. I think guidance in general is a good thing because it helps people provide structured care, and for someone whose memory is increasingly poor it is good to have something to refer to in a succinct way. ***(GP 12; Interview 18; Page 2; Paragraph C)***

> "Clinical governance, and of course the new GMS contract will make practices look at the services they are providing, and look for different ways of doing things. Very small changes can lead to very big gains within a practice. There is not a lot of money around so we have to look at smarter ways of doing things. A lot of things we currently do are by habit or ritual, so we need to question why we are doing things, remove the barriers and a lot of the red tape" ***(NA 1; Interview 25; Page 4; Paragraph D)***

> "The strength of the approach is that we are learning from experiences and sharing those experiences across professions and not just within professions. In general practice this will be challenging, because being independent practitioners, the culture of sharing and learning from each other is just not there. We (allied health professionals) are more cohesive, where GPs are very independent; particularly those that were fund holders. They feel threatened by

> learning from each other and see it very much as policing of their work." ***(A.H.P; Interview 26; Page 2; Paragraph C)***

Both the PCT Directors and managers and the professional group identified many weaknesses of clinical governance. Directors and managers believed that the title 'clinical governance' was unhelpful in achieving its goals. The title was seen to be misleading and ambiguous, leading some individuals to believe that it is a purely clinical concept and therefore of no relevance to their work. The title was also perceived to antagonise the medical profession who might interpret 'governance' as a potential managerial challenge to their professional autonomy.

> "Its weakness is that it is called clinical governance. This leads some people to believe that it isn't necessarily for them, and that it is a difficult kind of concept to get your head round" ***(CEO; Interview 1; Page 2; Paragraph F)***

> "I think the title gets in the way (of effective implementation). If I went out to staff and said, what does clinical governance mean to you, I don't think many of them would have much idea to be perfectly honest. I think it is a bit of a turn off as well!" ***(Director of Human Resources; Interview 5; Page 7; Paragraph M.)***

It was suggested by the managerial participants that clinical governance might be more politically driven, than quality driven, a response to recent highly publicised adverse incidents. Thus the title 'clinical governance' is sufficiently strong to create the image that something is being done about under performance of medical professionals. That laxity in professional standards is to be no longer tolerated.

> "I don't think the term clinical governance goes down too well with the professions. It is the governance part, obviously, rather than the clinical. But it has to be called clinical governance because of Shipman and Bristol and Alder Hey. Publicly we have to be seen to be tackling the issues and governance is sufficiently strong a term to give this impression." ***(Clinical Governance Facilitation Manager; Interview 10; pages 21 and 22; paragraph K2)***

There was concern expressed that subsuming risk management, itself a large and significant task, within the massive clinical governance agenda, may lead to a loss of focus on this crucial area. Clinical governance was perceived to be very prescriptive and difficult to apply in complex and diverse independent contractor organisations. This prescriptiveness was also perceived to inhibit creative problem solving, something necessary for effective risk management and continuous improvement processes.

> "It (clinical governance) is seeking to improve quality of care and it is seeking to manage risk more effectively. Much of clinical governance has however found its roots in clinical disasters. As much as being a care imperative it is therefore a political imperative. The government could not afford the number of embarrassments. If you look at Bristol and Alder Hey, they are examples of breakdowns in the delivery of care and the management of the delivery of care. It's about being responsible and accountable. ***(Assistant Director of Clinical Governance and Professional Development; Interview 8; Page 2; Paragraph E)***

> "Risk Management forms one of the seven pillars of clinical governance and in some ways has become subsumed by the larger clinical governance agenda. This is a good in-road into general practice, but there is a need to ensure that the focus (on risk management) is appropriately strong within that. Primary Care does seem to be focusing attention on clinical governance rather than risk management which is seen more of a side issue." ***(Risk Manager; Interview 12; Page 8; Paragraph Q).***

> "The weakness is that people find systems and procedures sometimes quite difficult, also, the more regimented the systems and structures become, the more difficult it is for staff, it sometimes thwarts innovation. Staff are always looking for an answer rather than asking a question.....so rather than going to staff and saying, here's a clinical risk management system, this is the answer to all of your problems in terms of clinical risk, it's about getting them to develop ideas about how they should manage clinical risk." ***(Risk Manager; Interview 12; Page 4; Paragraph H).***

Finally, the managers suggested that the focus on achieving the national targets associated with NSFs and NICE guidance was perceived to potentially detract from different local

priorities, possibly even reducing the quality of such services which may be important to local populations. PCTs were after all set up to serve the needs of local populations.

> "NSFs in one way are good because it means you keep your eye on everything and you performance manage progressively and continuously. On the other hand it can mean that you concentrate on those areas, at the expense of other pieces of work...(NSFs) are important because PCTs are monitored against these, but its about achieving an appropriate balance between making progress on the targets and actually continuing to improve the health of the population locally.....I think there is a general perception from primary care, of being swamped with the sheer quantity of work involved.....It is a massive agenda and some NSFs are beyond the remit of one organisation to sort out....." ***(Head of Health Improvement; Interview 11; Page 4; Paragraph J).***

> "It's really the first time we've ever had a fairly robust way of benchmarking the services in the organisation against organisations in other parts of the country. It has its faults because of the crude measures that the indicators use.... the danger of star ratings is that because it does get picked up by the ocal and national press, it gets very political and can be very damaging and takes the focus away from the good work that has been done. The other problem is that because we have been asked to perform against 30 targets that have been decided nationally, that doesn't give the flexibility to concentrate on important local targets specific to our local population which is what PCTs are set up to do, to address local needs." ***(Corporate Affairs Manager; Interview 13; Page 5; Paragraph N).***

> "Quite often targets and meeting those targets can mean that we miss out on quality. We have to get the balance right between hitting the targets and delivering a quality service.....I do think that the targets and the performance framework will have a detrimental impact on delivering quality." ***(Clinical Governance Facilitation Manager; Interview 10; Page 11; Paragraph V)***

The professional group stressed the key weakness to be the excessive time involved in implementing all aspects of clinical governance, and the excessive paperwork which was perceived to be overly bureaucratic, and unnecessarily increasing the workload of GPs and other healthcare professionals in general practice.

> "GPs dread the over burgeoning bureaucracy and paper filling that undoubtedly comes along with it (implementing clinical governance) I mean, at Utopian PCT we have got screeds and screeds of paper covering every last thing, how you are

> supposed to open a door! I exaggerate, but I think there is a limit to how far the end result is worth the depth of navel gazing that seems to be required a lot of the time. So, I think that most GPs, if it is user-friendly with positive outcomes at the end of it, will accept it. If it is thought to be a waste of time and another form filling exercise with no perceived benefit, then it may be a struggle to get GPs to take that particular aspect on board. I think it is coming though, whether we like it or not!" ***(M.A. 2; Interview 16; Page 3; Paragraph I)***

Whilst recognising that NSFs and NICE guidance are a useful reference point, some GP participants suggested that these are, in effect, more of a tool for the government and managers to control healthcare expenditure than they are a vehicle for the continuous improvement of healthcare services.

> "Some of the NICE frameworks are not always practical. For example, there is some very good NICE guidance on flu and how you treat it if you pick it up in the first 48 hours. But, how do you pick it up in the first 48 hours? It's alright in theory but in practice it's not terribly practical. I suppose the good thing about NICE is that it looks at evidence. I personally think that NICE stands for the National Institute for the Controlling of Expenditure! That seems to be its main criteria. It's fair, all things being equal to consider using the cheapest treatment, I don't have a problem with that, but it does seem to be the main driver of whether you should use a treatment or not. If it is a form of rationing, fine, but they should come up front and not hide it behind something else." ***(GP 2; Interview 30; Page 2; Paragraph C)***

> "It is difficult to audit the implementation of NICE guidance in general practice. There may be data that shows that doctors are using drugs that are promoted by NICE, but we don't know they are being used on the right patients. The data we use tells us the quantity of drugs going out but it doesn't
> tell us any patient details, which are of course confidential. If you want to audit the appropriateness of prescribing we have to go into the practices and look at the details on their systems, which they don't like. We can ask them to audit those themselves, some of them have fairly high tech. computer systems, but it takes their time and their commitment. Many doctor's attitudes are NICE guidance comes out, we'll have a meeting, we'll implement it, we've done it, we know we have done it, we haven't got the time to demonstrate for you that we have done it!" ***(P.A. 1; Interview 29; Page 4; Paragraphs N and O)***

GPs also highlighted as a weakness the focus of clinical governance on measurable outputs, stating that a lot of very important work done in general practice does not have measurable outputs and is therefore invisible to the systems. One GP participant stressed that clinical governance detracts from the 'art' of medicine.

> "The problem with it is that the work in general practice is so varied. You can't monitor and measure everything that we do, but it is all very important. For example, we might have somebody who has had a stroke, so we have to record all the stuff about the stroke, but the thing the person wants to talk about is nothing to do with the stroke, you know, how they are feeling about it, how they are coping, social issues, those things that don't come into the agenda that is being measured, but in actual fact they are as important and impact probably more on the patient's life, and that just is not measurable." ***(GP 4; Interview 19; Page 3; Paragraph A)***

> "You can look at how many of your diabetics have blood-sugar levels below a certain amount. Yes, that tells us we have got a number of people controlled and that is good or bad or whatever, but it doesn't tell us anything about the quality of the consultation, the patient and GP interaction, how GPs are perceived by patients, how the reception staff treat them. So you get a view of quality but not the whole picture. There are severe limitations I think." ***(N.A.1; Interview 25; Pages 5 and 6; Paragraph I)***

> "There is a lot of good advice, a lot of it is based on evidence, but there isn't always evidence that evidence-based medicine is the best way of practicing. Clinical governance is a science if you like, the practice of medicine is knowing your science, but using it to practice your art. I think clinical governance sometimes makes that difficult." ***(GP1; Interview 17; Page 1; paragraph A)***

An interesting feature of the professional group's response is the position of the nurse, pharmaceutical and allied health professional representatives to the Professional Executive Committee (not the GP representatives). Although their responses have been reported with the professional group, it is more managerial than professionally focused. The practice nurse advisers stressed the weakness of clinical governance is that it is voluntary in general practice and that it relies on self-reporting and self-regulation on the part of GPs because

they are independent contractors. This was perceived to be too open to manipulation by the GPs. The pharmaceutical advisers similarly highlighted the problem of auditing GP prescribing in relation to NSFs and NICE guidance. The PCT does not have access to the confidential records of patients in the practices, and has therefore to rely on GPs and practice staff to undertake some aspects of the audits. The reliability of the results was therefore questioned.

> "The weakness is that at the moment it (clinical governance) is voluntary. Practices don't have to take it on board. It is left to the individual practice to look at its own clinical governance. How does the PCT assess that? The PCT is responsible for clinical governance, that includes independent contractors, but how can it assess the quality of the services in the practices? Because we are dealing with professional people, GPs, nurses, the ethos is around self-regulation, self-management, self-reporting, so we are very much reliant on what they say. We have to take it on face value. We can go in and do the clinical governance visits, but that only gives you a snapshot of the types of issues. How effective clinical governance is will very much depend on whether the GPs and to some extent, the nurses sign up to it." ***(N.A. 1; Interview 25; Page 4; Paragraph E)***

> "At the end of the day, it is their (GPs) business; they are not salaried employees, so they have got to have that business mind. It is not that they don't want clinical governance, that they don't want good quality, but if it comes at a cost to them, they won't do it, or they'll do the basic minimum. It makes a mockery of improving patient care and the whole underlying principles of the NHS really." ***(N.A.1; Interview 25; Page 13; Paragraph J1)***

6.3 Theme Two: Implementing Clinical Governance at Utopian PCT.

6.3.1 Strategies for Implementing Clinical Governance at Utopian PCT.

The strategies employed by Utopian PCT for the implementation of clinical governance in general practice were described by the directors and managers of the PCT. The professional

group was not asked to describe the strategies put in place by the PCT, but was asked to comment on these instead, in order to assess their awareness of the strategies.

a.) Implementing National Policy Guidelines and Developing an Appropriate Culture Locally.

The government provides detailed guidance for implementing clinical governance. The PCT is in its first year and has focused on getting appropriate policies, procedures and systems in place in line with this guidance. In this context the CEO observed that the process has been more operational than strategic. The guidance has outlined the audits that have to be completed to determine the PCT's baseline position in relation to risk management, controls assurance, corporate governance and clinical governance. The key issue has been to demonstrate that the PCT has appropriate structures, policies and procedures, systems and staff in place in relation to these. With respect to the PCT's own strategic approach, the CEO reported that the focus has been on developing an appropriate culture for clinical governance. This culture was variously described by different participants as open, transparent, a learning culture, a continuous improvement culture and a no blame culture. The CEO was clear that within the new culture the focus will be on improving the patient experience, rather than on risk management, which was perceived to detract from quality.

> "Where we have been looking at our overall strategy, it has been more about how we develop the culture of clinical governance in the organisation. How we can get people to think positively about clinical outcomes and benefits for patients, rather than focusing on risk management and 'watch your back' systems. Risk management in many ways is the flip side of quality, and I guess the detail that we have had to work on is all about risk management. What we are trying to do is to achieve high quality and high quality, well motivated staff who will deliver a good service." ***(CEO; Interview 1; Page 6; Paragraph K.)***

b.) Management Style.

The PCT has chosen to introduce clinical governance to general practice in a non-threatening, non-time consuming way. It is taking an educational / developmental supportive approach rather than a performance management approach. It has attempted to respect the professional autonomy and independent contractor status of GPs. Attempts have been made to demonstrate to GPs the financial benefits and the benefits to patients afforded by clinical governance.

> "It's how you implement it, and the time frame. You don't do it in a way that they (GPs) will feel threatened by it. It must be open and transparent it must be clear what the outcomes are and what inputs are required to get those outputs..... It needs to be seen as a way of improving practice, improving the services they (GPs) give to patients and improving their income stream." ***(Director of Modernisation; Interview 4; Page 8; Paragraphs S and R)***

> "You need to take a gentle but consistent approach. Supportive and not a tick-box approach, but with some drive behind it. You know, 'this is real, and you are going to have to do it, so why don't you let us help you with it'." ***(Non-executive Director; Interview 9; Page 20; Paragraph Z1)***

> "They (GPs) must see a positive benefit to general practice, not a carrot and stick approach, or not that it is being introduced because something has gone wrong. They must see positive improvements as a result of clinical governance, and it needs to be introduced as something they want rather than something that is being imposed. It needs to be seen as something to improve their day and the lives of their patients, rather than a tick-box activity." ***(Director of Modernisation; Interview 4; Page 3; Paragraph G).***

> "They (GPs) have to really see some benefits (from clinical governance), and they will probably have to learn that the benefits are not always money! That there are other benefits than a few thousand pounds! But that's a cultural thing because that is the way it has always been in general practice." ***(Non-executive Director; Interview 9; Page 9; Paragraph Z)***

The practice managers had noted the approach of the PCT in relation to clinical governance, it was a gentle 'softly, softly approach, but recognised that they were not in a position to take a harder line with general practice. They pointed out that the GPs were also well aware of this and would not respond positively to a directive approach from the PCT.

> "Well it's all been a bit slow getting off the ground here in Utopia. We had a meeting a while back with the PCT, that was interesting because they got the full force from the doctors here. (Laughter) Never mind, they can take it! They are the commissioner of the services at the end of the day and they have to be assured that the services are being provided at an appropriate standard, in an appropriate format, but they are taking a very softly, softly approach. I would say pussyfooting around at the moment. But they are not really able to enforce anything are they? And the doctors know that, I think that might be why." ***(Practice Managers Focus Group 1; Page 5; Paragraph L)***

The Director of Clinical Services, the Director of Primary Care, and the Clinical Governance Manager particularly identified the Protected Education Time (PET) scheme for general practice as a very important strategy for implementing clinical governance. GPs may use the time for their professional development and primary care teams are able to meet together, either as individual practice teams, or sometimes in small groups of teams, to discuss PCT-wide issues, matters pertaining to their individual practices, or to disseminate and share good practice. Practices are reimbursed for the time.

> "I think development has to be the whole ethos of clinical governance in general practice, because if it is seen as big brother, and we're policing them and watching them, you will not make any progress whatsoever. It has got to be developmental and supportive, you know, we are here to help you. ***(Clinical Governance Facilitation Manager; Interview 10; Page 14; Paragraph F1)***

> "A key strategy is the PETs scheme, which is about protected time, in order to get the GPs out of the workplace, looking at how they update their knowledge and information base, and looking at how to move this forward in a multi-professional manner. Not only looking at GPs as a homogenous group, because they are not, but also looking at what might be meaningful for them in terms of their own practice. Built into the PETS scheme are generic education sessions across the PCT, but also

> practice specific education programmes." ***(Director of Clinical Services; Interview 2; Page 3; Paragraph H).***

c.) Organisation Structures.

There is a formal management structure and committee structure at the PCT to support clinical governance. The Chief Executive Officer (CEO) has statutory accountability for clinical governance. The Director of Clinical Services has the lead corporate role for implementing clinical governance for the PCT, and has an Assistant Director of Clinical Governance and Professional Development. The Director of Primary Care has a delegated responsibility for implementing clinical governance in primary care independent contractor practices. There is a clinical governance facilitation team, headed by a manager at the PCT to assist independent contractors (in this study GPs), to implement clinical governance in their practices.

There is a Clinical Governance and Risk Management Committee at the PCT which meets quarterly and reports to the Professional Executive Committee of the PCT, which reports to the PCT Board. The Clinical Governance and Risk Management Committee has sub-groups for each professional group of independent contractors which also meet quarterly to discuss matters arising from the Clinical Governance and Risk Management Committee, having particular relevance for the professional group in question. There is professional representation for GPs and practice nurses and other allied healthcare professionals on the Professional Executive Committee (PEC) of the Primary Care Trust (PCT), the Clinical Governance and Risk Management Committee and the relevant sub-groups to this committee. These representatives are a conduit for information regarding the implementation of clinical governance feeding information to and from GPs and practice nurses in the field via Locality Groups and a Practice Nurse Forum.

> "Those sorts of approaches (discussed at the Clinical Governance and Risk Management Committee), to general practice are bureaucracy, therefore we didn't feel that within that committee we were going to make an awful lot of progress in

> implementing clinical governance in general practice. We have representation on that committee, I'm on it, as is our medicines management representative and our clinical governance facilitation manager, but we took the decision that our time would be better spent taking from that committee, the things that we needed to implement in general practice, then having a sub group to identify how we could do this within general practice. We have GP representatives involved in this group. So we have the Clinical Governance and Risk Management Committee at the PCT level, and the sub group for practitioners, then we have the clinical governance facilitation team headed by the Clinical Governance Facilitation Manager. We have just appointed two clinical governance facilitators as extra pairs of hands to do work for the individual practices" ***(Director of Primary Care; Interview 3; Page 3; Paragraph H).***

d.) Clinical Governance Facilitation

The Director of Primary Care and the Clinical Governance Facilitation Manager have visited every practice in the locality to discuss their individual needs in relation to the implementation of clinical governance, and to identify what support can be provided by the PCT. A self-assessment tool has been developed encompassing all seven pillars of clinical governance, and has been introduced to GPs during these visits to enable them to honestly assess their starting point in relation to clinical governance, and to produce an action plan for each practice according to their individual needs. Folders have been left with the practices for them to collect evidence of progress made towards implementing clinical governance, and for GPs and practice teams to evidence their continuous professional development. Two clinical governance facilitators have been appointed as employees of the PCT but to undertake work for individual practices in relation to their action plans for implementing clinical governance. Much of the necessary work for implementing clinical governance is perceived to be already in place in many general practices, but requires the underpinning evidence-base to demonstrate this.

> "We are trying to get people to do a self-assessment against a tool that we have developed, and we have said, you know, to be honest, we want to know the areas where you are struggling so that we can help. We don't want people to say they have got things if they haven't, because they think that if they say that they haven't got them, we are going to penalise them in some way. We have a team dedicated to

> support them, and we are trying to get that across, but I think this is one of the issues." ***(Director of Primary Care; Interview 3; page 2; Paragraph E).***

> "We have developed a quality monitoring tool which encompasses all the seven pillars of clinical governance, the clinical effectiveness, the risk management, patient experience etc, it is a self-assessment tool and we ask them to be really honest so that we can provide the necessary support. There might be policies and procedures that we have already got, that they haven't in the practice. It is mostly about evidencing the quality they are providing; this takes the time and the resources. When they look at this quality assessment tool, they see that they are often already doing it, putting it under the clinical governance umbrella helps them to focus on areas where they might not be doing so well. It is just giving them the pointers of what they should be doing." ***(Clinical Governance Facilitation Manager; Interview 10; Page 6; Paragraph K).***

e.) Implementing National Service Frameworks.

Local Implementation Teams (LIT) are responsible for implementing NSFs. On each team is a representative from the Professional Executive Committee (PEC) often a GP. Other interested GPs are also invited to attend. The team examines the standard and the associated targets. It is necessary to consider both primary and secondary and sometimes tertiary care, and to look at the interface between these. The LIT is broken down into sub groups to look at different aspects of the standard. Some are on a Central Utopian basis, because secondary care providers are shared with a neighbouring PCT, others are on a PCT basis, depending on the nature of the tasks. The sub groups may operate on a continuous basis, or may have a time-limited task to complete. Appropriate clinical representation on the sub groups ensures that outcomes are credible. Major change results in Protected Education Time Sessions (PETS) to provide necessary training for GPs and other practice staff as appropriate. This may take place on an individual practice basis or sessions may be shared by several practices. There are then follow up visits to the practices to see what progress has been made.

f.) Implementing Key Performance Indicators.

The Corporate Affairs Manager reported that there are 30 performance indicators falling into 4 general area of clinical work. The main indicators pertaining to general practice are in relation to the 48-hour access targets and in relation to the management of chronic diseases. Much of the information on performance indicators is collected centrally by the Department of Health, but the PCT is in the process of implementing strategies to monitor its progress in relation to indicators where the necessary information is available in-house. Attempts are being made to avoid duplicating the data collection exercise, but to be in a position to be able to report progress in relation to key indicators to the PCT Board on a monthly basis, highlighting problem areas and the measures that are to be implemented to address these. Information is reported by the PCT to CHAI after the financial year-end; this is eventually incorporated into a public report, and contributes to the star rating of the PCT.

With respect to the 48-hour access target in general practice, the PCT undertakes a telephone survey every quarter, asking every practice when is the next available appointment with a GP or other primary healthcare specialist. It was noted by the Corporate Affairs Manager, that this approach has produced a lot of criticism from GPs, and some practices have refused to take part on the grounds of outright objection to the national access target.

> "Each quarter the PCT undertakes a telephone survey. A member of staff rings every GP practice between 11.00am. and 1.00pm, and asks the receptionist to look at the appointment book and tell them when the next appointment is available with a GP and when the next appointment is available with a primary care specialist. There was lots of GP criticism about this..... There have been a couple of practices who have refused to give us the information because they have got issues with the whole 48-hour access target, all wrapped up in issues to do with the new contract, you know." ***(Corporate Affairs Manager; Interview 13; Page 4; Paragraph I)***

g.) Implementing Risk Management.

The Risk Manager reported that within the Primary care Group (prior to the formation of the Primary care Trust), a range of risk management strategies had been implemented dealing with the identification, assessment and control of risk. The PCT has decided to build on these existing strategies, particularly building systems for independent contractors including general practice. It was stated that these are being developed as part of the clinical governance agenda, using the independent contractor sub groups of the Clinical Governance and Risk Management Committee, and the clinical governance facilitation team.

"I've just written a risk management policy all around what systems we need, the targets and objectives for the organisation (PCT), what we are trying to achieve in terms of risk management. Now it's about cascading this down to independent contractors through the sub groups of the Clinical Governance and Risk Management Committee." ***(Risk Manager; Interview 12; Pages 6 and 7; Paragraph N)***

h.) Implementing GP Appraisal.

The Director of Clinical Services highlighted the introduction of GP appraisal this year as a significant tool for clinical governance. This is the first year that GP appraisal is a compulsory requirement. Plans for GP continuous professional development result from this process, and eventually it will be linked to GP revalidation. At the time the data was collected there were six trained GP appraisers with more volunteers waiting for training. All GPs had a date for their appraisal and nine GP appraisals had already taken place.

> "GP appraisal has got off the ground this year, obviously it is very elementary at the moment, but this will help us really move the clinical governance agenda forward." ***(Director of Clinical Governance; Interview 2; Page 3; Paragraph H).***

i.) Communication Strategy.

The Corporate Affairs Manager stated that clinical governance was being addressed also in the new Communication Strategy with the aim of helping to break down barriers to clinical governance. The strategy covers key areas including communicating with staff, patients, the media, and independent contractors. In particular, a staff newsletter is issued every two months in which there is a regular feature on progress in implementing clinical governance. There is also a monthly team briefing following the PCT Board meeting, to ensure everyone knows exactly what has been decided. Clinical governance is a major theme addressed in this. A further objective of the new strategy is to implement an organisational intranet, which independent contractors would also have access to, making available up to date information and documentation, including clinical governance material. There are also to be new strategies for communicating with patients. The new Communication Strategy is still under development and is to address how to involve independent contractors more in PCT decision-making. The strategy was perceived to be very important to the effective implementation of clinical governance at the PCT and in independent contractor practices, since it would provide all of the information required and would demystify the process. It was noted however, that providing appropriate information for patients in relation to services provided by independent contractors might be more difficult.

> "Its (clinical governance) about everyone having access to the information they require, providing information about clinical governance and trying to demystify it slightly. It's more difficult to make information available for patients because I can't go into independent practices and say, right, I want to re-write your practice leaflets!" ***(Corporate Affairs Manager; Interview 13; Page 9; Paragraph T).***

Not all of the professional group was aware of all of the strategies implemented by the PCT in support of clinical governance. In particular, six of the twelve GPs were unaware of the two clinical governance facilitators employed by the PCT to assist the practices with work associated with implementing clinical governance. At the time however, these were new appointments at the PCT. The doctors who were not aware suggested that the PCT would be most likely to use these staff in practices that were experiencing difficulties first, and

with single-handed GPs. They did not perceive their practices to fit into these categories. All of the GPs were aware of the Clinical Governance and Risk Management Committee, and that there were GP professional representatives involved in this, but four of the twelve GPs were unaware that sub-groups to the committee had been set up for the different independent contractor groups, including general practice. All of the GPs were aware of the Professional Executive Committee but were unclear about its remit. All of the GPs had been allocated to Locality Groups but only two of the twelve had attended the first meetings of these groups. Five of the twelve GPs had participated in Local Implementation Teams for the implementation of NSFs locally. All the practices represented by the GPs participating in the study had received practice visits from the Director of Primary Care and the Clinical Governance facilitation Manager. They had all received the self-assessment questionnaire to determine their starting point for clinical governance. Half of the GPs had been involved in producing an action plan to progress clinical governance in their practices. Three of the twelve GPs had received their appraisals and the remainder had dates for theirs. All GPs and their practice staff had participated in the PETS sessions.

6.3.2 Perceptions of the Progress made in Implementing Clinical Governance at Utopian PCT

Both the PCT directors and managers and the professional group were generally positive about the progress that has been made in implementing clinical governance in general practice. The PCT managers were able to identify clearly the areas that still need to be addressed. The professional group, with the exception of the nurse and allied health professional representatives, was more concerned to comment on the negative impact this was having on their working lives.

The managerial participants suggested that on the whole the GPs have been accepting of the strategies put in place by the PCT to implement clinical governance. The Clinical

Governance Facilitation Manager was clear that whilst positive progress has been made there is still work to be done. It was observed that the goal is to establish a clear framework for clinical governance at local level, in the context of national level priorities, but that this needs to be devolved to general practice, to ensure GPs take responsibility and accountability for improved service quality in their own practices. They should not expect to be told what to do, but should see the PCT in a supportive role. It was also recognised that whilst a lot of good work has been accomplished in many of the practices, there is still the need to provide clearer evidence of this. There was reported to be a significant challenge with data quality and the vehicles used for collecting data. It was also suggested that practices need to be encouraged to be more open and transparent within and between themselves in relation to complaints handling, sharing information (particularly in relation to adverse incidents) and to disseminate good practice more widely to facilitate the new desired 'learning culture' in general practice. It was suggested that a significant programme of staff development and team building for GPs and practice staff is required to underpin clinical governance.

> "I think we need to establish a framework, not just at national level, but at local level and to devolve it down to practices, to ensure their accountability. There is good work going on out there (in the practices) all the time, but actually evidencing it can be very time consuming, and can be very threatening. I think that is unfortunately because of Shipman and Bristol, but I think this is a good opportunity for celebrating good practice as well, which I think we tend to forget to give ourselves a pat on the back for. So I am trying to get that out into general practice.....we need to disseminate the good quality work going on out there to bring standards up.....Staff development and team building I think has been a real issue. The culture is different out there, some GPs don't talk to the rest of their staff, and I think we have made great in-roads into actually getting those teams to work together. ***(Clinical Governance Facilitation Manager; Interview 10; Pages 2 and 3; Paragraph D)***

> "A lot of the stuff that is coming out from the GP clinical systems is not evidencing quality care, so we've still a lot of work to do. If they (GPs) do a clinical audit they need to be assured that the data quality on their clinical systems is robust and at the moment it isn't. For a number of reasons, they might not be getting results through from the hospital, they might not be putting everything onto the computer, they

> might not even be using computers and it's very laborious to do this manually. There is a whole issue around data quality." ***(Clinical Governance Facilitation Manager; Interview 10; Page 11; Paragraph V)***

> "Obviously if you are implementing guidance then you will need audit programmes which check that process. Then there is the audit relating to how effective the guidance has been when we have implemented it. So we are auditing process and content. This is absolutely massive and I don't think we have got this sorted out yet. ***(Assistant Director of Clinical Governance and Professional Development; Interview 8; Page 5; Paragraph P)***

The practice managers observed that a lot of progress has been made in implementing clinical governance in general practice. It was confirmed that staff in the practices and increasingly GPs, recognise the staff of the PCT to be approachable and experienced, and believe this to have a positive effect on the implementation of clinical governance. Some GPs were reported to still be very sceptical and lacking in trust however. It was observed that more of a team-like approach was developing between the PCT and the individual practices. Practices were less inclined to hide things away from the PCT than had been the case with the Health Authority previously. It was observed that there were financial and political incentives for both the PCT and the practices for working together effectively as a team in the implementation of clinical governance.

> "They (the PCT) are doing very well, they are very approachable. In the past, it has been, don't let them know what you are doing, when it was the old Health Authority, but now you are working together, it's a team. If we don't meet this clinical governance target, they are not going to get their three star award, they will not get the resources, then they can't pass them on to us, it's a vicious circle, so we have to work together. They do a good job with the resources they have got. They are pushed themselves, most of them have got different hats on at the same time, they used to have only one job." ***(Practice Managers Focus Group 2; Page 10; Paragraph W)***

In line with the perceptions of the managers, the professional group were indeed mostly positive about the strategies and approach of the PCT for implementing clinical governance, and believed that progress has been made in their practices. The staff at the PCT were perceived to be experienced, open, approachable and supportive and to have done a lot of practical work to help the practices to set up the necessary systems and

procedures for clinical governance. The slowness of the publication of government guidelines for implementing clinical governance, and the tight deadlines that have been set by the government for achieving milestones was identified as detracting from the successful implementation process, along with insufficient time and resources to support clinical governance.

> "To be fair to (Utopian) PCT they have got a very good primary care directorate, they have a lot of experience, they took a lot of the best managers out of the Utopian Health Authority, and they also work well as a team. They are very fair-minded people. The systems and procedures they have put in place have been supported (by GPs in the field). A lot of assistance has been given with (patient) note summarising, access enhancement schemes, pharmacy support, all of that is still ongoing. I've gone in (to the practices) as a medical adviser, xxx has gone in as a practice nurse adviser, to practices having other problems concerning clinical governance. There are the PETS sessions that we have gone on. They have been well attended. You will always find some (GPs and practice staff) who are unhappy, but you sometimes find these are the practices that are not attending. One of the problems we have had isn't that the PCT isn't helpful; it is that the government is too slow in bringing out the guidance, and then expecting things to be done at too rapid a pace of change. And when the guidance has come out it has been on the hoof." ***(M.A. 1; Interview 15; Page 5; Paragraph U)***

> "Clinical governance has been only seen in theoretical terms by GPs until the last two years when it has got down to practice level. To get everybody on board it has to be done fairly softly-softly with lots of support from the PCT. They have done a good job; most of what has been done has been reacted to positively. They (GPs) see that it is useful, so they say OK, well that's fine. Time and resources are the key issues for GPs. Most GPs don't have enough time to do what they are already supposed to do, let alone giving them extra to do." ***(M.A. 2; Interview 16; Pages 4 and 5; Paragraphs N and O)***

Two of the twelve GPs believed there are too many staff at the PCT working on clinical governance issues, and that this is not an effective use of resources. One GP was highly critical that there was not a GP on the clinical governance team visiting the practices to assess their starting point in relation to clinical governance, suggesting the team is not therefore qualified to make such an assessment. Other GPs commented however, that where

a professional opinion was required, GP Professional Executive Committee representatives had visited. The GP Chair of the Professional Executive Committee was positive about the IT support provided by the facilitators for general practice but observed that in spite of the assistance from the PCT, the practices still struggle with the workloads and time pressures associated with clinical governance. The practice nurses were positive about the support provided by the PCT in implementing clinical governance but were highly critical of their deferential attitude to GPs. The practice nurses perceived PCT managers and staff to be sensitive to the impact of GPs acting as a collective group in opposition to the implementation of local clinical governance strategies.

> "I'm pretty disgruntled that the clinical governance facilitation team don't have a medic on it. Nobody with general practice experience, no medical personnel, and they think they can assess where we are up to! I don't think I can say any more there! We did get a questionnaire and we did spend some time, 25 minutes or so after a practice meeting ticking boxes. We returned it to them, but what does it mean? They promised support; though I can't say we've seen a lot of that yet.....I think the most valuable thing is being able to see how you compare with other practices locally and nationally on certain things. .....Coding is the big issue, we need to be assisted in getting the coding right but they haven't got the codes yet. We also need assistance in training our staff to use them. They (PCT) set themselves up to help, but they haven't come up with the goods.....I mean, we get bogged down just doing the work, we can't be chasing around after them all the time, saying, you know, come and help us with this" ***(GP 4; Interview 19; Pages 15 and 16; Paragraphs C1 and D1).***

> "The practices are all struggling with workloads and time pressures and so on. There is a shortage of IT skills. They have now all got really sophisticated IT systems within their practices and they are very often struggling with those. The idea is to go out and help people set up templates on the computer for example, because it makes it easier and more consistent for entering information. How to go about auditing, organise the clinics and so on. I think if you just told the practices what to do, it wouldn't be implemented nearly as well as having a facilitator actually going out and showing them how to do it. Not to do the work but to do the organisation side of it for them. Seeing what's working, what's not working and how to make it work better." ***(GP Chair; Interview 14; Pages 6 and 7; Paragraph C1)***

> "The only thing I would criticise them (PCT) on, is that they pander to the GPs. Even down to, you go to a nurses meeting, and you'll be lucky to get a cup of tea; but if the GPs are there, they (PCT) will put on a spread for them! That shows you the difference between us (GPs and Nurses). The GPs stick together like glue, maybe not privately, but if they ever turned on the PCT, the PCT could not function without them. The PCT knows it has to keep the GPs on board, and if that means pandering to them, they will do it because they are not going to implement clinical governance, or anything without their (GPs) co-operation!" ***(Practice Nurse Focus Group 2; Page 11; Paragraph V2)***

The GPs demonstrated a mixed response to appraisal and continuous professional development. Two of the twelve GPs believed this to be a useful and enjoyable experience, whilst the others perceived it to be time consuming, and a challenge to their professional autonomy and self-regulation. Similarly there was a mixed response to the Protected Education Time Scheme (PETS) sessions. The GPs recognised that these were being used to support the implementation of clinical governance, but stated that they were pitched at too low a level, and the multi-disciplinary approach was unsuitable to support the professional development of GPs. One GP stressed that the PCT was using the sessions to progress its own agenda and to attempt to influence GPs in their prescribing habits in order to control expenditure, this was strongly resented. All of the GPs believed that attending PETS sessions takes them away from seeing patients which is a more effective use of their time. They confirmed that they would however continue to attend the sessions because of the funding that is tied to their attendance.

> "The PET Scheme is fundamentally for GPs continuing education, but you cannot really separate that out from clinical governance because many of the sessions have been about significant event audit or risk management and so on. So, important information about clinical governance has gone to the practices via this scheme. The education content obviously supports the improvement of clinical standards. The actual formal sessions are once a quarter, the ones in between are on a monthly basis and are in-house for the practices. That gives them some protected time when they can close the practice covered by the out-of-hours service. The wages of staff that wouldn't normally be working are paid, so the whole practice team can come together and look at what's going on within the practice. That's all very supportive of clinical governance." ***(GP Chair; Interview 14; Page 8; Paragraph D1)***

> "I think the amount of assistance (from the PCT in implementing clinical governance in the practices) has been variable. The only thing that springs to mind is the PETS sessions, some of which have been alright, some of which have been frankly terrible. I think it is a useful scheme, but I think there are some very real concerns about the subject matter and the way it is delivered. As an example, we had a session about a certain class of drug, which seemed to be almost entirely related to trying to persuade us not to use these things because they are expensive. Now that's not going to work. And we don't need to be told that they are expensive, we know they are expensive! So, that was a complete waste of everyone's time. It leads to resentment, because it is actually mis-using the scheme because it is something that is on their agenda not ours. But to have some opportunity, as we have done, to look at certain things in the practice is very good." ***(GP 12; Interview 18; Page 5; Paragraph J)***

> "Some people have expressed concern that the multi-professional environment (in the PETS sessions) is not an ideal environment for GPs to learn, and has dissolved some of the good things (development events) that were going on before. The problem is that organisational changes have led to training initiatives changing. You know, PCGs were just beginning to do things and were settling down, and then PCTs arrived. The PETS sessions were set up and local groups were just starting to form and now we have the new contract. Some GPs feel we should go back to the kind of training events we used to have before the PCTs were set up, but there is a lot of money tied up with attending PETS sessions." ***(GP 10; Interview 23; Page 7; Paragraph Q)***

The practice nurses valued the PETS sessions as opportunities of development for some practice staff who had not had development for years, or who had always avoided development sessions.

> "PETS is very good, everybody moans about it, but it is actually good because people that have never been to an educational session for years now attend one every three months, and that's better than nothing and there chance to meet other people and find out what is happening." ***(Practice Nurse Focus Group 2; Page 11; Paragraph P2)***

One of the GP professional executive committee representatives observed the resource intensive nature of the clinical governance practice visits. It was reported that these visits in the future will need to be longer and more detailed to be meaningful in assessing progress,

and for inspection purposes, and will therefore become even more resource intensive. This was viewed as a key resourcing issue and as problematic for the PCT in the future.

> "If clinical governance visits (from the PCT to the practices) are going to be useful, they are going to have to take more time and be more thorough. It should be equivalent to the PMS visits which currently take around three hours, and have various professionals going in, managerial, pharmacy, medical advisers, if you were to do that one or twice a year, it is quite an undertaking for the PCT if you spread that across every practice in town,. Think what it will be in terms of time and manpower to do an adequate job, there is no point in merely paying lip service to it. It needs looking at, and I think we (PCT) are already on with that. There will be some practices who will view this as a necessary intrusion, some practices might even want to shine at such a visit and enjoy the process. Some who don't want to take part at all might not see the relevance, or they might even be nervous about the whole process." ***(M.A. 1; Interview 15; Pages 5 and 6; Paragraph V)***

6.3.3 Key Managerial Challenges in Implementing Clinical Governance in General Practice at Utopian PCT.

The PCT directors and managers identified many challenges in implementing clinical governance in general practice. These were in relation to the independent contractor status of GPs and their professional autonomy. The size, complexity and diversity of general practice, the time and resources involved in implementing clinical governance were also identified as problematic. Other issues were in relation to GP acceptance of the various elements of clinical governance; encouraging GPs and other staff to respond appropriately to increasing public expectation of the quality of health care services; problems experienced by single-handed practitioners; creating a new culture in general practice; building understanding and trust between the PCT and general practice; and dealing with perceived flaws in organisational and managerial structures at the PCT which have the potential to hinder the progress of the implementation of clinical governance in general practice.

The professional group, with the exception of the Professional Executive Committee representatives, although asked for their perceptions of managerial challenges, had very little to say about this. The GP participants suggested that their own resistance to clinical governance, and the fact that they are independent contractors, and cannot therefore be 'directed' to implement clinical governance is probably the most challenging aspect for PCT managers.

a.) Independent Contractor Status.

The PCT directors and managers did indeed suggest that the status of GPs as independent contractors and effectively small business owners is probably **the** key managerial challenge of all. The PCT has responsibility and accountability for the implementation of clinical governance in its independent contractor organisations, including general practice, but has no formal managerial authority to support this. The PCT can only encourage and persuade GPs to implement clinical governance by drawing attention to the positive benefits to be gained by doing so. A contrast was drawn with hospital consultants who are part of a formal bureaucratic hierarchy.

> "One of the key challenges is having responsibility and accountability (for clinical governance) in general practice but not having any direct management control. They are like small independent businesses. There may be low graded staff in practice management doing a wide range of jobs with some quite key responsibilities. I don't think they always have the necessary level of expertise. It is true that the GPs take final responsibility, but they are clinicians not managers. We (the PCT) can have an input at arms length, but, all we can do is try to persuade and influence using funding, or whatever mechanisms we can. When push comes to shove, if you have got a hospital consultant who is not performing, the authority for that lies with you because you are the employer, the responsibility comes right back to the CEO, whereas if a GP is not performing well, or some of his staff are not performing well, we don't have any authority.*"(Human Resource Director; Interview 5; Pages 8 and 9; Paragraphs O and P)*

> "The PCT can only produce the structures, processes and procedures and say, this is our best advice, but we can't make them (GPs) follow it. So we seem to have all of

> the responsibility as a Trust, but no authority. I find it very difficult to see how we can do that job, or how the PCT can do that job as it is presently structured, it does seem to be untenable." ***(Assistant Director of Clinical Governance and Professional Development; Interview 8; Page 4; Paragraph L).***

> "In terms of making it work it must be seen as a positive benefit to general practice, not a carrot and stick approach or not introduced because something has gone wrong. So positive improvements must be identifiable, it must be seen as something that is wanted rather than something that is imposed. Clinical governance needs to be seen by GPs as something that will improve their day, and their lives and the lives of their patients, rather than as a tick box exercise." ***(Director of Modernisation; Interview 4; Page 3; Paragraph F).***

> "I think it is important to work with them (the practices) in a supportive role rather than a directive one, and to move at different paces and not expect all practices to move at the same rate and address the same issues. Then it isn't seen as the same for everybody. There are 15 single-handed practices in very deprived areas for example; they will have very different priorities. It is important to bring in local priorities as well" ***(Non-executive Director; Interview 9; Page 5; Paragraph M and N)***

The managerial group recognised that there is the potential for GPs to hide behind their independent contractor status; making out that clinical governance is nothing to do with them. At the extreme they could refuse to implement it at all, although this would not be supported by their professional bodies. This was perceived to have a significant impact on the possible approaches to general practice available to the PCT. The only levers are financial, to try to persuade and influence GPs to be responsive. The CEO however, stressed that team working between the PCT and general practice, in a supportive environment is the most effective way of dealing with this organisational complexity. The CEO recognised that GPs are professionally accountable to their professional bodies and suggested these have an important role to play in supporting clinical governance in general practice. The Director of Modernisation and the Clinical Governance Facilitation Manager observed that the new GMS contract provides GPs with the option of becoming salaried employees of the PCT. The PCT currently directly employs two GPs, but hopes this number will increase in the future. It was suggested that this may be an attractive option for GPs who do not wish to invest a lot of capital in premises or buying in to a partnership. It is also an attractive option because it enables GPs to solve the problem of being unable to

control their workloads in private practice. Becoming salaried employees of the PCT will bring GPs into the hierarchical line management structure of the PCT. The GP Chair of the PEC did not believe however, that salaried status for GPs would be a very attractive option for many, observing that GPs recognise this may curtail their professional autonomy and freedom.

> "Whenever they (GPs) feel challenged or threatened they always run back to the fact that they have independent contractor status, and that this (clinical governance) has nothing to do with them. I'm afraid it has everything to do with them. I guess the precursor to this is Shipman, and now we have to have much more open and transparent systems and procedures in looking at how they take on that responsibility and mantle of governance for the work they do and the services they provide within general practice. ***(Director of Clinical Services; Interview 2; Page 4; Paragraph J).***

> "Because it (clinical governance) is not a term of service at the moment, they (GPs) could actually turn around and say we are not doing it, although professionally that would not go down well because they have to practice in line with recent developments." ***(Director of Primary Care; Interview 3; Page 4; Paragraph J).***

> "I am not under any illusion about the complexity of having all of those people working out there! .....They are not professionally accountable to me; they are accountable to their own professional body. They have their own systems in place. It isn't for me to look over their shoulder, telling them what to do, because they are clinicians in their own right.....There's no real reason for people to feel alone and solely responsible. I recognise that at the end of the day, I have the ultimate accountability, but I would expect teams to be working to support me in the same way I am working to support them." ***(CEO; Interview 1; Page 5; Paragraph J)***

> "We have just appointed a Business Development Manager, and put together a pack to try to recruit new GPs and we have had quite a lot of interest. Directly employing GPs will be good for clinical governance because we (the PCT) can say, well, 'we are employing you, it has to be done'. You know, we will have much more control than with independent contractors, and I think it is a way forward in breaking down some of the barriers if these GPs are out there working in some of the practices, it's another in-road for us really." ***(Clinical Governance Facilitation Manager; Interview 10; Page 10; Paragraph T).***

> "What would it mean for clinical governance if all GPs were employed, because it could be quite different. It's like corporate governance for an organisation, if it's there you abide by it, if you don't abide by it, there are rules and regulations to apply. Rather than, well, what is the incentive to make them (GPs) keep doing it? It becomes part of an employment contract rather than a quality contract." ***(Director of Modernisation; Interview 4; Page 15; Paragraph M1)***

> ' I was discussing this (salaried status for GPs) with xxxx (GP Chair of PEC), you would expect GPs to want a more structures type of workload, but xxxxxx had the view that some young GPs were coming in to general practice to have clinical freedom, and that perhaps it (salaried status) was becoming a bit too restrictive." ***(Director of Primary Care; Interview 3; Page 5; Paragraph P)***

The Practice Nurse Adviser as part of the professional group of respondents similarly believed the independent contractor status of GPs to be a significant challenge to the effective implementation of clinical governance in general practice. Because of their professional and independent contractor status, it is only possible for the monitoring by the PCT of progress towards clinical governance to be based on the self-reporting of GPs. Now that clinical governance is so closely aligned with the GMS contract, it was suggested that this is open to manipulation and falsification by GPs. Also, clinical governance is effectively a cost to be minimised by small business owners, it was suggested that this makes a mockery of the underlying principles of the NHS and the concept of the continuous improvement of primary healthcare services.

> "The weakness is that at the moment it (clinical governance) is voluntary. Practices don't have to take it on board. It is left to the individual practice to look at its own clinical governance. How does the PCT assess that? The PCT is responsible for clinical governance, that includes independent contractors, but how can it assess the quality of the services in the practices? Because we are dealing with professional people, GPs, nurses, the ethos is around self-regulation, self-management, self-reporting, so we are very much reliant on what they say. We have to take it on face value. We can go in and do the clinical governance visits, but that only gives you a snapshot of the types of issues. How effective clinical governance is will very much depend on whether the GPs and to some extent, the nurses sign up to it." ***(N.A. 1; Interview 25; Page 4; Paragraph E)***

> "At the end of the day, it is their (GPs) business; they are not salaried employees, so they have got to have that business mind. It is not that they don't want clinical governance, that they don't want good quality, but if it comes at a cost to them, they won't do it, or they'll do the basic minimum. It makes a mockery of improving patient care and the whole underlying principles of the NHS really." ***(N.A.1; Interview 25; Page 13; Paragraph J1)***

b.) GP Professional Autonomy.

A strong barrier for managers to overcome was perceived to be in relation to GPs who believed clinical governance to be an attack on their professional autonomy and self regulation. As a professional group GPs have for centuries closely guarded their professional freedom and the freedom to control their own work. These GPs see clinical governance as a vehicle for managerial control of their work. This leads them to be resistant to and unwilling to comply with clinical governance strategies, for example NSFs, performance appraisal, continuous professional development. It was suggested that to overcome this it is necessary for GPs to be able to continue to exercise clinical freedom within the framework of clinical governance. Some managers believed that GPs welcome clinical governance because it protects them from accusations of medical negligence.

> "I think a great many GPs are positive about clinical governance, others are merely paying lip service to it and see it as a passing phase, but its early days. A big problem is that health becomes part of a political imperative. There are big politics around at the moment, doctors contracts, revalidation, one way to view clinical governance is as the thin end of a much bigger wedge of bringing doctors to heel, whereas in 1948 with the development of the NHS, part of the deal was that they would continue to have autonomy, they always have had it. Maybe some see clinical governance as a reduction in that." ***(Assistant Director of Clinical Governance and Professional Development; Interview 8; Page 2; Paragraphs F and G)***

> "I think they (GPs) do see NICE as a threat to their professional autonomy, but what we say to them is, if you still want to go with it (alternative course of action than identified in the NICE guidance) and you can support it and provide evidence for why you want to go down this route, that's fine, go ahead." ***(Clinical Governance Facilitation Manager; Interview 10; Page 13; Paragraph 2)***

> "(GPs) see, by necessity, as a result of their training, the importance of evidence-based practice, but we know they are not the best people at following protocols and practice that is driven by protocols. I think that it is important that as practitioners they are also able to exercise clinical judgement, because that is all part and parcel of being a practitioner." ***(Director of Clinical Services; Interview 2; Page 2; Paragraph G).***

> "They (GPs) are very threatened by it (appraisal). They see it as a threat to their clinical judgement or whatever it is. They are very easily threatened by anybody questioning their judgement at all. They see it as negative." ***(Non-executive Director; Interview 9; Page 8; Paragraph U).***

> "I don't think they (GPs) like it, they feel very threatened by it, and view it as the first step to being controlled, as it will eventually be linked to revalidation. They see it as resulting from all of the bad examples, as a knee-jerk reaction to Shipman and the other cases. They see it as a hammer to crack a nut." ***(Director of Human Resources, Interview 5; Page 22; Paragraphs W1 and X1)***

The practice managers similarly perceived that GPs may perceive clinical governance as a threat to their professional autonomy and might resist this.

> "GPs don't like it (clinical governance) they feel threatened by it, they are self-employed and have always had their professional freedom, they have never had to answer to anybody before. They see themselves as professionals and they really don't like it..... Up until this point GPs haven't really been scrutinised, but now somebody is going to come in and see what they are doing. Before, they were very autonomous, quite detached; they could do what they wanted. Now clinical governance is bringing an outside body in, which has never happened before. It will show up all of the gaps in their practice."
> ***(Practice Managers Focus Group 2; Page 1; Paragraph D and Page 4; Paragraph K))***

c.) The Size, Complexity and Diversity of General Practice.

The size of general practice as an area of responsibility in relation to clinical governance, and the complex and diverse nature of the different practices each with its own organisation culture was deemed to present challenges, particularly in relation to designing systems and procedures that suit all of these very different organisations in different circumstances,

getting the practices to communicate with each other and the PCT, and to share information and disseminate good practice.

> "The surgeries are all quite different, lots of little businesses. I think sharing information and standardising practice is going to be very difficult. I think there is a lot of professional protection goes on and they are very reluctant to take on anybody else's ideas. There is a natural resistance to all of that'. ***(Non-executive Director; Interview 9; Pages 3 and 4; Paragraph H)***

d.) Time and Resources.

The challenge associated with the time and resources necessary to implement clinical governance in general practice was identified. The PCT directors and managers recognised that GPs and other health professionals in general practice already have heavy workloads. Even when the bureaucracy associated with clinical governance is minimised it is difficult for general practice to respond positively. The examples cited were in relation to the time associated with GPs reading and digesting NICE guidance; the time involved for GPs who involve themselves in Local Implementation Groups for developing the local implementation of NSFs; the time it takes to prepare for GP appraisal; the time to then undertake any development activity identified by the appraisal, and to construct the necessary portfolio to provide the evidence that this has taken place; the time out for attending PETS sessions, which even though 'protected' does not cover everything a GP does in the day; and the additional work associated with constructing the evidence-base in general practice. The practice managers reported that many GPs do not currently use computers in their consultations and have no wish to learn to use a computer. The time it will take for these GPs to learn and become sufficiently competent to use a computer in their daily practice was perceived to be a problem for many practices. It was suggested that GPs need to be encouraged to see clinical governance as integral to their existing workload and as a means of assisting with it, rather than as additional work.

> " Its the time factor, its perceived to be just another load of paper, more boxes to tick and eroding choice around clinical practice. I think the time one is genuine though. Life is more and more hectic in general practice. The public are more and more demanding, though that is not necessarily a bad thing. There's a lot of pressure on GPs and they don't want another burden adding to it. ***(Non-executive Director; Interview 9; Page 20; Paragraph Z1)***

> "When you think about the breadth and the depth of their existing workload, the work they have to do in day-to-day practice, this can be a barrier. Rather than seeing clinical governance as something that assists with that workload they see it as adding to it. I think it needs a change in mindset, getting people to see how it all fits together and becomes an integral part of daily work," ***(Director of Clinical Services; Interview 2; Page 2; Paragraph G).***

> "Even though we provide protected time they say, OK well you provide emergency cover but when we come back to the practice the next day, there are numerous patients that want to be seen, and with advanced access, they say PETS impinges negatively on advanced access. If you have half a day out of surgery you have got to catch up on that time.....I think GPs see it (training) as an extra thing to do on top of everything else, on top of seeing the patients, they see it as extra work." ***(Clinical Governance Facilitation Manager; Interview 10; Page 4; Paragraph H)***

> "You have the GPs who are already fully engaged (with clinical governance) and are therefore the ones that you tend to approach because they are willing to be involved and are easy to work with. I think we need to look at spreading the work out really. We are very under-doctored in this (geographical) area and the PCT is a young organisation, we won't be able to achieve this overnight." ***(Head of Health Improvement; Interview 11; Page 9; Paragraph A1)***

It was highlighted by the professional group that, once patient registers for chronic disease management are set up as part of the clinical governance regime, GPs have to follow through with all of the health checks and follow up consultations dictated by NSFs on a regular basis. Although practice nurses can undertake some of this work, the patient's test results come back to the GP for a clinical decision. This was perceived to significantly increase the workload of GPs.

> "I think they (GPs) feel they (NSFs) put some pressure on workloads in relation to patients with specific conditions. Now registers have been set up, it means they

> have to ensure that they are having all of the appropriate treatment and the follow up checks on a regular basis." ***(Head of Health Improvement; Interview 11; Page 9; Paragraph Z).***

Funding clinical governance was also identified by PCT directors and managers as a challenge. Continuous improvement costs money. There was concern that PCTs are not funded adequately to implement clinical governance. Developing and implementing NSFs, paying GPs to undertake appraisal and continuous professional development, funding the training and development of other practice staff, the systems underpinning clinical governance and the monitoring of these in general practice will consume a lot of resources. The concern was also expressed that, if clinical governance is not funded properly, it will lose credibility with already sceptical GPs.

> "The problem with NICE is, a lot of recommendations come through, but what is going to be the full long term cost of implementing that guidance? There is no way that PCTs are funded for that level of service. Another issue is, when previously approved treatments are subsequently withdrawn. Are we continuing to offer that treatment? I suspect it's easier to put in guidance than to withdraw it if it does not ultimately have national approval..... When GPs have their appraisals there are outcomes in terms of necessary actions for their development. The PCT has to support this or it will be ridiculed. Quality improvement costs money! ***"(Director of Finance (Acting); Interview 6; Pages 3 and 4; Paragraphs F and G).***

> "Guidance could be seen as a way of confirming practice. GPs will see advantages and disadvantages. The problems will come if there are not the resources available to implement the guidance. This will be seen as a very big deal especially around prescribing. This could be very damaging to acceptance of the NSFs". ***(Assistant Director of Clinical Governance and Professional Development)***

> "We should be monitoring what we are doing in preparation for CHAI. This is bigger than just clinical audit; it is a complete organisational review of whether the organisation is achieving its objectives. It costs to take corrective action. We need to be careful we do not spend more (resources) on monitoring than doing." ***(Director of Finance; Interview 6; Pages 4 and 5; Paragraphs H and I)***

The GP Chair of the PEC as part of the professional group confirmed that time and resources for implementing clinical governance in general practice will be a significant

managerial challenge. It was reported that if GPs perceive that there are not adequate resources available to implement clinical governance they will lose interest. GPs already carry a huge work load and will expect appropriate support from the PCT if they are to be expected to 'buy in' to clinical governance.

e.) GP Acceptance of Clinical Governance.

Getting some GPs to accept **all** the elements of clinical governance was identified as a key challenge for the PCT. Whilst most GPs welcome the central gathering and assessing of evidence and the availability of reliable advice in the shape of NSFs and NICE guidance, some will object to them and refuse to apply them. Similarly, getting GPs to take ownership of PCT risk management strategies, accept GP appraisal as a valid process and engage in systematic quality improvement were also identified as significant challenges.

National Service Frameworks and NICE Guidance.

> "I think many of them welcome somebody gathering the evidence centrally and assessing the evidence and giving out specific advice, especially around high risk drugs and procedures and in new areas. I think it also helps with planning their prescribing budgets to some extent." ***(Non-executive Director; Interview 9; Page 7; Paragraph Q)***

> "I think GPs will be quite happy (to accept NICE guidance) if the funding is there to back it up. They don't want to reinvent things for themselves all the time.....I think as long as the evidence is robust, and its coming from the Royal Colleges, they're quite comfortable with it." ***(Clinical Governance Facilitation Manager; Interview 10; Pages 12 and 13; Paragraph Y)***

> "There is a sort of rogue element, if you know what I mean, who say why should we do that? Why should we be told to do this? We have our day job as it is and we don't want to take on anything else!" ***(Chair of PCT Board; Interview 7; Page 4; Paragraph M).***

Risk Management.

Getting GPs to accept and apply the risk management strategies of the PCT which requires them to behave in a more open and transparent way, particularly in relation to adverse incidents, and sharing information about these was perceived to be a difficult problem. Some GPs were perceived to misunderstand the purpose of risk management, seeing it as a managerial tool of the PCT rather than a benefit to the practice, ensuring safe practice and minimising the chances of litigation.

> "I guess the biggest area of concern for me with general practice is risk management and how they discharge those responsibilities, because these are all single independent businesses that are trying to become part of a cohesive whole. What we are trying to do within the PCT is to look at how this can be addressed through training. We are also trying to develop a much more open culture around risk." ***(Director of Clinical Services; Interview 2; Page 3; Paragraph H).***

> "The process of risk management is about identification, assessment and control measures. Within an NHS Trust for example, you can implement these because you have control over the environment, and the staff who work in it. Within primary care this is different because there isn't an employer/employee relationship. Your strategy has to be to sell it, like a product, to general practice. You have to make risk management attractive to GPs." ***(Risk Manager; Interview 12; Page 6; Paragraph N).***

> "There seems to be a 'knee-jerk' reaction from practices, that risk management is about checking up on them, making sure they are doing things right, rather than seeing it more positively, as a means to safer practice. There is a lack of general knowledge about what it is all for, and with that lack of appreciation comes fear." ***(Risk Manager; Interview 12; Pages 4 and 5; Paragraph I).***

> "They (GPs) see it (risk management strategies set up by the PCT) as something provided for them, rather than as being their responsibility. They want to off-load their responsibility on to the PCT.....They see it as an intrusion if we go in and make recommendations. They say, 'you identified it so you pay for it! We're not concerned about that, if you're concerned, you do something about it." ***(Risk Manager; Interview 12; Pages 6 and 7; Paragraph N and Page 12; Paragraph S).***

GP Appraisal.

The managerial group observed that many GPs feel threatened by appraisal and view it as a necessary hurdle for revalidation rather than as a genuine process of development. Managerial participants suggested that over time GPs will come to accept the process as supportive and enabling and developmental rather than as potentially punitive. The practice managers observed that GPs feel threatened by appraisal and generally dislike being questioned or criticised even by peers.

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> "What is amazing is how threatened GPs feel by the appraisal process. They see it as punishment oriented rather than as developmental." ***(Director of Clinical Services; Interview 2; Page 3; Paragraph H).***

> "The rest of us have probably been appraised ever since school but it is a new concept for them. GPs see it as judgemental, you know, somebody else is judging their performance and telling them what to do. I was at a PETs session where they discussed it and there was a lot of fear about it, really. They were genuinely very, very worried about the process. Who was going to do the appraisals, and who would have ownership of the paperwork and where it would be kept. Now, I think some of them quite enjoy the process in some ways. I think probably once they got on with it, it went better than a lot thought it would. ***(Non-executive Director; Interview 9; Pages 8 and 9; Paragraph S)***

> "I think it is early days yet, because although we have had continuous professional development we have not had appraisal to accompany that until this year within the PCT. Part of developing maturity around this component will be getting to the point where it is seen as developmental and supportive, and something that enables them (GPs) rather than disables." ***(Director of Clinical Services; Interview 2; Page 7; Paragraph V).***

> "There was some initial concern, why is this being done, we managed perfectly well before, and its just more regulation, but it has been quite well received. We have some very good GPs now trained to do appraisals. Again, I think it comes back to handling things carefully. I think xxx, (Director of Primary Care) and her team do a great job, if you have got people who are respected and liked by the GPs it's easier. ***(Chair of PCT Board; Interview 7; Page 9; Paragraph A1)***

> "I think they recognise that unfortunately it has got to be done, and I think they are coming round to accepting it. Whether they like it or not is another matter!" ***(Clinical Governance Facilitation Manager; Interview 10; Page 14; Paragraph E1)***

> "They (GPs) were frightened, like anybody else. Especially because they were being appraised by another GP who knows nothing about how the surgery works or anything about them. They don't like to be criticised." ***(Practice Manager Focus Group 2; Page 8; Paragraph R)***

> "There was a lot of twitchiness, I think there are few GPs who can actually sit down and take it (criticism). I think they are really threatened by it..... "They (GPs) are unsure about revalidation though! It depends whether they (medical bodies) really do implement revalidation or whether they are just paying lip service to it." ***(Practice Managers Focus Group 2; Page 8; Paragraph R)***

The managerial group also suggested that the professional model of peer assessment for GPs, whilst to some extent solving the problem of GP resistance, may not be very effective as a vehicle for performance management and identifying under performing GPs. Also, other than in clearly defined situations where there is national guidance, it is still not clear what will be done if under performance is identified during the appraisal process. This is also causing concern for GP appraisers.

> "It's (the appraisal system) an interesting system but it is very much based on a professional model, it's not managerial, and I have some problems with that. The question is, is it a performance management system or is it a professional review? Our system is very much the latter. The appraisers are GPs, peers. Do they have the skills to appraise? They certainly do not do it like a manager would, in the sense of managing performance. I suppose you have to start somewhere, but I would have to ask the question, if we had a doctor who is not performing, and we do have, would we pick this up? I'm not sure that we would, and I'm not sure that the system is contributing much to clinical governance!" ***(Director of Human Resources: Interview 5; Page 3; Paragraph E)***

> "If something really fundamental came up (in the appraisal), and how would they find out anyway? They sit with the GP and all they (the appraisers) are going to know is what the GP tells them! They can ask questions, and I think as time goes on there will be more evidence, but at the moment it is about having a conversation about how the GP feels he is delivering the service, what difficulties they have got

> in doing that and where they feel they need to develop as a professional. I think the chances of understanding what is really going on in that practice during a conversation are very limited." ***(Director of Human Resources; Interview 5; Page 11; Paragraph U).***

> "We (the PCT) have responsibility to make sure that our GPs are appraised and we will get a summary of the appraisal. But it really is only a summary. The detail is confidential to them (Appraiser and appraisee). All we have done is facilitated it happening and funded the time and training, but actually it's not our process". ***(Human Resource Director; Interview 5; Page 5; Paragraph I).***

> "What a lot of them (GPs) are concerned about now is the link between appraisal and revalidation. It's not clear how this will happen yet, but I am not convinced it will be a robust performance management process based on evidence. It is still very much self-regulated for GPs, much more so than for hospital consultants who are actual employees and have to report through a management structure. ***(Director of Human Resources; Interview 5; Page 5; Paragraph H)***

f.) A Systematic Approach to Quality Improvement and Complaints Handling.

Encouraging GPs to take a more systematic approach to quality improvement and complaints handling was perceived to be challenging. In some cases, getting GPs to collect the information to construct an appropriate evidence base to underpin their practice might be problematic, but then getting them to actually *use* this information, along with that from other sources to actually improve their own practice and the healthcare provided by their practices in the future was perceived to be a major managerial challenge.

> "It (clinical governance) will have an impact, but they have been doing these things for many years. What will be different is setting benchmarks and targets for improvement, having the system of appraisal where they (GPs) are talking about their own need for development, obviously, Bristol, Shipman bring things to the foreground. People may unfortunately do it from a risk management point of view rather than out of a genuine desire for improving patient care and quality standards. ***(CEO; Interview 1; Page 7; Paragraph M).***

> "Another significant area relating to general practice, different from the PCT as a whole, is complaints handling. In general practice it is much more about counting

> beans, looking at the numbers of complaints, rather than looking at what are the lessons to be learnt. We are working with the Chair of the Professional Executive Committee to try to change that culture. We will be bringing them into a much more open process around complaints." ***(Director of Clinical services; Interview 2; Page 3; Paragraph H)***

g.) Increased Public Expectations.

A further managerial challenge identified was in relation to raising the awareness of staff at the PCT and in the practices about the implications of clinical governance in relation to the patient experience. There is also a need to recognise and respond appropriately to the fact that the general expectations of the public about the quality of healthcare services has increased. Also the wider availability of information and advice about disease and healthcare services means that some patients want a greater input into the services provided for them, requiring GPs and other health care professionals to adjust their attitudes and practices accordingly.

> "This whole thing about staff understanding is a big area. Trying to get them to understand the importance of it, understanding why things have changed in the way that they have. The big change has been the expectations of the public. People used to be prepared to put up with anything in the past, that has changed. People are much more discerning and want a decent service. With that, some staff haven't changed, they don't understand, don't appreciate how important it is, especially in general practice" ***(Director of Human Resources; Interview 5; Page 10; Paragraph T).***

> "Patients do desire more information, more involvement in their treatment, and with the advances of the internet and more programmes on television, people are better able to look at the options available to them. I think this has an impact on GPs, changing their practices. Clinical governance is the framework that professionals and managers can use to encourage people to work together, but the real pressure for change comes from patients." ***(CEO; Interview 1; Page 8; Paragraph O).***

h.) Single-handed Practices.

Almost half of the practices in the Utopian area are single handed (13 out of 30). Clinical governance was perceived by the PCT directors and managers to be particularly challenging for them because they do not have the same infrastructure that larger practices have to support their work. They often have inappropriate accommodation for providing some of the services now associated with general practice, and they do not have the support of colleagues on a day to day basis and the development opportunities this presents. Single handed GPs in many cases have worked alone, in the sense of being the only GP in the practice for many years, and may find it difficult to adjust to having to justify their actions and practices to anyone else, particularly the PCT. Although single-handed GPs have smaller patient numbers, and do still have practice nurses, and in most cases a practice manager, it was perceived that the workload associated with clinical governance will be prohibitive. Only two single-handed GP were able to participate in my study. Others were invited but declined because of a lack of time. The single-handed GP participants confirmed the time now taken up with paperwork in relation to satisfying the PCT's demands with respect to clinical governance was proving very difficult for them and their practice managers.

> "I think it is challenging because they do not have the same infrastructure behind them in terms of practice staff, and some of the premises are not conducive to delivering some of the services we would like them to deliver. The PCT Directorate are active in looking for ways to support these GPs and are trying to encourage them to work together in groups". ***(Head of health Improvement; interview 11; Page 10; Paragraph E1)***

> "GPs in big practices can swap ideas all the time, bounce ideas off each other, you have access to a lot of information, but if you are on your own you are very isolated, not just for medicine, but for all of the other queries that you have every day." ***(Chair PCT Board; Interview 7; Page 11; Paragraph E1)***

> "If you are a single-handed GP, you are the boss, you don't have to answer to anyone, you can do whatever you want to, clinical or anything; but when there are 1, 2, 3 or more of you, you have to take other people's opinions into consideration. They (GPs in larger practices) don't always agree with each other, but they have to give and take. Single-handers can do what they like, clinical governance will be a big change for them, it will be a very big change". ***(Practice Managers Focus Group 2; Pages 2 and 3; Paragraph G)***

> "My GP is completely against them (the PCT), he sees them as snooping around. In fact at one point he said to me to write them a letter telling them not to come over the threshold of the surgery ever again! .....Virtually all of the single handed ones think like that. They don't have that exchange, that sharing, it's very insular in a single-handed practice. I think a lot of good practice goes on, but how do you know? I think the PCT has got its hands full with this one, half the GPs are single-handers!" ***(Practice Managers Focus Group 2; Pages 10 and 11; Paragraph X)***

i.) Creating a New Culture.

There were perceived to be challenges associated with developing a more open and supportive culture at the PCT and within the practices. Clinical governance requires an open, transparent, 'no blame' learning culture to underpin continuous improvement. This in itself was perceived to be very different to the culture that exists in many of the independent contractor organisations, each with its own unique culture. In particular a lack of communication within and between the practices in the past was perceived to present a challenge to the implementation of clinical governance. Continuous change in the NHS over the years was also perceived to be a barrier to the development of a new culture.

> "The existing culture in general practice is a barrier (to implementing clinical governance), getting teams to work together and developing staff is new for general practice." ***(Clinical Governance Facilitation Manager; Interview 10; Page 4; Paragraph H)***

> "Going back, the PCG did a cultural assessment with general practice and fed the results back to them. This gave some of the practices a shock because they could see that communication was a big issue, GPs were not communicating with receptionists, nurses were not communicating with GPs, so there were lots of issues and we needed to get the teams working together. Since then, the PET scheme has

had an enormous impact on getting the teams together, but there is still a lot of work to be done with this". ***(Clinical Governance Facilitation Manager; Interview 10; Page 5; Paragraph J).***

"I think there is a culture (in general practice) to resist change. You have to convince people why this (clinical governance) might be a good idea. There has been a lot of change happening very quickly in the NHS and in general practice in recent years. Sometimes it feels as though there is not enough time for things to bed in before everything is changed again. I think people have got tired of it. You've really got to convince them that it is in their best interest, and have got to do a bit of a selling job on it." ***(Head of Health Improvement; Interview 11; Page 5; Paragraph K)***

There was also perceived to be a tension between the culture necessary for continuous improvement, and the culture necessary for risk management, which requires individuals to be vigilant and willing to report incidents and practices they believe to be questionable. Risk management however, is to be regarded as a part of clinical governance. The Chief Executive Officer reported that the PCT will focus on building the sort of culture necessary to underpin continuous improvement. Risk management was described as potentially detracting from this, and the 'flip-side' of quality, although a very important area of work for the PCT to address.

"My anxiety about clinical governance is that you can have all of the systems in the world, but unless you get people working in a way that they are prepared to put their head above the parapet, they are prepared to actually do something that might not be quite within the normal framework or alert someone, take a risk, knowing that the organisation (PCT) will support them, it won't work. The bureaucracy gets in the way, particularly around professionals, I'm on a hobbyhorse now, but I worry about confidentiality, because they take it to extremes, and it's probably one of the things that is the biggest culprit for why things go wrong. As an HR specialist some of the cases I have dealt with where people have had confidential conversations, keep these confidences and it never gets connected. It's very dangerous.....It's a (no blame) cultural issue, but it needs reversing. This organisation expects you....and if you don't do...., **that's** the blame bit, that you've not alerted somebody. Obviously it has to start at the top, but how do you permeate it through the organisation? How do you make people feel safe to say, when they see something that is not right?" ***(Director of Human Resources; Interview 5; Pages 13 and 14; V, W and X)***

> "The pressure is what do you do? (When something irregular is noticed during a GPs appraisal) We have had this debate with people who are doing it (the appraisal). What is their legal position, if the GP says;' you didn't have the right to do whatever.' We (PCT) say, we are giving them the authority to do the appraisal, and with that goes the responsibility (of the PCT) for any fallout. Equally, if you have done a GP appraisal, and in six months time that GP, I don't know, kills somebody or something, and it's asked, who did the appraisal? They have only facilitated it, they are not performance managing, they are not really doing it on our behalf." ***(Director of Human Resources; Interview 5; Page 11;Paragraph U).***

An interesting point was made by the Assistant Director of Clinical Governance and Professional Development who questioned whether managers could in fact *create* a new culture. It was suggested that they may be able to influence and nurture an appropriate organisation culture but probably not *'create'* one.

> "I don't think we (managers) can create cultures, and I don't think we can dissolve them. What we can probably do is try to influence them, try to create fertile ground for something to happen. But this takes time, and if you look at the PCT, it is a combination of a number of cultures. You have what was previously a Health Authority, a Community Trust and a whole collection of independently functioning practitioners, they are not going to form a new culture overnight. We are still in year one and it will take time, and it will probably take new staff coming in to the organisation. It will take years, by which time it will have all been re-organised again!" ***(Assistant Director of Clinical Governance and Professional Development; Interview 8; Page 3; Paragraph J).***

The Allied Health Professional representative to the PEC as part of the professional group agreed that there is a strong need for a new culture in general practice. She suggested that in many practices a blame-culture exists, where GPs and other healthcare professionals are afraid to admit to error or to providing less than high quality services. She also stressed that general practice has a very independent culture, stemming from the independent contractor status of GPs; this is not conducive to effective clinical governance.

j.) Building Trust between the PCT and General Practice.

A key challenge was believed to be building up trust between the PCT and general practice. Both need to see the world from the other's perspective. The PCT needs to respect the professional autonomy and independent contractor status of GPs and to understand the very real pressures that are experienced in delivering health care. On the other hand, general practice needs to recognise that the PCT is held accountable for the implementation of clinical governance in general practice. Also that whilst the PCT is there to support the practices there are limited resources and expectations should not be unrealistic. This will require significant communication between PCT managers and GPs.

> "I think it is trust between us (PCT) and the practices that is important. Because they are independent contractors, it (clinical governance) isn't a term of service, but they have to do it! It should be part of their professional registration that they have a duty to make sure that the quality of care they provide is in line with modern practice, but the rest of it, they say, you know; we haven't the time and the resources. So I think part of it is to demonstrate to practices that they are probably doing most of it any way, it is clarifying what clinical governance actually is and establishing trust." ***(Director of Primary Care; Interview 3; Page 2; Paragraph F).***

> "I think it is about keeping people on board really, we are continuing to try and support them (practices) but it is about being honest and up front about what we can deliver. In the visits we are conducting at the moment, they say, Oh great, there is somebody going to come and help us, but I have tried to manage that expectation, by saying, yes, but we won't be able to do everything. It is about trying to prioritise what we need to look at first, and then slowly developing across all areas. So I think it is about keeping them on board, keeping them motivated and providing that support." ***(Director of Primary Care; Interview 3; Page 4; Paragraph I).***

> "Time, they (GPs) haven't got the time. If we can go in and do something for them, then I think we are on a winner. Building up relationships, they have got to value us as well. We have got to respect them, getting into the practices can be very difficult. Over the last two or three years we have built up good relationships with the practices. We are fortunate, we have only got 30, we can get round to them all. Some PCTs have 40 or 60! I think it is that individual touch, going around saying, how can we help you. If you have not got that trust and respect for doing good work to support them, they are just going to see you as another person knocking on their doors wanting to take up their time. I don't think money is always the issue, I think

> it is the time. They have patients coming through their doors all of the time and they can't see beyond this fog, but if we can help them get through it, I think this is very important". ***(Clinical Governance Facilitation Manager; Interview 10; Page 6; Paragraph L).***

> "I think the key to this (building trust) is for managers to try to see the GP view of the world, and vice versa, for GPs to see the manager's view of the world. There needs to be a coming together and a more collective understanding, and establishment of more common ground. In essence, for success, GPs need to see value added, rather than something which is increased bureaucracy for them, or that it is something being used to bring them to heal." ***(Assistant Director of Clinical Governance and Professional Development***

All of the Professional Executive Committee representatives in the professional group also stressed that there needs to be greater trust between the PCT and general practice in order to overcome the scepticism of many GPs in the field. It was observed that sometimes there is a tendency for GPs to be lacking in respect for the work of PCT staff. It was believed that this will be a significant managerial challenge because there has been so much change in the NHS in recent years that GPs tend to be automatically sceptical and resistant.

k.) Poor Communication at the Interface between General Practice and Secondary Care.

Poor communication at the interface between general practice and secondary care was believed to be a significant problem for effective clinical governance. GPs are still the gatekeepers for secondary care services and often receive patients back for follow up treatment or health checks after episodes of care in hospital. Often GPs do not receive test results from the hospitals in good time, and do not always receive other patient information in a timely manner, making it difficult for them to provide high quality services to patients. It was suggested that the key to the problem is a general lack of respect between hospital consultants and GPs, leading to a failure in communication patterns. NSFs and integrated care pathways as part of the clinical governance framework now provide the mechanism for linking primary and secondary care sectors. PCT directors and managers reported however that it was difficult to get hospital consultants to join the relevant Local Implementation

Teams (LIT) to work out local delivery of the NSFs. Hospital consultants were perceived to be very dictatorial with GPs in relation to integrated care pathways, causing tension and resistance, detracting from high quality healthcare experiences for patients.

> "Communication is paramount and consultants and GPs don't necessarily do that with each other very well. Some consultants think, well, you know, its only general practice, they (GPs) haven't specialised. There is a block in getting the two together and getting them to communicate, but it's got to happen. They are going to have to start working together. As an example of what I mean, we had difficulty in getting consultants from xxxxxxx Trust to join in our Coronary Heart Disease and Diabetes LIT groups. If we don't have representatives from primary and secondary care we're going to be a long way down the line in sorting out our local services." ***(Clinical Governance facilitation Manager; interview 10; Page 24; Paragraphs L2 and M2)***

> "Our GPs are not getting communication from the hospital, they're not getting the right information about patients and test results, though some specialists are better than others. Unless someone's results are with primary care in a timely fashion, or any information about the patient really, how can GPs offer a quality service, if they haven't got the information they need? It's a real big issue.....Integrated Care Pathways is another problem area. They are very secondary care oriented, then all of a sudden they rain down on the GPs, this is the pathway that your patient will follow, but with no input from the GP. Where did the patient come from in the first place!" ***(Clinical Governance Facilitation Manager; Interview 10; page 24; Paragraph M2)***

I.) Flaws in Organisational and Managerial Structures at the PCT.

Two PCT Directors identified flaws in the organisation and management structures of the PCT having the potential to hinder the progress of clinical governance in general practice. The Chief Executive Officer has implemented a form of matrix organisation structure for the implementation of clinical governance. The Director of Clinical Services, supported by an Assistant Director of Clinical Governance and Professional Development has a delegated responsibility to lead the development of clinical governance corporately across the PCT. Because the work of the PCT is so diverse, each directorate has responsibility for implementing clinical governance in its own area of work. The Director of Clinical

Services however, has the lead role and is responsible for co-ordinating the work of the other directors in this respect. The Director of Primary Care is therefore responsible for the development and implementation of clinical governance in primary care, including all independent contractor organisations. She has constructed a clinical governance team of administrators, headed by a Clinical Governance Facilitation Manager to work with independent contractors to develop and implement clinical governance in their practices.

The separate directorates report to the Clinical Governance and Risk Management Committee which is chaired by the Director of Clinical Services (lead director for clinical governance), which in turn reports to the Professional Executive Committee, which reports to the PCT Board. More recently however, independent contractor sub groups to the Clinical Governance and Risk Management Committee have been established to deal with the key issues stemming from the Clinical Governance and Risk Management Committee, pertaining to the different professional groups. These sub groups are chaired by the Clinical Governance Facilitation Manager. This has created extreme tension between the Assistant Director of Clinical Governance and Professional Development and the Clinical Governance Facilitation Manager. The former has a corporate remit for clinical governance which includes the preparation for the forthcoming CHAI inspection. The Clinical Governance Facilitation manager is very 'go ahead' and keen to develop clinical governance in the independent contractor units. Although she is managerially 'junior' to the Assistant Director, there is no formal line management relationship between the two. There is little informal communication and co-operation between the two on a day-to-day basis and a lot of tension has emerged. Whilst the activities of the clinical governance facilitation team eventually appear on the agenda of the Clinical Governance and Risk Management Committee, these meetings are only held quarterly. This means the Assistant Director has little in the way of up to date information about the progress made in implementing clinical governance in general practice or other independent contractor practices. The Assistant Director believes that this situation is seriously undermining his corporate role, and particularly the preparations for the forthcoming CHAI visit. On the other hand, the

Director of Clinical Services and the Clinical Governance Facilitation Manager believe that good progress has been made in implementing clinical governance in general practice. The GPs generally are responding well to the clinical governance facilitation team. There is concern that if there are any changes made to structures and procedures, this may seriously hinder the continued progress of clinical governance in general practice.

> "There isn't a totally integrated approach within this PCT. The PCT has one clinical governance committee which reports to and advises the Professional Executive Committee and the PCT Board. The department that I lead has a corporate role and a very clear responsibility for clinical services. However, the Primary Care Directorate has its own resources and team which I have no direct remit towards. My own view is that there should be a single integrated department. It may well be that there are issues around my role. I report to the Director of Clinical Services who is the delegated clinical governance lead. It is very difficult for me to give you views on clinical governance in general practice because I am not involved. I find out eventually what is going on through the Clinical Governance and Risk Management Committee, but I'm always out of date! This a problem with trying to prepare for CHAI and everything." ***(Assistant Director of Clinical Governance and Professional Development; Interview 8; Page 3; Paragraph I).***

The Human Resource Director also had concerns about the structure for implementing clinical governance, suggesting that the delegated responsibility for clinical governance to the individual directorates 'fudges' where responsibilities start and end in relation to clinical governance, and might lead to duplication of effort or important things being overlooked at the interfaces between directorates. The Human Resource Director was confident of the work that has been done in her directorate to support clinical governance in general practice, but emphasised that she has no idea how or if this is being taken forward appropriately in the practices. This was particularly of concern because of the forthcoming CHAI visit which will include visits to some of the practices.

> "We all play a part, but where do responsibilities start and stop!?" ***(Human Resource Director; Interview 5; Page 7; Paragraph N).***

> "I couldn't be confident that we have done everything we need to out there. As an HR specialist, all I can do is make sure the systems and procedures are right, but I rely on the managers out there, that they are managing their staff well, making sure they are well developed. I can put the processes in place, but they have to deliver. I am concerned about the bits I don't have control over. I am only as good as the people out there!" ***(Human Resource Director, Interview 5; page 32; paragraph B3)***

m.) Preparation for the CHAI Inspection.

There were perceived to be a number of challenges associated with preparing for the forthcoming CHAI visit. It was suggested that the inspection will provide a useful Baseline Assessment for the PCT as a starting position to work from in the continuous improvement process. Because the PCT is a new organisation, just one year old, it was suggested that it lacks a history in the audit cycle, there is little in the way of comparative information. Also the PCT has not yet got all of its policies, procedures and systems in place, not all of the documentation and audit trails are available. Staff will also need to be adequately prepared knowing exactly what clinical governance is, how it impacts on their work and what will be required of them in a CHAI visit. Also, to be prepared for how they will feel after the visit regardless of the outcome of it. It was also observed that GPs in the practices associated with the PCT were in some cases ignorant of the implications of CHAI, seeing it as an inspection of the PCT and believing that it has nothing to do with them. CHAI will however wish to visit some of the practices and GPs need to take ownership of the preparation for CHAI in their own practices. The practice managers participating in the study however believed that general practice should not prepare in any way for CHAI visits. Inspectors should be allowed to see the real situation in general practice so that they will understand the pressure points and get a national picture of this.

> "As a new organisation we're putting a range of policies, procedures and systems in place. If you're following the usual audit cycle, you're continually reviewing things, putting new actions plans in place. The most managerially challenging part is that

we haven't got any history to base this on. We're having to do things without really being able to test out whether that is the way to do it. We need to have confidence that the systems are OK." ***(CEO; Interview 1; Page 12; Paragraph S).***

"The biggest job is in putting all of the systems and processes that we need in place, but it's not just that it's about the documentation, the evidence that is required to support them. Certainly there will be a significant amount of work to do in putting that information together." ***(Director of Clinical Services; Interview 2; Page 7; Paragraph W).***

"Preparing our workforce will be challenging, getting them ready for what it is that CHAI will expect from them as practitioners, and ensuring that they know the clinical governance agenda and what their role is in it, particularly the GPs!!" ***(Director of Clinical Services; Page 9; Paragraph F)***

"They (GPs) believe its (CHAI visit) something for us (the PCT) to worry about not them (GPs)! And I think it will come as a grave shock to them when they find out, we're all in this together boys! I'm not sure how much gets through from PEC members to colleagues, whether the message is getting through, particularly to single-handed GP. I think this one is going to be a severe culture shock, I really do!.....They probably wonder why we are running around like headless chickens appointing people to do this, that, and the other." ***(Chair of PCT Board; Interview 7; Page 10; Paragraph B1 and C1).***

"We are still trying to get across to our GPs what NICE and CHAI are! The attitude at the moment is well they are coming to inspect you; they are not coming to inspect us. I don't think they have quite got the message yet." ***(Clinical Governance Facilitation Manager; interview 10; page 15; Paragraph G1)***

"I said to one GP the other day, well if CHAI come you will now be able to demonstrate..... He said to me, if CHAI come, we will tell them to go away!.....I suppose at the moment they do have the option to say, well it is you that is going to be criticised not us, because they (CHAI) are not assessing individual practices." ***(Director of Primary Care; Interview 3; Page 6; Paragraph R)***

"The challenges are going to be gathering all the necessary evidence and the documentation to support this and making sure there is an understanding out there (in general practice) because obviously CHAI are going to go out there and question people to find out whether what we are saying is actually happening.....Some of it is around how they (GPs) perceive the PCT is helping them to achieve clinical

> governance, hopefully we will get a tick in the box for that." ***(Clinical Governance Facilitation Manager; Interview 10; page 15; Paragraph G1 and Page 20; Paragraph V1))***

> "Don't make any preparations, why hide things? Let them come on a normal day and see what the pressures are really like? Let them see what it is like at the coalface!" ***(Practice Managers Focus Group 2; Page 11; Paragraph A1)***

6.3.4 The Impact of the New General Medical Services (GMS) Contract on Clinical Governance..

Both the PCT directors and managers (with the exception of the Risk Manager) and the professional group (with the exception of one GP) believed that there are strong links between the Quality Outcomes Framework (QOF) of the new GMS contract and clinical governance. The new contract was perceived to be an effective means of reinforcing the implementation of clinical governance in general practice. The practice nurses and some GPs suggested that the new GMS contract ***is*** clinical governance, and one GP believed it to be clinical governance 'by the back door.' The GP Chair of the Professional Executive Committee observed however, that if the new GMS contract proved to be bureaucratically cumbersome, the good work done with GPs in relation to the implementation of clinical governance would be lost. The practice nurses observed that since participation in the Quality Outcomes Framework of the new GMS contract is optional, any GPs not participating will become highly visible as potential problem practices in relation to clinical governance.

> "I think they (GPs) will be more interested in clinical governance now because there is a quality outcomes framework as part of the new contract which is about demonstrating good practice across a number of areas, and there are organisational standards in there as well as clinical standards, so I think the new GMS contract will be supportive of clinical governance in that way." ***(Director of Primary Care; Interview 3; Page 4; Paragraph L)***

> "In signing up to the new contract, GPs are in effect signing up to clinical governance because it is a quality driven contract.....They (GPs) will have given a lot of thought to this, they understand the quality implications and most, I think support it whole heartedly. What they worry is that it will be a bureaucratic nightmare to administer! If it becomes a form filling exercise, and the forms seem to disappear into a black hole, and they are unclear about their role in it and how they fit in with their colleagues and peer group, we will lose them entirely!.....We can merge them (the new contract and clinical governance) together. I think, that's going to be very important, getting them (GPs) to appreciate that a lot of what's set out in the contract is in fact exactly what we want them to do for clinical governance. It's not that we are putting something else on top, it's bringing it all together." ***(Chair of the PCT Board; Interview 7; Page 6; Paragraph Q)***

> "I think they (the government) are using the new GMS contract to get significant change accepted and to improve the patient experience." ***(Director of Clinical Services; Interview 2; Page 4; Paragraph J).***

> "(the new GMS contract) ***is*** the implementation of clinical governance basically! If you (GPs) want to make the money then you are going to implement clinical governance. The government has achieved that very well. It will impact on the PCT financially. Inevitably there are things they have to do, and talking to them at the recent PETS session, they don't know where the money is coming from. They can't make plans until they do and so they don't know where they are going. So, we have got contracts coming in, we are half way through our preparatory year and we haven't had any preparation money yet. It's going to be total chaos." ***(GP 3; Interview 34; Page 6; Paragraph P)***

> "I think it (the new GMS contract) is another route to follow to clinical governance. It provides the structure to work in and the financial incentive is there for the GPs to do it. It will also help to identify where the weaker surgeries are. Those who are not in the quality framework, or achieving the targets. You will be able to see clearly who they are." ***(Practice Nurse Focus Group 1; Page 6; Paragraphs H1 and J1)***

The contract was perceived by both the managerial and professional groups to raise the profile of quality in general practice and to provide a significant financial incentive for GPs to improve the quality of the services provided by their practices and at the same time implement clinical governance. The GPs also believed that the contract will reward them for the work they have already done to implement clinical governance and that this is a fair reward for the work that has been put in. The practice managers suggested the Government

is overtly using the new GMS contract to get clinical governance accepted and effectively implemented in general practice.

> "It's (the new GMS contract) another means of bringing quality into people's consciousness really. I believe it will reinforce what is happening, and hopefully it will give some benchmarks for people to set themselves against, it's another tool to help people." ***(CEO; Interview 1; Page 8; Paragraph N).***

> "Most GPs will have no problem with being rewarded for quality of services provided. Speaking as a GP it will not be difficult for many practices to acquire a lot of quality points, which in effect means more remuneration for what you have already done and are currently doing. There will probably be some extra work, but I think it is a fair reward for doing a good job, and I think most of us are in favour of that. I think what has been wrong with the health service is that there hasn't been any mechanism that rewards for good standards, it is about time it occurred and can only have a positive impact on clinical governance.....it will become obvious where a practice is struggling in terms of achieving quality won't it?.....Some practices may not opt in to the quality points system at all though. They know to raise standards from a very low level to a high level, the amount of time, effort, input and expense involved, it isn't worth it, and that is a big worry" ***(M.A. 1; Interview 15; Page 4; Paragraphs O and Q)***

> "More politically realistic GPs realise that you don't get anything for nothing and you are being rewarded for work you should have been doing years ago anyway. You are going to have to prove your standards, and you will have to be open to audit and inspection. I think there will have to be a culture of high trust on these inspections though, or it will lose the majority (goodwill of GPs) and it will become so bureaucratic, and the cost will not merit the activities. This is an issue that the PCT is thinking about, the actual auditing and monitoring of the arrangements. Each PCT can have its own model, but I think most will have an element of high trust. These systems will need to tie in closely with clinical governance arrangements as well, to avoid duplication of work." ***(M.A. 1; Interview 15; Page 5; Paragraph T)***

> "I think the government has been very clever really because with the new GP contract there is an incentive now, there is money at stake. GPs are changing their tunes (to quality issues) now because they are getting a feel for the sums involved, they realise that it is worth doing, so it might just have an impact." ***(Practice Managers Focus Group 1; Page 3; Paragraph F).***

The Risk Manager at the PCT suggested that unless the new contract is very explicit about what GPs have to do to implement clinical governance and risk management it will have no impact. GPs will simply manipulate the situation to their own financial advantage. The Risk Manager believed that the only thing that will impact significantly on GP compliance with clinical governance is if there is a change in the employment relationship between them and the PCT. One of the GP participants was similarly sceptical but for a different reason. He suggested that the new contract and clinical governance coincide significantly in only a few areas. Where this is the case the contract will reinforce clinical governance, other than that, it will not. It will therefore impact significantly in a few areas of clinical governance, but not overall. Another GP participant did not believe the funding would be available to meet the raised expectations of GPs in relation to the new contract. This was perceived to damage goodwill between the PCT and the practices and to work against the implementation of clinical governance.

> "There won't be any impact I don't believe unless there is an employer/employee inter-relationship. A lot of risk management is about external monitoring, and it is about meeting the requirements of the law. Unless you are in a relationship whereby you can dictate what is done within your organisation, you will never be satisfied with the level of compliance. Some GPs are great, they appreciate what needs to be done and they will go out of their way to do it, and some of the practice managers are very interested in things like health and safety. There is often this reluctance to take part, unless the GP contract really does have teeth and is telling the GPs what they have to do, at the end of the day they will manipulate it to be whatever they want it to be." ***(Risk Manager; Interview 12; Page 10; Paragraph U)***

> "(The new contract will) not necessarily (impact positively on the implementation of clinical governance). It will to a degree in those areas that attract the 'points means prizes' part of the new contract, you know, numbers of people with heart disease on aspirin or whatever it is, chronic disease monitoring type issues which is really what all these quality points in the new contract are about. There are also some quality points for management and organisational areas as well. So in those areas it will have a significant impact but less so in other areas." ***(GP 12; Interview 18; Page 4; Paragraph H)***

> "I think there is scepticism about the new contract that it is not going to be as rosy as you first think. I think there is potential for relationships between general practice and the PCT to be damaged because they are not rolling in funds, they are going to

> have to prioritise where funds go. If people say they are going to achieve 700 points in the new contract, and the PCT says yes alright then, and they do, and then they don't get paid for it! I have very considerable worries that this has not been thought through. If you work out how much it is going to cost if everybody gets as many points as they say they are going to, you are talking about several hundred million pounds. Are they really going to let us earn that much money?" ***(GP 12; interview 18; Page 7; Paragraph Q)***

There were concerns expressed by all of the GP participants and the practice managers in relation to the funding of practice staff in the future. At the time of the study the PCT reimburses practices with 70% of staffing costs, under the new contract GPs will pay practice staff out of the 'global sum' element of the funding formula. The GPs and practice managers recognised that this presents GPs with the incentive to keep the staffing levels in the practices as low as possible in order to maximise their own income. On the other hand, clinical governance and the QOF in the new contract implies more rather than less staff are required to improve the quality of health care services delivered by general practice

> "Payment for staff is going to be in the global sum, so if you want more staff to achieve more for patients, then we (GPs) drop our income and pensions and so on. It's a perverse incentive to keep your staff costs as low as possible, and then it is harder to achieve quality targets. You feel as though you are being squeezed. That's how I feel." ***(GP 2; Interview 30; Page 6; Paragraph O)***

> "My reservation is that if you (practice nurse) want to go on a course or something, it will come out of the global sum, so we will all be fighting for a small pot of money, whereas before the PCT has paid the GPs back for anything we have ever done. That will go now and I think our personal development will suffer." ***(Practice Nurse Focus Group 1; Page 6; Paragraph K1)***

The PCT directors and managers and the Professional Executive Committee representatives recognised the need to bring clinical governance strategies, policies and procedures in line where possible and appropriate with those for the implementation of the new contract in order to minimise duplication of effort at both the PCT and in the practices, and to maintain the interest of GPs in clinical governance.

6.3.5 The Impact of Clinical Governance on the Work of GPs.

Both the PCT directors and managers and the professional group had clear perceptions about the impact of clinical governance on the work and status of GPs. The PCT directors and managers comments were largely repetitive of the points they had already made in their responses to the questions about the managerial challenges associated with clinical governance. Obviously the effects of clinical governance on the work and status of GPs creates a reaction in them, which may well present a managerial challenge for the PCT which is responsible and accountable for the implementation of clinical governance in general practice. The whole of the professional group had views on this, but the points made here are largely those of the GPs themselves.

Both the PCT directors and managers and the professional group stressed the key impact on the work of GPs to be the amount of time it takes and the increased workloads associated with implementing the various aspects of clinical governance. It was emphasised by both groups that most GPs already have a huge workload before they even begin to address the implementation of clinical governance.

a.) National Service Frameworks and NICE Guidance.

The PCT directors and managers stressed that NSFs and NICE guidance would have an impact on the way in which GPs will practice in the future. In particular it will influence their prescribing and referral habits. It was highlighted that whilst GPs are not obliged to implement NSFs and NICE guidance they have been advised to justify carefully any alternative courses of action and to keep careful records of this. It was perceived that GPs will mostly implement the guidance because of fear of litigation in the case of an adverse incident occurring when they have not implemented the guidance. It was recognised by the directors and managers that GPs are inundated with huge amounts of guidance and it is the aim of the PCT to try to summarise the main guidance to make this easier for GPs and also

to focus their attention on implementing the guidance that will contribute to achieving national targets. It was recognised that some GPs resent NSFs and NICE guidance as a challenge to their clinical decision making.

> "Prescribing is what will have a particular impact on GPs. Technology appraisals will have less impact except if it is around a procedure that is no longer continuing at an acute trust. What we are trying to do is to pull out all the information that is relevant to GP practice and to disseminate that information through clinical governance structures and networks. I think the trouble is, they (GPs), are bombarded with different types of guidance around disease management, and it is trying to get them to focus on the ones that are nationally recognised." ***(Director of Primary Care; Interview 3; Page 5; Paragraph O).***

> "I would have thought that to some extent they (GPs) welcome it because it means they have got a framework, whereas in the past, whether they did it one way, or issued a particular prescription, it was down to them and they got all of the backlash from that. The fact that there has been an agreement about which drugs to use avoids them suggesting the use of a drug and then the health authority saying, no we are not going to fund it, and then they are left in the middle with the patient saying, why can't I have it, so it kind of takes the heat out of the situation..... Does it compromise their professional judgement, not really, because professional judgement is often more about the diagnosis than the treatment." ***(Director of Human Resources; Interview 5; Page 21; Paragraph S1 and T1).***

Mostly the professional group including the GPs recognised the value of NSFs and NICE guidance as an up to date, evidence-based reference point for GPs. Also, they determine service levels that will be supported financially by the NHS for specific medical decisions. The legal implications of not following NSFs and NICE guidance in the event of an adverse incident, was also noted by GPs, along with the cost implications for the PCT. The GP Chair of the PEC observed that implementing NSFs creates additional work for GPs in terms of reviewing hospital test results and medication regimes for patients with chronic diseases covered by the NSF.

> "Looking for evidence of treatments, what works and what doesn't work is a really very recent concept, and it's very difficult to stay up to date. The NICE frameworks are obviously evidence-based and are a useful means of keeping up to date, but they do potentially create a huge amount of extra work. Some of the work can be done

> by nurses but at present it is only GPs who can sign prescriptions. They are the people taking the ultimate clinical responsibility. So if NICE say, certain things should happen, you know, you should be offering annual screening or whatever, that work can be done by a practice nurse, there is a desperate need for more practice nurse hours, but the results of the tests obviously come back to the GPs who have to make decisions about what should be happening. Often it all comes back to the GP in terms of workload." ***(GP Chair; Interview 14; Page 4; Paragraph K)***

> "NICE frameworks are certainly going to be significant legally, whatever they may feel on an individual basis, doctors are going to be constrained by what is legally applicable. People will have to take notice of these given that they are tablets of stone in the current state of play. So they will have a significant bearing on therapeutic options, which may well prove to be expensive. PCTs are not going to be able to say no, we can't do it, if NICE say this is the way it is to be done. If there is no money, well money will have to be made available, so, yes, they will be significant." ***(M.A. 2; Interview 16; Page 2; Paragraph C)***

> "GPs worry about the provision of guidelines and protocols that if you don't follow something you do lay yourself open to being sued. But, there are so many ifs and buts about any bits of guidance, you know, you could have not put someone on aspirin, but there could be so many reasons why they are not on aspirin. I'm not sure that they are hard enough rules though to be made to stick in a complaints situation." ***(GP Chair; Interview 14; Pages 4 and 5; paragraph M)***

The GPs were overwhelmed by the amount of reading involved in assimilating the information contained in the guidance. One GP stressed that even if she could read it all she wouldn't be able to remember it all. She preferred to use her own existing knowledge in clinical decision making. Another GP did not know where to store all of the files full of guidance. He believed that whilst NICE guidance is up to date it is inaccessible in the consultation situation and preferred to use electronic guidance like 'Mentor' and 'Prodigy.' It was acknowledged however that these databases are not always as up to date as the NICE guidance.

> "I think they forget that we (GPs) get something like 800 pages of guidance a year. I have got two files here, but I can't remember what is in this guidance. If you can't remember the guidance you get, you tend to work on experience, which brings into

> question the whole value of it. There is some good guidance on the computer, 'Prodigy' and 'Mentor' which I tend to use a lot, but that is often a year or two out of date, but at least it is accessible and easy to find!" ***(GP 2; Interview 30; Page 2; Paragraph C)***

> "I can't read it all! I am far too busy trying to keep up to date with medicine. I mean, you tend to pick on the ones that you think perhaps you ought to look at, but then you get all these documents, and you think, where am I going to put them? I mean, where do I store them, so I know where it is? Will I ever refer to them? We are just overwhelmed with paper." ***(GP 4; Interview 19; Page 7; Paragraph I)***

The unnecessary work caused for GPs due to the publication of NSFs to the general public was also highlighted. Expectations are sometimes falsely raised leading to individuals seeking inappropriate medication and referrals from GPs.

> "NICE guidance comes out and the GPs get inundated with requests from patients within minutes of the publication of the guidance. That causes a lot of undue pressure on GPs. NICE guidance is published in the local and national press, we can't stop it, it is in the public arena, but it does put a lot of pressure on GPs. Everyone likes sound bites and headlines, but it doesn't always say which patients these interventions are not suitable for, then GPs are inundated by patients, many of whom are excluded, and then they don't believe the GP when he says he can't prescribe it. The other aspect is that there are some interventions that don't directly relate to GP prescribing, but the patient needs to go to a GP to get a referral, this also put pressure on them." (P.A. 1; Interview 29; Page 6; Paragraphs Y and A1)

It was reported that many older GPs see NSFs as a 'dumbing down' of their specialist knowledge and skills. This is resented as a challenge to clinical autonomy and decision making. It was also observed that younger GPs, whose training now includes the use and acceptance of guidance and protocols, might be more willing to comply and not see this as constraining their practice as much.

> "A lot of it is good stuff, but it is overwhelming. In the past we have known what we're doing, and it's all been up there (in her head), now you have to refer to guidelines for everything you do. So, you've done the job for 20 odd years and now you can't! If I'm doing something I am supposed to check on the guidelines to make sure I'm doing it correctly, but the guidelines themselves keep changing, so you are

> spending your time having to not only read to keep up to date, but also checking for updates on the guidance. And at the same time you've got stuck in your memory what you used to do, and you can't always clear that stuff out, so it can be confusing. The younger generation of doctors have come through working to protocols. That's the way they've been taught, so they are used to not expecting to know everything. Fine, we just knew what to do, OK, there wasn't as much you could do, but you just knew what to do." ***(GP 4; Interview 19; Page 7; Paragraph I)***

> "There is a lot of this literature (material from NICE) hitting GPs at the coalface, it's not easy to digest and there is a lot of it and its not always relevant to general practice, although sometimes it is. I think people are put off with the idea of protocols, they see it as 'dumbing-down'. There is a certain amount of resistance from the medical profession not wanting to be told what to do. They will have to see that it leads to better care, that it is relevant and achievable. I think once people understand that they are more likely to accept them.....they (younger GPs) are perhaps more computer literate, they are perhaps more accepting of being questioned on what they are doing, they have been brought up in that culture. An older doctor was brought up in a very doctor centred culture, they were never questioned, for example with consulting, it's moved to doctor/patient partnership and maybe even swings to patient empowerment. It's easier to adapt sometimes when you are younger, though this is of course a generalisation, everyone is different." ***(M.A. 1; Interview 15; Page 2; Paragraph F)***

Several GPs made the point that GPs use their tacit knowledge and experience in their clinical decision making. This often produces a different decision to that which would be made if the guidance were to be applied. The GP stressed that in such situation she would always implement her own decision. Other GPs made the same point that if NSFs and NICE guidance conflicted with their own opinions they would be inclined to follow their own instincts rather than apply the guidance. Some GPs questioned the underpinning rationale for NSFs and NICE guidance believing it to be managerially and financially based rather than clinically based. The genuine autonomy of the committee producing the guidance was also questioned.

> "Over the years I've known when I suspect cancer and when to refer someone. I mean in the old days, you would ring hospital and get an appointment within the next two or three days, now they (patients) have to fit a set of pre-defined criteria (outlined in the guidance) to fall within the 'two week rule'. But sometimes people don't fit the guidelines yet you know clinically there is a strong suspicion the person

has cancer. So what do you do? Do you follow the rules, or do you say, this person falls outside the criteria, but I'm referring anyway? A colleague and I both had examples of this yesterday, we knew those women were vulnerable but they didn't fit the criteria for the two week rule. Anyway, they both have referral letters!.....It worries me that it is perceived that you can fit everything into strict criteria or protocols.....it concerns me that younger doctors do not have the knowledge and are not developing the right kind of experience to be able to make those judgements. Also, a lot of work is going to be handed over to nurses, that's fine but they are just working to protocols, where will the clinical judgement come from?" ***(GP 4; Interview 19; Page 8; Paragraph K)***

"The initial work of NICE was in limited areas and obviously is becoming wider and impacting on primary care now. In some ways it is quite a positive development, because it says this is the level of service you will provide for this problem, you know, mental health, the elderly, there is a particular framework for those services, and it is down to the locality how they are going to deliver those services.....traditionally the guidance has been contentious and it has been economically driven, so there has been debate about this, but things have moved on from there. If you look at the guidelines, they are fairly general, most of it still requires clinical judgement, and it hasn't been as restrictive as originally perceived, largely because tricky areas are difficult to pin down anyway!" ***(GP 10; Interview 23; Page 3; Paragraphs G and H)***

"There is quite a degree of cynicism in general practice amongst GPs about the reasons for NICE guidance, and GPs as a whole do not agree with some of the guidance, especially when it comes to budgetary matters. So I think there is still a lot of work to be done in selling it to the profession. Sometimes they (the guidelines) are eminently sensible, but I think the true autonomy of the committee has been questioned. In general though, I think people are coming round to the idea." ***(M.A. 1; Interview 15; Page 2; Paragraph F)***

"I think NICE is a laudable concept, but being the hardened cynic that I am, I do sometimes suspect that these are important for political, managerial, and financial reasons, rather than necessarily issues that GPs seeing patients on a day-to-day basis would see as important in terms of either the seriousness of the condition in question, or in terms of how much they are a day-to-day common problem." ***(GP 12; Interview; Page 2; Paragraph C)***

b.) GP Appraisal and Continuous Professional Development.

The PCT directors and managers recognised that preparing for an appraisal, undertaking continuous professional development and preparing all of the paperwork is time consuming, and that some GPs feel threatened by the process and are unhappy about taking part. It was suggested however that appraisal means that GPs will definitely keep up to date, especially when appraisal and CPD is linked to their revalidation. This is essential to and underpins high quality health services and is necessary because of the constant and fast pace of change in the medical world. It was stressed that the PCT has attempted to assist GPs by ensuring that the paperwork for their appraisals and professional development is integrated into the systems for clinical governance to try to minimise the work associated with this. The same folders will also be useful for revalidation purposes. The PCT also funds the preparation time for GP appraisal and constructing the continuous professional development portfolios.

> "We have to recognise that the world they (GPs) live in is changing all the time, it is necessary to keep up to date. On the other hand, the workload they have and the responsibility they have is enormous, they never know who is coming through their door, what they are going to ask and they are expected to make the right decisions every time, it's easy to let development activities go. I think appraisal will help them keep a focus, so they've got to keep up to date, and revalidation will help with this as well, it's a prompt. None of us like to think we are stale in what we are doing, but there is every chance without development, because the world has moved on." ***(Director of Modernisation; Interview 4; Page 7; Paragraph P).***

> "There was a lot of cynicism at first around appraisal. We have now actually set up GP appraisal in Utopia, we have done nine and are just evaluating it. I think the fear has been overcome. We haven't had any major implications coming out of these first nine assessments. We (the PCT) are trying to support them (GPs) in terms of gathering of information to demonstrate the way they are practicing. Again, going back to the clinical governance visits that we have done, we left them all with a folder where they can collect evidence to support the clinical governance activities, and at the same time help them with their appraisal and revalidation. They can use the one tool, it's all part and parcel of the same, it is all inter-linked. I think the GMC revalidation still hasn't come into place yet, it is still to be tried and tested. Obviously it isn't nice to have somebody looking over your shoulder, I think it is

like audit and everything else, they are obviously nervous, but I think if we can introduce it in a positive way it is less threatening." ***(Director of Primary Care; Interview 3; Page 5; Paragraph Q).***

Most GPs participating in the study to varying degrees did resent having to take part in appraisal. Two were the exception, one of whom was a trained GP appraiser and PCT medical adviser, and the other was one of the salaried GP employed by the PCT who had also volunteered for training as an appraiser. They believed the experience could be useful and enjoyable. It was stressed however, that the system employed should remain supportive and developmental and not become judgemental or punitive. GPs have never had the opportunity before to talk about themselves and their practice at length with another GP.

"I don't think they (GPs) are falling over themselves with delight actually (at the prospect of appraisal), but I think it is recognised that it is a necessity. It really depends how it is undertaken. I think we need some more confidence building in the system. CPD, again, is a new name for things that have always gone on. Most GPs have made an effort to keep themselves reasonably up to date. I guess the new bit is looking at your areas of weakness and addressing those rather than just looking at something you are interested in. Maybe that is a slightly different take on it. Appraisal depends on how well it is undertaken. It can be positive because it is taking the time out to look at where you are and where you would like to be, having the chance to talk about yourself for a little while with somebody, confidentially, which we have never had. So, if it is undertaken well and is seen to be supportive rather than threatening, then I think that could be good. I hope that all the different bits can be made to fit together, so that it is not duplication of effort. So your CPD folder is part of your appraisal folder, and part of the clinical governance practice action plan." ***(GP Chair; Interview 14; Page 5; Paragraph R)***

"I did six appraisals of GPs last year (in another geographical area) and I have also been appraised myself as a GP. Speaking first as a GP, I didn't find the process threatening. The GP appraiser was very experienced and it was actually an enjoyable experience. It was nice to have some time out to prepare for it and to actually have the appraisal. It was a useful exercise and if you are a reasonable doctor you shouldn't have any reservations or worries about appraisal. So long as it is implemented properly and it is a formative process and not judgemental GPs should come to accept it.....The biggest theme that comes through is a lack of time that is the issue for primary care. You could look at it cynically though, that it

> is just another hoop you have to jump through in order to achieve revalidation with the GMC. " ***(M.A. 1; Interview 15; Pages 2 and 3; Paragraphs H and I)***

Again, it is the time involved with the process and the amount of evidence that has to be collected to prove that the professional development determined by the appraisal process has indeed been undertaken, that concerns the GPs. They saw that the process will become a necessary part of the revalidation process to remain in practice. None of them believed it would however lead to any more or better professional development than they had previously, or that it will make them better doctors. Some had refused to answer questions or had given misleading responses to the GP Appraisers.

> "It (appraisal, CPD and revalidation) is yet another time-consuming burden on GPs, it is not just about doing those things for professional development, but it is showing that you are doing them. I think that providing the evidence that you are doing these things is almost as much of a burden as actually doing it. I think the system is cumbersome.....Appraisal has sort of sanctioned the probing of professionals in a way, which I think is unreasonable. I was asked a question about financial probity and I refused to answer it. The answer to that is, sod off, it is none of your business! I think it is unfair and obtrusive to use these mechanisms. If these things are increasingly used as a stick to beat you with, rather than a carrot to help you then that will be an unfortunate development. This is yet another burden on an already over-burdened profession, at a time when recruitment needs to be improved." ***(GP 12; Interview 18; Page 2 and 3; Paragraphs D and E)***

> "It's working to the lowest common denominator. Because you have a few poorly performing GPs you have to throw it at everybody, I think that is a waste of time and money. I had mine (appraisal) last week with xxxxxx, and we had a nice chat and talked through a few issues but I wasted a hell of a lot of time getting the paperwork together. But it did make me stop and think about what I'm doing and where I'm going I suppose." ***(GP 4; Interview 19; Page 11; Paragraph O)***

> "Lots of them (GPs) are cynical and see it (appraisal and CPD) as a paper exercise to satisfy a process rather than a real vehicle for personal development and changed behaviour. As time goes on it may develop. The concept of development is not entirely new although it is structured differently. Most of us have continued to have development although to different degrees, because of the rapid change in treatments, particularly in the last two decades. Some of us have always had a

> positive approach to it, for others it is more artificial. Most people have accepted that appraisal is here but see it as very threatening. A lot of GPs are worried about revalidation. I try to see the two things separately." ***(GP 10; Interview 23; Page 4; Paragraph K)***

There was still concern expressed about the system of appraisal that is being used. GPs appreciated that they are assessed by peers, but were still suspicious about what will happen to the resulting paperwork and who will have access to it and for what purpose. Even if the answers to these questions are acceptable now, it was perceived that the system may become more performance management focused in the future. One GP described the current situation as 'the thin end of a potentially very fat wedge.'GP appraisers expressed concern about what would happen if under-performance was identified during the appraisal process. There was still perceived to be a lot of ambiguity about this at local level.

> "It is a worry for the appraisers about what they do if during their supportive role, they uncover something which is of serious concern. That does worry appraisers and it worries us (PCT) as an organisation because there is a little bit of contradiction in that situation. Again, we have to have a supportive mechanism to help, if you want to use the term, under-performing GPs or practice nurses. So that is something we need to work on, and we are in the process of setting up mechanisms to deal with that. ***(GP Chair; Interview 14; Page 6; Paragraph R)***

The practice nurses observed that appraisal is a new experience for GPs who are not used to being questioned in any way. It was perceived that GPs would resent appraisal as managerial interference. The nurses suggested that the model of peer appraisal will mean that GPs will act collectively and support each other in the process of peer evaluation.

> "It's (appraisal) going to be strange for them, because they have never had it before. It will be gentle appraisal though! They won't rough each other up; GPs always support other GPs. But just the concept of it will be so alien to them. Doctors have always been gods they have never been questioned. I'm not saying they are arrogant, the public has done it, people admire them, they are the doctor, end of story!" ***(Practice Nurse Focus Group 2; Page 4; Paragraph X)***

c.) CHAI Monitoring.

Both the PCT directors and managers and the professional group believed that CHAI monitoring will have no impact on the work of GPs. They will make no preparations for a CHAI inspection in the practices and very much view anything that does have to be done as the responsibility of the PCT. It was perceived that it is the PCT that is being inspected not the practices. Most of the GPs were unaware and unconcerned that CHAI might choose to visit some practices as part of the inspection and might ask to select for themselves the ones they go to. In line with the observations of the practice managers, the professional participants believed that no preparations should be made in the practices. CHAI should be able to see the situation as it really is.

> "We have to be realistic about the impact of CHAI on independent contractors. It may have no impact on them (general practices) whatsoever, it depends on how well informed they are. A lot depends on what the outcome of an inspection is. We may be asked to drive clinical governance further into general practice. But then they would see this as our (PCT) job anyway. The difficulty is in preparing for a visit, general practice doesn't prepare for a CHAI inspection anyway, there's nothing in the system that allows them to do that. All you can do is ensure all of the processes and systems are in place in the practices." ***(Director of Modernisation; Interview 4; Page 7; Paragraph Q).***

> "Most (GPs) are probably too busy doing their jobs, they aren't aware of it (CHAI visit) or they probably haven't spent much time thinking about it. They're initial reaction would be really quite antagonistic I would expect. They would view it as management interference, maybe the type of thing that your multinationals should undergo, or maybe the PCT should have a bit of its
> own medicine! GPs might turn around and say, well if you think that you can do better, come and have a look and see what you would do in the circumstances we are working in!" ***(M.A. 1; Interview 15; Page 3; Paragraph J)***

> "I'm not even sure what it is! (CHAI visit). I mean there are umpteen committees with lots of well meaning lay people who are retired and have nothing better to do with their time, and people who are on committees and don't see patients, and there are vast numbers of liaison officers, I think there are 25000 or more administrators in the NHS, more than there are hospital beds for example. And every time we have

> more reforms we have more measurement and more inspection, but there are no extra people seeing patients. No doubt we will be giving up seeing patients to be preparing for this CHAI visit!" ***(GP 2; Interview 30; Page 3; Paragraph)***

> "If I heard they were coming in tomorrow, I would hide the biscuits! I wouldn't be very clear about why they were coming, and what they would expect to achieve by coming, what they would expect to see, who they would expect to talk to and about what. Also, whether we could say, no!" ***(GP 12; interview 18; page 8; paragraph)***

d.) Systems and Resources to Support Clinical Governance.

The professional group expressed mixed concerns about the information technology (IT) and information systems (IS) underpinning clinical governance. Some of the GPs are not making regular use of IT in their practice and expressed concern that they will need to use it in the future. Some did not wish to use it at all. Two GPs on the other hand were concerned because, whilst the PCT has pledged to fund the maintenance and replacement of IT in the practices, the systems that these GPs have are far beyond the basic requirements for implementing clinical governance. They were concerned that the PCT will be unable or unwilling to replace their IT systems to the same high specifications. Another GP suggested that in the interest of providing equitable services locally, the PCT will have to focus its funding on practices that are perceived to be under resourced. The concern was that for advanced and diverse practices like his own, the PCT may not be able to resource the developments he and his partners wish to implement in the future.

> "Unless you put a lot of money in you are going to be levelling down as well as up! For a practice like ours my big fear would be that they (PCT) will say, well you have already got more than we think is required, so when it comes to replacement, we are not going to replace that, that and that! We have four terminals in our office upstairs because we all do our paperwork together up there so that we have time to talk to each other. We think that is important and a good investment, but you are talking about several thousands of pounds. I can imagine them saying it's not worth doing, but it makes us a very cohesive team, it makes us work well as a practice." ***(GP 2; Interview 30; Page 7; Paragraph R)***

> "The PCT's own performance is being monitored and the star status is being determined by various criteria so these will be embraced in their clinical governance criteria. It will need to support under-developed practices and get more equity across general practice. I admit, I am sceptical about it, they are dealing with problem areas and the gaps, but if some already well-developed practices want to move forwards, they may be prevented from doing so because there are no available resources. In an attempt to get universal equity resources have been re-directed, this may hinder the development of innovation in other practices." ***(GP 10; Interview 23; Page 4; Paragraph M)***

e.) Single-Handed General Practitioners.

The managerial participants recognised single-handed GPs have special problems in implementing clinical governance. They do not have professional partners with whom to discuss issues as they emerge, and to engage in professional reflection and development. Other GPs in larger practices demonstrated a mixed reaction. Some observed that since single-handed GPs have smaller numbers of patients and they do still have practice nurses and practice managers, the workload associated with implementing clinical governance should not be any greater than for any other GP. Other GPs believed that implementing clinical governance will be an impossible task for single-handed GPs. One of the practice nurses participating in the study, attached to a single-handed practice, suggested that it may be easier to implement clinical governance in a smaller practice where there are smaller numbers of patients mostly known to the GP and nurse. Also because there are smaller numbers of individuals inputting into the systems, who work very closely together all of the time, it is easier to control.

> "It must be very difficult (for single handed GPs to implement clinical governance), I mean, it's just not going to happen is it! There are those who would say that Shipman was a single-handed GP and we need to be able to spy on these people. Whereas, the people who spy on me are my partners! I think this is a rather under-hand suggestion, but I can't help thinking there may be something in it!" ***(GP 12; Interview 18; Page 6; Paragraph M)***

> "They (single-handed GPs) miss out on the opportunity to discuss cases and other issues with other GPs on a regular basis. Reflection and feedback are essential elements of personal development, so unless they have been trained in personal reflection, they miss out really.....Time should not be any more of an issue than it is for GPs working in larger practices. They have smaller numbers of patients, so the workload should be the same no matter whether you are single-handed or in a larger group practice. Every practice should have a practice nurse and a practice manager as well. They should be able to manage their workload effectively" ***(GP 6; Interview 21; Pages 2 and 3; Paragraphs E and G)***

> "There shouldn't be any difference really (in the workload of a single-handed GP in implementing clinical governance); they also work in teams with practice nurses, health visitors and other professionals." ***(GP 10; Interview 23; Page 3; Paragraph J)***

Only two single-handed GPs took part in the study (Others were approached but declined to be involved because of time pressures). One of these GPs insisted on his practice manager being present at the interview. He appeared to know very little about clinical governance and encouraged the practice manager to answer most of the questions. They reported they were indeed experiencing problems implementing clinical governance, feeling 'overwhelmed' by the volume of paperwork required by the PCT merely to determine their starting point in relation to clinical governance. They were also concerned at the prospect of having to keep more detailed records of their work in the future. The GP was however accepting of appraisal and the need to undertake continuous professional development, although he was not aware he would need to construct a portfolio of evidence to support this, and dismayed at the amount of time it would take to do this. He was very uncomfortable with the prospect of having to use a computer in his day to day work. The GP observed that he might have to 'tell a few lies' to satisfy the PCT in relation to clinical governance.

> "To me, the problem with it (clinical governance) is, having to record things that we would never have bothered with before. You have to record everything accurately to prove you have done this, that and the other." ***(Practice Manager to GP 11; Interview 24; Page 2; Paragraph K)***

> "The self-assessment tool was quite good, but it was a lot of work to fill it in. It was a lot of work just to find out where you start from! I presume they have all been looked at now and the assessment made, but nothing has come back to me yet, to say, you need to do this, that or the other. It's the time it all takes, its the 'nitty-gritty' it's having to record every little thing." ***(Practice Manager to GP 11; Interview 24; Page 4; Paragraphs R and S)***

> "They (PCT) came, and were doing things with the computer. I had to learn about the computer, that took a lot of time. I don't use it much. We had a problem with the monitor and nothing was done until quite recently. If they (PCT) could take prompt action on things like that it would help doctors like me." ***(GP 11; Interview 24; Page 4; Paragraph T)***

> "We do everything as far as practical things are concerned, but they (PCT) are imposing rules, you can't say no, the intention behind what they are doing is good..... I don't know whether this (clinical governance) is going to achieve anything or not. I don't know whether we will have to tell one or two lies to meet the criteria, that's the main fear!" ***(Single-handed GP 11; Interview 24; Page 3; Paragraphs L and M)***

6.3.6 The Impact of Clinical Governance on the Professional Autonomy and Self-regulation of GPs.

The responses of the PCT directors and managers were focused more on the impact of the professional autonomy and independent contractor status of GPs on clinical governance than the impact of clinical governance on the professional autonomy and independent contractor status of GPs. Those comments are already documented in an earlier section of this chapter.

The GPs participating in the study believed that clinical governance is a challenge to their professional autonomy and right to self-regulation. Whilst in varying degrees they have accepted NSFs and NICE guidance, appraisal and CPD (leading soon to the requirement for

them to be revalidated every five years in order to maintain a license to practice), they regard these as intrusive and resent being told what to do and how to do the job that they are all medically qualified to do after undertaking many years of education and training. The GP Chair of the Professional Executive Committee of the PCT explained that GPs have always been individualistic as a profession and have carefully guarded their autonomy and clinical freedom, their right to organise and control their own work, and their right to self regulation against many NHS policies over the years. Clinical governance however is perceived to challenge or to have the potential to challenge significantly, all of these areas. Because of their independent contractor status however, the NHS and the PCT has no formal managerial authority over GPs and has therefore to take a 'soft' approach to the implementation of clinical governance in general practice. It can only use strategies of encouragement and persuasion bolstered by financial incentives and now, the new GMS contract with its Quality Outcomes Framework.

> "GPs are all very different, they say organising GPs is like herding cats! I think a lot of people go into general practice because you have a lot of clinical freedom and you are free to organise your day very much as you choose. Up to now we have been free to do work in ways that we choose. The negative aspect of NICE is that some GPs bitterly resent being told how to do their work. The idea that if they are not doing it that way, they are not doing it well, that causes a lot of resentment among GPs. They (NSFs and NICE guidance) are not obligatory. There is nobody who can say to a GP, you have to do this. That is not the framework in which we work. I guess the only thing that can work is encouragement and the resources with which to do it (implement clinical governance). You know, we are not going to get struck off or prevented from working as a GP if we don't implement them. So it is up to the PCT and its management to facilitate the implementation of the guidelines, but they cannot be imposed on GPs because they are independent contractors." ***(GP Chair; Interview 14; Page 4; Paragraph K)***

> "I think there are GPs who see it as a help and as an aide memoir as to what they should be doing. Other GPs see it as interference. I think there is a very fundamental difference between GPs in their approach to work. Some people just don't like any feeling of being directed. They want to make those choices for themselves rather than have it imposed." ***(GP Chair; Interview 14; Page 7; Paragraph A1)***

> "It's challenging isn't it? (Implementing clinical governance with independent contractors) It means we have got to persuade, change hearts and minds. We mustn't put people's backs up!.....We have to make things acceptable to people, not being too dictatorial, just gradually moving the climate of opinion towards the acceptance of new ways of looking at things really. It's a gradual process, you can't do it quickly." ***(GP Chair; Interview 14; Pages 7 and 8; Paragraphs C1 and E1)***

> "You mustn't be too heavy handed with it (implementing clinical governance in general practice). You have to coax some people. I think the main thing to do is to actually introduce it in a way that the practice sees the benefits of doing it. It might be something esoteric, it might be a money enhancement, it needs to allow the practice to do something it couldn't otherwise have done." ***(GP 6 [salaried GP]; Interview 21; Page 4; Paragraph H)***

Four of the twelve GPs participants questioned the reality of the professional autonomy of GPs and their independent contractor status. It was perceived that ever since the beginning of the NHS in 1948, the government has attempted to control their work. It was suggested that whilst in theory GPs are independent contractors, to the degree that they work in the NHS, successive GP contracts, including the new GMS contract have contained detailed rules and regulations about what work GPs must undertake. It was suggested that clinical governance, reinforced by the new GMS contract has moved a step further than in the past, by attempting to also dictate *how* this work should be performed. In this context clinical governance was perceived to be a more significant challenge to professional autonomy than anything that has gone before. The GP medical advisers were perceived by some GPs to play a key role in 'selling' clinical governance to GPs in the field.

> "To a degree it is semantics, you are an independent contractor, but the contract you have signed up to has a lot of rules and regulations around it, so a lot of the autonomy in general practice has gone in terms of what you have got to achieve. I think there is still some freedom around how you do it, but clinical governance could be perceived as eroding this. Some people will accept this; others will just point blank refuse on principle. This is where the Medical Advisers at the PCT can perhaps try to sell the project (clinical governance), inverted commas, you know, and help to build the relationships with the PCT..... Naturally, there are barriers there, and it all depends on the individual relationships between GPs and the PCT. This depends on the image of the PCT, the staff it has got and the competence they have." ***(M.A. 1; Interview 15; Page 4; Paragraphs M and N)***

"There are significant numbers of GPs who get seriously twitchy about other people coming and interfering with what they do. But, the government has been interfering with what we do since 1948, so us being independent contractors and able to do what we like is cobblers really.....We ain't independent contractors, end of story! I think this is just one of the myths GPs put out. I mean we are independent in the sense that at any time we can say, 'sod off, I'll go and be private!' but, whilst ever we work in the NHS we are, I suppose, independently contracted to the NHS, but constrained by the way we get paid and what we have to do." ***(M.A. 2; Interview 16; Page 3; Paragraph H and Page 4; Paragraph K)***

"It (independent contractor status of GPs) impacts less than you might imagine. We are supposed to be independent contractors but we have less freedom than for example dentists or opticians. We are independent in the sense that we are self-employed. We are contracted to the NHS and are pretty closely scrutinised. People have argued that the new contract will increase that. These days you can't really go out on a limb and do your own thing. I think clinical governance will make people look at their practice in a slightly different light, taking quality a bit more seriously than they did before." ***(GP 12; Interview 18; Pages 4 and 5; Paragraph I)***

"We're being interfered with all of the time, it's no longer our practice even though the buildings are ours, and you know, we are self-employed supposedly. We are being increasingly directed as to how we should work." ***(GP 4; Interview 19; Page 13; Paragraphs T and V)***

"I don't like being controlled. I like to think I work well; I don't think there are any problems with my work. I think it (clinical governance) is control, it is interference and it goes against everything I came into the profession for. I came into the profession in the days when professionals were professionals, now we are just standard employees, we do what we are told and if we don't we get our bottoms smacked. That's an old fashioned view maybe, they (PCT) will argue they are spending money they are entitled to a service. I agree, but it does seem a shame to lose that state of professionalism..... I love seeing the patients. Clinical medicine is as good and as much fun to me as it has always been, but the rest of it, the paperwork, ringing the hospital 2 or 3 times every day to sort things out because of poor communication, long waiting lists, whatever, that's what gets you down. Doing good for your patients that's the only thing that makes it worthwhile now." ***(GP 2; Interview 30; Page 4; Paragraph H)***

"I think it (independent contractor status of GPs) makes it harder for them (PCT) because they can't enforce it (clinical governance). From our point of view the new contract makes it increasingly difficult not to comply with it, because it's my pension, and my income and my partners' income it's all tied to it now with the new

> contract. You know, what we do, what we achieve, whether we follow the prescribing incentives, which are put together based on what somebody else has decided is the best for the prescribing statistics, and not what is necessarily the best for each individual patient. My policy is very much that I want to do the best for the patient that is in front of me whether it concords with clinical governance or not. I accept that a lot of the time clinical governance is based on good research and I follow that, but there are times when you have to provide what the individual needs even if it doesn't seem to be traditionally orthodox. But I think increasingly they are getting control and it is harder and harder to be independent. If I was talking to a new GP now, I wouldn't even begin to tell him about professionalism as I understand it because he isn't going to encounter it!" ***(GP 2; Interview 30; Pages 4 and 5; Paragraph K)***

One GP stated that the title 'clinical governance' aptly describes what is happening. GPs are being governed, brought to heel, controlled by managers who are in effect saying, you can exercise your professional autonomy, but within the confines set by us. Two of the twelve GP participants perceived that clinical governance represents a failure to trust GPs to do their jobs, replacing this trust with a managerial control mechanism, and reinforcing it with the new GMS contract. Many GPs expressed a desire to fight to maintain their professionalism, whilst others appeared resigned to a reduction in this.

> "I think its title tells you everything (clinical governance), it's there to govern you, to bring you to heel. It is governing you, controlling you, saying, yes, you can do these things but within the confines that we set. At the moment it (NICE guidelines) is advisory, but that's how it starts, it's the thin end of the wedge." ***(GP 1; Interview 17; Page 5; Paragraph I)***

> "I feel it (professionalism) is virtually non-existent now. I think we (GPs) fight to maintain it, and those of us who are maybe more balchy and difficult, will be obstructive and prepared to fight, but I think a lot of people are just resigned. We are going to have a new contract which specifies very tightly what we should and shouldn't be doing, we'll go along with it, but some of us will make a noise about how stupid we think it is. If we make no protest, we can't complain when it's foisted upon us. I'll continue to fight, though it will probably do me no good." ***(GP 3; Interview 34; Page 4; Paragraph G)***

> "The whole system needs to be built on trust, and increasingly we don't trust anybody else, so you have got to write it all down in triplicate. But writing things down doesn't mean to say that you have done it! Nobody is going to be sitting next to you for 24 hours a day, making sure that what you write down is what you did. The whole thing gets bigger and bigger, it costs loads of money and the quality or the outcome at the end is no different. If anything it is less, because it soaks up all of the money trying to sort it all out. The government has to be seen to be delivering on its promises, and all the people who work for it have to be seen to be doing what the government says they are doing. The only way you can do that is to check on people. In days gone by GPs got their qualifications and generally the bulk of them were trustworthy. Of course there are going to be shirkers, people who lie and cheat, but you get that whatever. I don't think there is any managerial system, including clinical governance that is going to weed that out so that everybody is going to get 100% service all of the time." ***(MA. 2; Interview 16; Page 7; Paragraph W)***

Clinical governance was similarly perceived to challenge the GPs right to self-regulation. The GP Chair of the PEC believed that this was however an inevitable consequence of the laxity of the professional bodies, who in the past had 'turned a blind eye' to unacceptably low standards. Although NSFs and NICE guidance are voluntary, GPs are advised to be ready to justify and provide evidence of this justification if they deviate from these. The GPs were particularly concerned about what would happen if they did deviate from guidelines, and an adverse incident occur, would they be supported? Most of the participants in the study however stated that they would be willing to implement an alternative course of action than that dictated by guidance if they felt strongly that it was in the patient's best interest. The main challenges to professional self regulation were seen to be the compulsory appraisal, continuous professional development and eventually revalidation of GPs to remain in practice. A view was also expressed that the current professional model of appraisal, peer assessment, will before long be viewed as inadequate and unacceptable and may be replaced with a more rigorous performance management system, controlled by managers rather than professionals.

> "I guess it has to happen doesn't it? (Increased government attention in professional self-regulation) I mean, if we haven't carried out that self-regulation ourselves, somebody has to take an interest in it. The general public won't stand for any more laxity really. I think in days gone by, really appalling situations, and appalling

standards have been allowed to exist. Patients have got very poor service from a minority of GPs. I don't think it is the majority. I think there are a minority, for reasons of ill health or burnout, or in a very small number of cases, just sheer badness, who have not given their patients a decent service. If as a profession, we have not sorted them out, the government has to do something." ***(GP Chair; Interview 14; Page 5; Paragraph P)***

"NSFs and NICE guidance come indirectly down from the government; it is interference in their professional self-regulation, even though it is a self-regulatory approach that has been taken. The government has gone that step further by saying what they (GPs) have got to do and how they have got to do it. They have got to have appraisals, they have got to have CPD and provide evidence of this in portfolios and they will have to be revalidated. So, whereas before, they kept themselves up to date, they didn't have to do anything active from the learning, now they have to produce evidence of their CPD.....they didn't have to do any writing up or portfolio building. Now clinical tutors in each area assess these. It must be difficult for them, all of a sudden to be told this is what you have got to do to be able to continue to practice." ***(N.A. 1; Interview 25; Page 14; Paragraphs N1 and O1)***

"I think that most GPs, given that they have not been appraised yet, would feel apprehensive, whether it is being done by another GP or anybody else. I suspect that as time goes by they will get used to the idea and it will not be such a shock to them. However, whether the public perception, which is really what all this is about, is going to be assuaged with GPs assessing GPs, given the sort of publicity that surround other people policing themselves, you know, it doesn't go down too well when there is a mistake! Appraisal by other GPs may not in the cold light of day, stand up to rigorous scrutiny. I think it is the thin end of the wedge, it's probably a way of getting the whole thing off the ground and accepted, but it may well be stiffened up as time goes by. Become more rigorous. I'm not saying that it isn't rigorous at the moment, but I think the first off is likely to be a kind of softly-softly approach." ***(M. A. 2; Interview 16; Page 3; Paragraph G)***

"Self-regulation is getting to be a difficult concept. One of the issues with clinical governance seems to be that people no longer trust professionals to be professionals, and the degree to which they are self-regulated is to an extent offset by the desire of other people to control them. In the context of general practice, this is the politicians, the Strategic Health Authority the PCT. I think it is across other professions as well, that they are no longer trusted to regulate themselves. Without wishing to make too much of a political point, it seems that politicians, who are themselves probably the least regulated ones, actually want to control and regulate the others all the more. I think there are cultural and societal issues here, no longer is it enough to do the right thing, we have to prove that we are doing the right thing,

> almost the case of guilt until proved otherwise. And when something goes wrong, there always has to be some villain, somebody they can blame, be it the profession as a whole, be it the individual, be it the regulatory mechanism. This, I think is colouring people's attitudes to professional self-regulation." ***(GP 12; Interview 18; Page 2; Paragraph C)***

6.4 Theme Three: Clinical Governance and Managerial / Professional Relationships.

6.4.1 The Impact of Clinical Governance on Managerial Relationships at the PCT.

The CEO directors and managers were clear that clinical governance places a statutory accountability on the CEO for clinical governance. They did not believe that this has had any significant impact on the way the senior management team work together. The directors of the PCT believed they had always felt accountable for the quality of the healthcare services provided. The CEO was not under any illusion of the significance of being statutorily accountable for clinical governance should anything go wrong, but suggested that all she could do was to select the right team, ensure they are well qualified and trained to deliver the agenda, and then trust them as colleagues to do their jobs. There was a perception however, that clinical governance has raised quality and risk management to the top of the PCTs agenda, so that all decisions made by the senior management team take account of the implications for clinical governance and risk management. The Risk Manager reported that the CEO and the senior management team are much more concerned to be kept up to date in the event of adverse incidents and to be kept informed about what actions have been taken to address the issues involved.

> "There will be no change (to the way the CEO and Directors work and relate to each other), because when you are appointed to a senior position you feel accountable anyway. The fact that the CEO is the accountable officer is really only formalising the process. At the end of the day you are as good as the decisions you make and the team you employ. Sometimes that will go well, others it won't. It doesn't make any difference to me, I still feel responsible." ***(Director of Modernisation; Interview 4; Page 8; Paragraph S)***

> "I don't think it (clinical governance) changes the dynamics of the senior management team, but it will inform the decisions that are now made by the team. You think of it more, hang on, what are the clinical governance aspects of this? I may need to have a clinical input to this. So I don't think there is an explicit change but there is an implicit change in how we behave." ***(Director of Modernisation; Interview 4; Page 9; Paragraphs T and U)***

> "I think it has made the CEO a little more wary and nervous about the impact of something going disastrously wrong.....the worst a CEO can do is to be unaware of a situation. It's OK to say we have got some horrendous risks, this is what they are and this is what we are doing about them, but to be unaware of them is the greatest sin. At the moment they (CEO and Directors) want to know all about everything. Once they know all the bad things, then they needn't worry about them, because we are doing something about them". ***(Risk Manager; Interview 12; Page 10; Paragraph V)***

The professional group, other than the Professional Executive Committee representatives had little idea of the managerial relationships and dynamics of the management team at the PCT. The GPs acknowledged the Director of Primary Care and generally respected her, believing that she does a difficult job well. The GPs tended to be sceptical however about the numbers of administrators and managers employed at the PCT and questioned whether there needs to be so many, and whether this is an effective use of resources in an overstretched NHS. The professional group did believe that the new statutory responsibility for clinical governance will have a significant impact on the management team. It was highlighted that on the one hand the CEO has a responsibility to the community, the PCT and to patients for the quality of services provided by the PCT and the independent contractors in the area. On the other hand, should for example an under performing GP be identified as part of delivering this responsibility, she will also have to face the GP's legal

team, possibly claiming he/she has been treated unfairly or discriminated against. It was stressed that GP under performance is very difficult to prove.

> "There are responsibilities to the PCT, the community and the patients served by practitioners; but you have also potentially got a practitioner's legal team standing there to say you have been unfair or discriminatory or you're picking on them. You know there are tremendous competing things to take into account. Taking this against a backdrop of a shortage of GPs, we don't wish to lose any GPs, so we have to try and support people whose practice doesn't come up to scratch to help them improve it. But there does unfortunately come a time when you have done all you can, and you have to say, well someone is in danger here. That is really quite difficult to prove and does lead you into quite dangerous legal territory. This is not new but it has now become more explicit. The GMC has published standards of good general practice which covers more than just medical competence, you know, attitudes, availability, environment and so on. I guess the scope for finding practices wanting has increased" ***(GP Chair; Interview 14; Page 11; Paragraph P1)***

6.4.2 Clinical Governance and Roles and Relationships in General Practice.

Both the PCT directors and managers and the professional group believed that clinical governance will not impact on the status of GPs as dominant figures in general practice. As independent contractors GPs are the employers of the other practice staff, both clinical and administrative. The roles and responsibilities of other staff may expand and develop as a result of clinical governance and implementation of the new GMS contract and GPs may have to accept a more team-based approach to the delivery of primary care, but GPs will still remain responsible and accountable for everything that occurs in the practices.

> "GPs have always been responsible for staff in their practices and clinical governance won't change that." ***(Chief Executive Officer; Interview 1; Page 9; Paragraph O).***

> "I think GPs should be more aware of the important contribution made by other healthcare professionals. A lot of GPs tend to dismiss the role of nurse practitioners, but I think they're (GPs) gradually coming out of the big black hole they have been living in, where they are the only people who count! I think there will have to be a better balance of responsibility, and acceptance that these people have a key role

> and that it is almost of equal importance to the GP." ***(Chair PCT Board; Interview 7; Page 14; Paragraph K1)***

Both groups recognised that in most practices GPs are adopting a more democratic approach to management, are becoming more reliant on other staff in the practice and are adopting more of a team based approach to delivering health care. The increased workload of GPs resulting from chronic disease management alone means that GPs have increasingly relied on practice nurses particularly and other healthcare professionals to undertake most of the routine work previously done by them. Clinical governance is set to continue this trend. The new GMS contract will intensify this as GPs seek to achieve as many quality points as possible within the Quality Outcomes Framework, maximising their income. In addition the role of practice nurse will expand to free GPs up to develop their 'special interest' work also within the parameters of the new contract.

> "I think nurses will become more powerful because there aren't enough GPs and healthcare professionals to deliver the NHS Plan and clinical governance. We need to look at expanding and developing expertise of all healthcare professionals to make sure people can be seen by appropriately trained staff. It doesn't always have to be a GP, it can be nurses and other allied healthcare professionals as well. We need to work smarter, not do more of the same!" ***(Head of Health Improvement; Interview 11; Page 11; G1)***

> "The sheer practicalities of implementing clinical governance, the NICE guidance, there is no way GPs can do that by themselves. We'd have nothing else to do, we wouldn't be able to see any patients if we were spending all of our time doing preventative work on even just one of the NSFs. So, I think it (clinical governance) has turned us more into team-players whether we like it or not! I guess this makes a difference, although GPs still see themselves, rightly so, as responsible and accountable for what goes on in their practices. So even though your practice nurse has her own professional accountability we have the overarching responsibility for her competence within the practice." ***(GP Chair; Interview 14; Pages 11 and 12; Paragraph P1)***

> "GPs have got a very strong power-base in primary care and they will maintain that. They will want to have a very large say in anything clinical that affects their lives or the lives of their patients. Clinical governance won't change that. What might be happening though, is that they are starting to share, and they are starting to listen to other professional groups. They are more appreciative of our knowledge and our skills, they are becoming more accommodating. I think they still have that authority that was given them, and that is perpetuated by the government and the PCT by allowing them still to be self-regulatory. Clinical governance, yes, has to be implemented, but it is still a self-reported system. So it is still relying on their authority and their power to comply and to report accurately. They still hold the ultimate power base, because they are employers and they are responsible for what goes on in the practices. The buck stops with the doctor. He makes the decisions; it is not the nurse or the practice manager. With nurse prescribing, for example, the GP has to agree that he will allow the nurse to prescribe for his patients. So it is controlled by the GP. For nurses to develop their clinical skills, the GP has to delegate that function to them, but they still have to report back to him. He has to support the nurse through training and give them the time off to go. He still has the ultimate control. So the workload is shifting down but the control still stays with the GP". ***(N A. 1; Interview 25; Pages 17 and 18; Paragraphs A2; and D2)***

The GP participants in the study all confirmed that they were very reliant on practice nurses, who had in many cases already developed specialist skills, and knew more than GPs in small areas of work. The GPs were supportive of nurses continuing to expand their skills in the future, but expressed concern about the funding to support the necessary training to facilitate this. Also, that nurses would understandingly expect to be paid more, which will have to come out of the 'global sum' in the new GMS contract. It was perceived that if nurses are not paid according to their skills that they may seek to return to the more structured hierarchical secondary care sector, or possibly leave the nursing profession altogether in order to maximise their income. The practice nurses participating in the study did not believe that clinical governance (or anything else) will change the dominant position of GPs in general practice, that nurses are destined to remain 'the handmaidens' of doctors. The nurses believed their position might change a little if they are employed by the PCT and seconded to the practices, rather than being employees of the GPs themselves.

> "The vital group (in the implementation of clinical governance in general practice) are the practice nurses. They already do a lot of the chronic disease

management which is a key part of clinical governance. They are also often computer literate, I think what is happening is that a different kind of organisation is emerging, one that is less autocratic and where people's abilities and skills are more recognised, nurses may take more of a lead in some areas.....In terms of raising the quality of services, you (GPs) can't do it all yourself, you have to delegate some of it." ***(M.A. 1; Interview 15; Pages 6 and 7; Paragraphs W and Z)***

"Well they'll (nurses) have to do more of the work we (GPs) are currently doing. They will have to train more. There used to be funding for training hopefully that will be alright. They will need to specialise and so they will also need to be upgraded and paid more. If they are not paid at higher levels they will go back into hospital care or out of nursing altogether which is quite a trend now, or agency nursing, where they can make more money and control their time." ***(GP 1; Interview 17; page 10; Paragraph C1)***

"We work far more as a team, doctors, nurses and other clinicians than we ever used to do. And probably more with the clerical staff, but you still have to remember, at the end of the day, the buck stops here! I'm responsible, so, you know, when the shit hits the fan, it's the doctor who has to sort it out. I mean, about a year ago, someone made an error in our practice with immunisation, you know, it was a nursing error, but who had to sort the whole thing out? Who feels responsible for it? I was the only doctor in the building so I was responsible. I'm the one doing the letters to the family and the letters to the medical defence team. So I think even though we work very much more on a level, and we work in partnership with nurses, if something goes wrong, or if they have a problem, who do they get to sort it out, us! Having said that I would go to them and ask what shall we do about, you know, this diabetic or something. They now have much more specialist knowledge in some areas." ***(GP 5; Interview 20; page 7; Paragraphs P and Q)***

"I don't think they (GPs) will see their role changing at all, not for clinical governance, not for anything. Nurses have always been the handmaidens of doctors, full stop! We (nurses) are secondary! I was reading in the paper today, they are thinking of changing the nurse's title to try to encourage recognition of professionalism, and how we aren't recognised really, apart from the image of matron or Barbara Windsor, sex bomb. Nurses are not seen as professionals; certainly GPs see it as, doctors full stop. Even the PCT still see it like that. I don't think we are valued enough actually. The PCT has one aim in life, to keep the GPs happy at all costs.....We (nurses)are their (GPs) employees, they could sack us tomorrow, just like they could sack a secretary. There is no line manager except for them. Things will only change if we are employed by the PCT and seconded to a practice.....Its also about how the public sees it. Doctors are up there somewhere. Nurses are seen totally differently, as approachable,

> understanding, sympathetic and talk on their wave length. They see doctors as the person with the power, the person who knows everything, who is going to diagnose and treat them. I think the public see you like that, the PCT see you like that, and you see yourself like that!.....In a single-handed practice you (nurses) have more power in a sense because you just rely on each other, you and the GP and that is it.....The younger doctors who come in training are different, its more like colleagues, the problem is, get them on the wards for a few years and they get all cocky then, but they are really willing to learn when they are still young."
> ***(Practice Nurse Focus Group 1; Pages 8 and 9; paragraphs X1, Y1, Z1 and E2, F2 and G2, H2 and I2)***

The Allied Health Professional representative suggested that clinical governance does have the potential to break down traditional boundaries between GPs and other health care professionals and to make the best use of the diverse skills that these groups have. It was observed however that whilst many GPs claim to accept this they will not relinquish their overall control of the medical work undertaken by everyone in general practice.

Both groups similarly perceived that the role of the practice manager will expand and become a more professional role. Practice managers will be responsible for setting up the administrative systems and procedures and the various patient registers required for clinical governance and the new GMS contract. They will have to co-ordinate the GPs and the other healthcare professionals in the context of the data collection necessary to generate the evidence base underpinning the work of the practices. They will also undertake most of the administrative tasks associated with clinical governance, including reporting to the PCT. It was suggested that presently practice managers are not a homogenous group. Their responsibilities and authority in some practices are very limited, they may not even be fully aware of the financial position of the practice. In other cases however, practice managers are full partners in the practice, even sharing in the profits. It was suggested that in the future the role will need to be clarified, particularly in relation to line management of other practice staff Presently practice managers are generally not regarded as the line managers of practice nurses and other health care professionals, although they may be included in the staff appraisal of these individuals. It was stressed that in the future practice managers are

likely to be more highly qualified managerially and professionally, and will have to have a basic understanding of clinical issues.

> "Their (practice managers) roles will change significantly; it will have much more responsibility. Well, if we think of governance, it is very much about risk management, financial management, and the structures and processes necessary to support the business of the practices. For some, it will merely make explicit some of the work they are already doing. It also makes it very clear where the responsibility for risk sits within the practices." ***(Director of Clinical Services; Interview 2; Page 8; Paragraphs Z and A1).***

> "The practice managers are the ones who are going to be left to manage everything (in relation to clinical governance) in general practice to support the clinicians. They will have to organise the admin systems, set up the practice registers, everything." ***(Head of Health Improvement; Interview 11; Page 11; Paragraph K1)***

> "It is likely that GPs will delegate as much of the bureaucracy associated with clinical governance to practice managers, but practice managers have already got an intensive workload, this is extra added on. Practice managers have always had a powerful hold in a practice but they could become even more so, because they become the ones that are knowledgeable and have designed the systems and procedures and others would become quite dependent on them". ***(NA 1; Interview 25; Page 12; Paragraphs E1 and F1)***

> "Their workload will increase, they'll be recording everything that we do, making sure we achieve targets that are laid down by clinical governance and the new contract so that we can get the brownie points, so that we can get paid. I think some practice managers will get involved in the medical system, so they'll have to have a better understanding of medical issues as well." ***(GP 5; Interview20; page 10; Paragraph W)***

The Director of Modernisation suggested that practice managers are a key group in implementing clinical governance in general practice. They know the GPs and other health care professionals well; they know how the practices are managed and how to get things done. They were perceived to be influential change agents.

> "They (practice managers) are a key group in general practice and are (currently) sometimes sold short. They are the people who know what is going on and how to get things done when you want to make a change. They will play a very important role in implementing clinical governance. They understand how the practices work and they understand the GPs and the other health professionals in the practices. They are a very good conduit for change and I would use them as part of a group to take clinical governance forward in general practice." ***(Director of Modernisation; Interview 4; Page 10; Paragraph X)***

The practice managers participating in the study also believed that their role is changing and there was a general perception that they were and increasingly will be expected to lead the implementation of clinical governance and the new GMS contract. GPs were perceived to be increasingly reliant on the practice managers to deal with clinical governance documentation and communication from the PCT. There was a mixed response to this. Some valued the opportunity this presented; others felt resentful, believing that the GPs should be leading from the top of the organisation.

> "I've set up every single register, the doctors have had no input into them at all. The first register I did there were over one hundred people who had ischemic heart disease and were on the register. He (the GP) came in and asked how are we doing, does it look good what we've done. I said no, and so he immediately knocked sixty patients off the register!" ***(Practice Managers Focus Group 2; Pages 4 and 5; Paragraph L)***

> I think the role of practice manager is changing a lot. I have just gone for another job, I don't know whether I have got it yet but the knowledge and skills that they want has really changed. I had to do computer tests on finance, create spreadsheets and do a presentation, then an hour-long interview with the partners. It was a very intensive process. What they want now is basically a business manager. The days of the receptionist moving up to practice manager have well and truly gone!" ***(Practice Managers Focus Group 1; Page 3; Paragraph G)***

> "I think the doctors should lead it (implementing clinical governance) but they won't! We'll do it (the practice managers). I think the leadership should come from the top. That's the problem though, they might be good at what they do but they are not managers, they haven't got a vague clue about management. That's why our role emerged. They didn't have practice managers twenty years ago, their wives did it!" ***(Practice Managers Focus Group 2; Page 2; Paragraph F)***

6.4.3 Clinical Governance and Managerial / Professional Relationships at the Interface between the PCT and General Practice.

Throughout the study participants from both the managerial and the professional group, whether they were positive about clinical governance or not, stressed that if clinical governance is to be implemented effectively in general practice there needs to be trust, respect and good communication between the PCT and the practices.

The directors and managers emphasised repeatedly the significant role the GP and nurse Professional Executive Committee representatives (GP Medical Advisers and Nurse Advisers) play as clinical advisers to the PEC of the PCT, and as a conduit of information between the PCT and general practice in relation to the implementation of clinical governance. These individuals are perceived to be key change agents in this respect. The GP Medical Advisers are expected to take the lead in the cultural change programme for general practice. They are expected to 'sell' the clinical governance agenda to their professional colleagues in the field and are perceived to be the main link between the PCT and the GPs and practice nurses and other allied health professionals in the field. They are a channel of information from the profession to the PCT, participating in and representing their professional groups in the managerial decision making at the PCT. They also feedback the decisions that are made at the PCT and other information, to the GPs and nurses in the field. These individuals play a key role in interpreting national guidelines on clinical governance at the PCT and in shaping the subsequent policies, procedures and systems for implementing clinical governance in general practice. The role was described as complex with a significant level of responsibility. The breadth of the clinical governance agenda which has to be assimilated and understood very quickly, and the amount of work involved with this alone was perceived to be daunting.

"The professional PEC members are a kind of bridge between the practices and the PCT in terms of understanding what has gone on, what has worked well, or not so well and why, and what can be learnt from that experience. They are passing this on to other practices and back to us as managers to look at.....They help to influence policy. If you have a PCT policy that is not working well, then we need their views to actually change that policy. We also need the clinicians view to actually develop that policy in the first place." ***(Chief Executive Officer; Interview 1; Page 11; Paragraph Q).***

"Undoubtedly general practice is changing and the professional PEC members have a key role in shaping the culture of general practice. Team-working, particularly in relation to developing and monitoring standards of care and delivering services; GP appraisal, which needs to be viewed as the norm and developmental rather than punitive; use of information technology in the practices, all of these things need to be taken on board by general practice." ***(Chief Executive Officer; Interview 1; Page 14; Paragraph U).***

"Their (medical advisers) role is so important. If GPs appreciate that it is not the PCT telling them what they have to do, that it's coming from their own professional colleagues I think it will be accepted more readily." ***(Chair PCT Board; Interview 7; Page 16; Paragraph R1)***

"We have just set up locality groups, where each PEC member (medical adviser) will invite the GPs in their locality to get that two-way communication going. They have had a forum organised by the LMC before, but that was all the GPs in (Utopia) with all PEC members, what we are trying to do now is to break that down into localities so that we can get some meaningful dialogue going." ***(Director of Primary Care; Interview 3; Page 8; Paragraph Z)***

"It's (the professional PEC role) a huge responsibility to take on a PEC role because you have to learn a much broader agenda very quickly. Although general practice, by its very nature is receptive to a diverse day (you never know who is coming through the door next with what problem!), its difficult for example when you have to start talking about detail and attributing large sums of money against it, its a huge responsibility.....There may be tensions between the professional and managerial aspects of the role, for example, there may be GP colleagues who desperately want a service to continue and you're making recommendations against it, but you are doing it on a wider informational base than they have. I would have thought that the clinical aspect is what they would fall back to because it is the comfort zone, the one they understand the most, so I think there would be tensions..... .These people are perceived by colleagues in the field maybe as being the ones who are always involved in everything, or maybe are getting some other incentive out of it,

> but when GPs have decided to put their heads above the parapet and are very good speaking for general practice and then sharing information and feeding it back, it is seen as quite different and accepted by the others". ***(Director of Modernisation; Interview 4; Page 11; Paragraphs A1 and B1)***

The GPs and nurses in the field were aware of the representative's existence but were very unclear about the role they are playing. The nurses had a clearer picture of this however than the GPs, who had very little idea, but believed it very important that GPs should be represented on senior committees at the PCT, and take a lead role in the decision making that will significantly impact on general practice. The GPs in the field were quite suspicious about why any GP would be willing to take on such a role however. It was suggested that perhaps they were bored with general practice, not so good at dealing with patients, or just careerists. It was observed by the Non-executive Director that GP representatives particularly get very little support from GP colleagues in the field.

> "I think somebody has to do it because it is important that we (GPs) are represented at the PCT. I wouldn't want to do it though. I think it is very easy to get pulled into committees and things, and it is reasonable to argue that I am very irresponsible not doing that, but I get too frustrated, then I say things that get resented. For those that do it, I think it is important they have their feet on the ground and that they spend most of their time in general practice rather than on committees, because otherwise they lose sight of the sheer pressure of it all going on five days a week! I would find it jolly easier sitting in a committee room than seeing patients." ***(GP 1; interview 17; page 11; paragraph E1)***

> "The PCT needs advice from people who know the demands on general practice, but there are so many people involved with fancy titles doing non-jobs, and I think it is an enormous waste of money, when there isn't the money for the basics. The other thing I always wonder as well, is, what sort of person is it who would want o do that job? The danger is they attract people who have got an axe to grind, or some zealot or some geek or whatever else! Are these people actually representatives of mainstream general practice? I'm not sure that they are. If suddenly they got rid of all of these people, would my job be any worse? I think it certainly wouldn't be worse, but we would have more money to slush around for where it is really necessary. Another problem is that GPs are such a heterogeneous bunch, getting an overall view of general practice, all the different types of practices, big practices, single-handers, getting any kind of consensus view I think is almost impossible. I

have my doubts about the usefulness of such things." ***(GP 12; Interview 18; Page 8; Paragraph S)***

"... it's vital that somebody does it, I' very grateful to them. I considered doing it, but I knew that I would be too irritated by it; I'm not good at sitting on big committees. Change is far too slow. So, I decided, for my health's sake, I wouldn't do it! But I'm desperate that GPs maintain a healthy strong position on the PCT, and that their places are not filled by other people who aren't GPs because its about general practice, and it's the GPs who know what is going on in general practice". ***(GP 5; Interview 20; Page 12; Paragraph D1)***

"I think it is a useful role. It is important for GPs to be involved because lay people don't understand the problems of general practice. Single-handed GPs are under-represented on the committees because we don't have the time to be involved. The problem is that other GPs don't know the problems experienced by single-handed GPs." ***(GP 11; Interview 24; Page 5; Paragraph F1)***

"I think sometimes they (medical advisers) are seen as just career people. People who want a management career. They like committee work and that sort of thing. They are perceived as a different kind of animal really. They like doing that sort of work. A lot of them (GPs in the field) don't really understand what it is. They know that they (medical advisers) are on the PEC, but they don't really know what the PEC is.....They (medical advisers)
don't get any real support from their colleagues or encouragement, and when things go wrong they get the blame for it. There isn't much appreciation for the positive work that goes on.....I think it is perceived that if they are on the PEC, their services will be better and their health centre will be better because they have influence over resources. I think they get a lot of pressure to deliver something that is different and really special" ***(Non-executive Director; Interview 9; Page 17; Paragraphs S1, T1 and U1)***

The GP Professional Advisers themselves recognised that the Government perceive them as change agents, used to get things accepted in general practice. They also recognised that GPs in the field often view them with suspicion, as facilitators of managerial control. The GP Professional Advisers perceived a lack of clarity about their role and found this frustrating and stressful.

> "I think the government definitely sees us (professional PEC representatives) as change agents in all of this (implementing clinical governance in general practice), and I suspect we probably are. I think GPs involved in management are seen by other GPs pretty much as, well, the thin end of the wedge. I mean its going to come anyway, (tighter control of GPs work), but yes, that's how they see us I think.....I didn't want to do it really, I mean I did it because no one else would do it, I mean somebody had to do it, we need GP representation on the PEC, but I'm fairly sceptical about the whole process. We are supposed to feed stuff back to the other GPs at locality meetings, but nobody turns up, well except my wife (also a GP in the area). We have a link with the LMC though, they go to that. I suspect there is still a lot of distrust, and the feeling that possibly we (professional PCT representatives) don't tell everybody the whole tale.....The representatives need to be practicing GPs to have credibility with the others. A lot of people who represent GPs on the BMA or whatever, they only work part time, they are not full time GPs, or they are retired, so other GPs don't have much time for what they say. They can't say that about me because I work 10 surgeries a week! On a personal level, I have no idea what they think of me because I am on the PEC." ***(MA. 2; Interview 16; Page 8; Paragraphs Z, A1, B1, E1 and F1)***

The GP Chair of the PEC and one of the GP professional representatives also perceived there to be a lack of clarity of the role of the Professional Executive Committee within the management structure of the PCT, and in relation to the role of the professional representatives.

> "We (PCT) are struggling as an organisation to work out the PEC roles, and I'm struggling to hold the PEC together at the moment as an effective body, but I'm realising we are not alone, other PEC Chairs are experiencing the same kind of tensions. The management team has to deliver, they have to make contracts with the hospitals, they have to achieve financial balance, they have to keep all of these balls in the air. The PEC is a bit of a fly in the ointment almost. You know, you have to get things through the PEC, it all has
> to be agreeable. It is very tempting just to ignore it altogether!" ***(GP Chair; Interview 14; Page 13; Paragraph W1)***

There was also contradiction apparent in the PCT directors perceptions of the role of the GP Medical Advisers. It was perceived that this has the potential to hinder the progress of the implementation of clinical governance (and other initiatives) in general practice. The

Director of Clinical Services and the Director of Primary Care, who are the two key senior managers in relation to the implementation of clinical governance in general practice, stressed that these individuals are first and foremost representatives of their professional groups in managerial decision making at the PCT. They are well known and respected professionals and are key change agents therefore in encouraging and persuading GPs and nurses in the field to accept clinical governance and carry it forward in the practices, and to advise and assist GPs in the field on clinical issues associated with this.

> "They (professional PEC members) come from a clinical background, it doesn't matter what managerial training or experience they have, the over-riding priority is always the clinical element. It's about being able to look at systems and procedures and asking, what does that mean for the patient experience. The patient always should be the centre of what w are doing and the reasons and rationales for it. This is what enhances their role and responsibility in the PCT.....They understand what it is that makes a difference to the way services are delivered to patients. It's about identifying where their skills can be best deployed to make a difference to the management of the PCT" ***(Director of Clinical Services; Interview 2; Page 8 and 9; Paragraphs B1 and D1)***

> "A lot of the role is about clinical leadership. As a member of the PEC they have a clear responsibility to support the work of the PCT, perhaps to alley any fears that their colleagues may have, and to demonstrate, as clinical leaders, that they are at the forefront of delivering clinical governance. I think it is a difficult role for them, but I would expect them to perform it." ***(Director of Primary Care; Interview 3; Page 8; Paragraph Y)***

On the other hand the Director of Modernisation, whilst agreeing that these individuals are potential change agents with respect to getting clinical governance accepted in general practice, stressed the corporate responsibility of these individuals to participate fully in and then support the decisions of the PEC.

> "The hardest thing is understanding their corporate role. They are not there as a representative of GPs or of nurses. They are there with their knowledge of being a GP to make informed corporate decisions. Around clinical governance, all of them, as are the managers, are there to develop and implement clinical governance. The fact that they are GPs or nurses is irrelevant. If you begin to use them as champions, you would then have to look at how the role impacted on other things. So, if you wanted to make changes to the way you dealt with secondary care, or to a commissioning function of a particular speciality, you couldn't take their word because they are not representatives. So we have to think about how we use our GP Medical Advisers, they are there to give you clinical guidance. With respect to clinical governance, if they promote it as good thing, which they would because of their corporate responsibility, could they impose this across the whole of general practice? Very unlikely, it is a hearts and minds thing." ***(Director of Modernisation; Interview 4; Page 11; Paragraph Z)***

The Human Resource Director, who had recently joined the PCT from a senior management role in a hospital believed that because PCTs are new organisations the role and the individuals undertaking it are still significantly under developed when compared to clinical directors, the parallel role in hospital trusts. Clinical Directors were perceived to be professionally more powerful and authoritative in their representation of their specialism than the GPs at the PCT. The problem was perceived to be that in hospital trusts clinical directorates are very cohesive groups. The consultants know each other well, they know each others strengths and weaknesses, they are able to clearly verbalise their various positions in relation to key issues. On the other hand, GPs are independent contractors, they operate in isolated practices; possibly don't know each other or the individuals who are representing them at the PCT. It was suggested that it is difficult for just a few GPs to represent such a large, diverse and fragmented professional group.

> "I don't understand the GP Medical ADviser idea; it's not very effective at the moment. In the case of clinical directors on hospital trusts there are tensions between wanting to do the best for the profession and the managerial aspect of the role. But clinical directors are realistic, they think about finances, and, yes, they might not like it, but they are realistic and we need their professional viewpoint, so

> it works OK. But, here, PEC members are not sure about their role, they are very under-developed, they don't have the power-base in the same way hospital consultants have. They are not the same calibre. With clinical directors you would have to work very hard to make them agree and to get them on board. I can't see that happening here. I think they are very unclear about their roles. But you have to start somewhere. Maybe it was like this in the hospital trusts in the early days. Maybe we (the PCT) are going through a phase of development. I don't think they (GP Medical Advisers) understand enough about management; they are very naive, not real power-influences. On Hospital Trust Boards, the Clinical Directors might be asked by the Chair, what is the feeling of the medics, and they would be able to give a clear viewpoint. If the same was asked of the GP Medical Advisers, the answer might well depend on which practice you talk to, the reality is, they might not even see their colleagues. I fear that it is the government paying lip service to the professions, it may develop in time, but I don't see it as effective at the moment. I don't think that people outside see them as key influences, though they may be glad that they have a foot under the table". ***(Director of Human Resources; Interview 5; Pages 26 and 27; Paragraphs N2, P2 and Q2)***

It was observed that the professional representatives experience a lot of tension between the managerial and professional aspects of their role. The Assistant Director of Clinical Governance and Professional Development observed that professional representatives are in effect clinicians as managers having to take responsibility for things that would previously have been done by managers. He suggested that it will be interesting to see how the relationship between these individuals and GPs in the field develops over time. The Human Resource Director believed that when the professional representatives start to really feel the tensions and pressure between the two facets of their role, they will opt out and let the managers make the difficult decisions, or simply resign from the role.

> "I guess it is about clinical freedom. I would like to give my patients everything they want without having to think about the cost of procedures or medicine or whatever. But we live in the real world. I guess my PEC role makes me more conscious than the average GP of the cost of the decisions I make and the constraints the organisation (PCT) has in terms of financial pressure. I think this is probably where the tensions come in." ***(GP Chair; Interview 14; Page 14; Paragraph B2)***

> "I have just been involved in the Local delivery Plan. We were asked as professionals to input into our service proposals under various headings and key targets. It was, how do we as a profession fit into those targets and what did we need to do to meet those targets. What would we recommend that the PCT do? So, as a manager with my manager's hat on for my profession I input into those targets; then, at the PCT Board meetings I'm faced with the fact that the pot of money becomes tighter and tighter, and the majority of things that the services have suggested, they aren't going to receive the support to take those initiatives forward. I think that's where the tensions and conflicts arise. Your natural instinct is to fight for your profession or your service, but that's not what you are there for. You have to step out of your professional role and look more widely. But then you have to go back to your professional colleagues, and people are saying to you, well, what happened to that? This can be really difficult because sometimes you can't give them an answer, because you don't clearly know what is going to happen. So people think you are not telling them, and that creates tensions." ***(AHP; Interview 26; Page 12; Paragraph G1)***

> "There will be tensions (on the PEC) but there should be advantage in bringing together different perspectives. If you have a situation where people are too cosy and they agree all the time, it's not healthy. I think there should always be a level of tension between managers and clinicians that shows they are checking each other out!" ***(Assistant Director of Clinical Governance and Professional Development; Interview 8; Page 7; Paragraph A1).***

> "It's early days, they (medical advisers) are the first PEC members and they are still finding their feet and seeing how it all works. I think one of the interesting things is that you have got clinicians as managers. They are now, for the first time having to come to terms with management realities that they have previously seen as someone else's problem. It is interesting times for them, and it will be interesting to see how the long-term relationship develops between the clinicians who are on the PEC and those who are not." ***(Assistant Director of Clinical Governance and Professional Development; Interview 8; Page 7; Paragraphs Y and Z)***

The GP Chair of the PEC perceived that her role is to 'build bridges' between different parts of the local health service and between the professional community and the PCT and between primary and secondary care. The remit of the role is to co-ordinate the activities of the other PEC members which involves a huge amount of paperwork. In relation to clinical governance at the moment, the role involves feeding information and decisions from the

PEC to the medical community via the Local Medical Committee and more recently, through the PCT's Locality Groups.The Chair believed that the PCT is struggling as an organisation to work out the role of the PEC and the role of the professional members on it. There was perceived to be a lot of conflict between the PEC members who are full time managers at the PCT and those who are part time professional representatives on the PEC and in general practice the remainder of the time. The managers have a significant clinical governance agenda to deliver to tight timescales set by the government. Any managerial decisions however, have to be cleared by the PEC before they can go to the PCT Board for ratification. Only then can implementation take place. It was reported that sometimes it is difficult to get issues agreed by the professional representatives on the PEC, the conflict resulting is creating tension for the GP Chair.

The Chair also believed that there was a lot of confusion around her own role in the minds of some of the PCT directors and managers. The Chair explained that she was having difficulty ensuring that she was making use of her clinical skills in the role, rather than spending too much time doing managerial / administrative tasks which she believed she was not trained to do as well as the manager PEC members. The Chair wished to use her negotiation and communication skills that she perceived she had acquired through years in general practice to make contact with GPs in the field and to assist them to accept and move forward with the clinical governance agenda. The Chair believed that other GP professional representatives were experiencing similar tensions. She highlighted the plight of the nurse professional representatives as more constraining. They are employees of the PCT and feel less able to 'speak their minds' than the GP representatives who are independent contractors. The Chair believed that if the PEC is to work effectively in delivering the clinical governance agenda and anything else, her own role and that of the other professional representatives needs significant clarification.

"The PCT is a very new organisation, and the PEC is very much under development. This is a completely new structure in primary care, with three bits to it the PCT Board, the PEC, and the management team. Obviously there is overlap between them because members of the management team sit on the PEC, and members of the PEC sit on the Board. As Chair of the PEC I would hope to develop bridges between different bits of the local health service in a wider definition than just medical, building bridges between the professional community and the PCT, and between primary and secondary care. I have to co-ordinate the activities of the other PEC members so that we each have our areas of special interest and responsibility. I see my role as a co-ordinating role, keeping an overview of the members of the PEC. The amount of paperwork this involves is incredible, we're bombarded with paper. I think someone needs to keep an eye on the background to what we are doing, so I spend a lot of time reading the context of what we are working on." ***(GP Chair; Interview 14; Page 1; Paragraph A)***

"I have to feedback PEC decisions and information to the medical community via the LMC. There's the opportunity for the PEC minutes to go onto the agenda of the LMC's monthly meeting. So things will come to my attention that are possibly of concern for GPs, I can always raise it at the LMC meeting, of which I am a co-opted member. We're also in the process of setting up locality meetings for primary care teams, they are not going to be just for GPs, but I would see that also as a mechanism for two-way communication with GPs. There are going to be 6 Locality Groups, each will be chaired by a PEC member, GPs will be invited with their primary care teams on a quarterly basis. Anyone in the health service in that area can attend. Things take a long time to set up. The first 12 months of the PCT has been about setting up structures and procedures, I think now we are moving into the second phase which is about making it function properly". ***(GP Chair; Interview 14; Page 1; Paragraph B)***

"I think we haven't worked out yet where the best input is for the GP Medical Advisers. We have to make sure their time is used to best advantage. How I use my time to best advantage of the PEC so that I don't get bogged down in all of the processy bits that other people can do, that I am making use of my clinical skills, with maybe a management hat on. I don't want to do things that other people can do better than me. You know they are trained managers, I'm not a trained manager, I'm an amateur in this game. I have got experience but I haven't got training. I need to use my acquired negotiating and communication skills, my ability to talk to other clinicians, and let the processy bits be done by people with expertise in them. We haven't really worked out how to do that yet." ***(GP Chair; Interview 14; Pages 13 and 14; Paragraph Y1)***

The GP Medical Advisers participating in the study similarly stressed that as practicing GPs and independent contractors they felt free to speak honestly and openly about the

clinical governance agenda. It was also observed that the directors and managers on the PEC were more constrained and had to concentrate on delivering the clinical governance agenda as outlined by the government. It was further recognised that the GP representatives and the PEC managers seldom agreed about key issues pertaining to clinical governance in general practice and that there will always be differences between those who allocate money and those who use it.

> "My feeling is that I can go to the PCT Board, or PEC and say exactly what I like. I mean I know this rigmarole that we have all signed up to (clinical governance), but the bottom line is I won't lose my job, but they (CEO and PCT managers on the PEC)will, and therefore they are constrained to do whatever the government says, even if common sense would dictate that we did something else. In spite of the fact the government says you can sort it all out locally, you can't because of the constraints it puts on you, not least of all the financial ones. One of the problems of making this (clinical governance) work is that medical professionals and PCT managers seldom see eye-to-eye on loads of things. Until you get a system where we are all working together as part of the same process, with the same degree of responsibility and accountability nothing is going to change. The way things are at the moment there is still a split between those who allocate the money and those who use it." ***(MA. 2; Interview 16; Page 6; Paragraph U);***

> "I think they (GPs in the field) are really quite glad that I do it, then they don't have to. They see it that I do something that has to be done so get on and do it. I think they are quite glad there is a GP involved. I think the nurses are in a difficult position because they are both employees of the PCT and PEC members. They are in a much more delicate situation than we are as GPs. It is more difficult for them to speak their minds about the organisation as a whole. I think the GPs (in the field) see the PCT as an organisation telling them what to do and that generates resentment. Having a GP Chair they see as supportive. When it comes to things like clinical governance I am a change agent as well." ***(GP Chair; Interview 14; Page 14; Paragraph A2)***

The nurse representatives were much less questioning of the clinical governance agenda and clearly saw and welcomed their role as change agents in getting clinical governance

accepted in general practice. They did not mention any tensions in the professional executive committee, or between their roles as professional representatives and their own practice as nurses. They did recognise that they were far more aware of the financial pressures faced by the PCT and believed that this did influence some of the decisions they made in their own practice as nurses. The nurse representatives were clearly comfortable with the managerial aspect of the professional representative's role. There were much stronger links between the nurse representatives and practice nurses in the field. The nurse representatives met frequently and regularly with other practice nurses and were often called in to the practices by nurses in the field in an advisory capacity. This was not the case with the GP representatives. The Allied Health Professional representative believed herself to be a champion and a promoter of clinical governance in her work with general practice. She perceived it necessary to be seen to be 'on board' and taking the lead in the agenda; this was particularly stressed to be necessary for the GP representatives. Not to do this was perceived to be potentially damaging to the progress of clinical governance in general practice. She did however experience tension when colleagues in the field asked for feedback which she was unable to provide because of the slow decision making of the PEC. She perceived that colleagues believed she was withholding information or not 'telling them a full story' generating mistrust and resentment.

> "One of the things I have established in my role (Nurse Adviser to PEC) is a monthly meeting for practice nurses that the PCT funds. It's lunchtime, so they come in their own time, but we provide lunch for them and we usually have a good attendance. We also have a professional nurse's forum and the locality groups that we can go to. I use these meetings to cascade information from the PCT and the nurses can feed back to me about important issues that are coming through. There are so many things on a strategic level that practice nurses who are relatively isolated aren't really aware of..... They (practice nurses) use me as a resource, if they have got any problems or issues they tend to ring me up. I mean, I don't know every thing but they know I will do my utmost to find things out for them. I think they see me as a facilitator. Because I am still a practice nurse myself, I think I am a credible figure to them." ***(NA. 1; Interview 25; Pages 18 and 19; Paragraphs J2 and K2)***

The GP participants in the field were unclear about the precise role of the GP professional representatives on the PEC. Although the GP representatives had been elected by GPs in the field they were not all known to many of the GPs participating in the study. The GPs were however keen that general practice is represented at the PCT since it a major sector of primary care, and had no wish to undertake the role themselves. There was concern that single handed GPs are not represented on the PEC of the PCT since they make up almost half of the practices in (Utopia). It was recognised however that single handed GPs would be unlikely to have the time to undertake this role. The GPs recognised that to be in any way credible in the professional representative role, GPs would have to spend a significant part of their time in practice, but they could not understand why any GP would wish to take on this responsibility.

6.5 Conclusion.

This chapter has presented the results of my study in the form of a comparative summary of the managerial and professional participants' perspectives on the three themes forming the core of the research, 'clinical governance in general practice', 'implementing clinical governance at Utopian PCT', and 'clinical governance and managerial and professional relationships'. The key points made have been evidenced with quotations from the interview transcripts. The next chapter discusses the results of my study and locates them in the context of the existing literature on the impact of clinical governance on the professional autonomy and self-regulation of GPs, outlined previously in chapter four of this thesis. The discussion also draws on the contextual material presented in chapters two and three, where, in line with Flynn's (2002) work, clinical governance was identified as the most recent manifestation of New Public Management in the English National Health Service.

Janet Hewitt
2006

Chapter Seven

Discussion.

Clinical Governance and Professional Autonomy: Deprofessionalisation, Proletarianisation or Restratification?

'We are pressed in every way, but not cramped beyond movement, we are perplexed but not absolutely with no way out' (2 Corinthians 4:8)

7.1 Introduction.

This chapter discusses the results of my study in the context of existing literature on clinical governance and recent studies examining the impact of clinical governance on the professional autonomy and self-regulation of GPs. The chapter is divided into two parts. Part one discusses the managerial and professional perspectives of the nature of clinical governance and the requirements for and barriers to its effective implementation in general practice. Part two draws on the content of part one and discusses the impact of clinical

governance on the professional autonomy and self-regulation of GPs in the context of the theories of deprofessionalisation, proletarianisation and restratification.

7.2 Part One: What is Clinical Governance and what are the requirements for and barriers to its effective implementation?

7.2.1 What is clinical governance – An Overview.

The Department of Health (1998:33) defines clinical governance as,

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

Freedman (2002) commenting on this definition suggested that clinical governance provides an 'umbrella' under which different facets of quality can be monitored, whilst Scally and Donaldson (1998) suggest that clinical governance is the main vehicle for continuously improving the quality of patient care and for dealing with poor professional performance.

In line with the Department of Health's definition, both the managerial and the professional participants in my study understood clinical governance to be a quality assurance mechanism, a tool for standardising access to and the quality of healthcare services nationally and locally. National Service Frameworks and NICE guidance were perceived to be the main vehicle for achieving these objectives.

Penny (2000) summarised clinical governance along four dimensions, professional performance, effective resource allocation, risk management and patient satisfaction. Both

managerial and professional participants in my study recognised the new GP performance appraisal and more formalised continuous professional development linked to five-yearly revalidation of practitioners to be a part of the clinical governance agenda in general practice. Both groups of participants observed that this will require a new open, supportive, 'no-blame' learning culture for general practice. The managerial and practice nurse participants described clinical governance largely in terms of systems and procedures and the new organisation culture, whilst the GP participants described the desired outcomes of clinical governance in terms of their own professional behaviour and patient's perception of this, and the process of clinical governance as a performance management system. Whilst all of the participants have the same understanding of the desired outcomes of clinical governance, there are differences in perception of the process for achieving this.

Alaszewski (2002) observed that the Bristol Inquiry was a 'watershed' case because it signifies that the government is no longer willing to unconditionally trust the medical profession to regulate itself and to provide consistent standards of care. This, along with other high profile adverse medical events was identified as the catalyst for clinical governance which seeks to regulate professional performance. Both the managerial and professional participants in my study recognised this and identified 'modernised professional self-regulation', through GP performance appraisal, continuous professional development and revalidation as a potential reduction in the autonomy of general practice. Most GP participants in my study expressed resentment of this element of clinical governance believing it to be more politically driven than quality driven and that due to a small number of poorly performing GPs the performance of the whole profession had been brought into question.

In line with Penny's (2000) definition of clinical governance, the professional participants in my study, particularly the GPs stressed the importance of effective resource allocation to underpin clinical governance. Risk management was also identified by both managerial and professional participants as part of clinical governance. There was however a difference in

managerial and GP understanding of the role of the PCT in relation to risk management. The GP participants perceived risk management to be a way of dealing with the increasingly litigious environment in which they have to operate. The managerial participants, on the other hand, stressed the 'learning from experience' and the dissemination of good practice elements of risk management in the continuous improvement process.

The managerial participants, the practice nurses and the GP Medical Advisers to the PCT believed clinical governance to be a new concept incorporating previous NHS quality assurance initiatives, whilst the GP Chair of the Professional Executive Committee of the PCT and the GPs in the field, suggested that clinical governance was no more than a re-labelling of what was already there. The PCT managers stressed the more rigorous, holistic and integrated approach to service standards across the primary, secondary and tertiary sectors of the NHS and at the interface between these. The focus on the patient experience and the involvement of service users was also perceived by the managers to be new. The statutory accountability of the Chief Executive Officer of the PCT was suggested to increase the credibility of clinical governance and also the motivation of managers to ensure its effective implementation.

A further definition of clinical governance was posited by Chandra Vanu Som 2004:89) as,

> 'A governance system of healthcare organisations that promotes an integrated approach towards management of inputs, structures and processes to improve the outcome of health care service delivery, where healthcare staff work in an environment of greater accountability for clinical quality.'

In this definition the main principles of clinical governance may be discerned as clear lines of accountability and responsibility for the overall quality of clinical care, a comprehensive programme of quality improvement and procedures to identify and address poor performance.

In a similar vein the managerial participants in my study defined clinical governance in terms of 'seven pillars' representing the work of the Primary Care Trust and reflected in the independent contractor practices. These were defined as clinical effectiveness, clinical audit, risk management, education and training, service user involvement, use of information and staff management. Clinical governance was believed to be about having a clear framework of quality improvement policies, procedures and systems at both the PCT and in the practices to support these areas of work. The professional group focused more on the nature of these policies, procedures and systems, suggesting that these will need to be simple, flexible, realistic and practical to maintain credibility with primary healthcare teams in general practice. Without such credibility it was suggested that clinical governance will not be whole heartedly implemented as has been the case with many previous NHS quality initiatives.

The managerial group stated that the new statutory accountability of the Chief Executive Officer of the PCT for clinical governance has resulted in an organisation and management structure at the PCT where there are clear lines of responsibility for clinical governance. It was also reported by the managerial group that clinical governance is now a significant factor informing managerial decisions taken at senior levels. The CEO and PCT Directors are more likely to think through the quality and risk management implications of managerial decisions than before.

In the field, the focus on clinical governance in every day practice was more variable. Practices have received clinical governance visits from the PCT and are required to undertake self-assessments of their progress in relation to the implementation of clinical governance and to file an action plan with the PCT delineating proposed future progression towards clinical governance. In many cases this has been delegated to practice managers. The evidence from my study indicates that whilst GPs are aware of clinical governance, and recognise the implications of it for their practice, they are less interested in its implementation than the managerial group at the PCT and the practice nurses. The GP

Chair of the PCT Professional Executive Committee and the GP medical advisers to the PCT suggested they have a key role in 'selling' clinical governance to GPs in the field, and that there is still a lot of work to be done in relation to this.

As implied by its title, and in line with Chandra Vanu Som's (2004) definition quoted above, clinical governance clearly is a system of 'governance' in the NHS including general practice. Both the managerial and professional participants in my study questioned the use of the title 'clinical governance' to describe a quality assurance system. The managers perceived the title to be unhelpful in achieving the stated aims of clinical governance because it gives the impression that it is a clinical concept and therefore not relevant to many non-clinical roles which are a crucial aspect of the patient experience. The managers perceived the title to be a political gesture to demonstrate a response to the public that the government will no longer tolerate lax professional standards, and the perceived failure of professional bodies to respond adequately to the regulation of poor professional performance. The GP participants perceived 'clinical governance' to be a title to describe managerial attempts to 'govern' the work of professionals.

In line with the observations of Salter (2000) and Flynn (2002) the GP participants in my study interpreted clinical governance as an attempt to regulate their work in the context of a managerial rather than a professional framework. The close links of clinical governance with the Quality Outcomes Framework in the new General Medical services (GMS) contract was perceived to be a vehicle to reinforce GP compliance with clinical governance.

a.) National Service Frameworks (NSFs).

In line with the findings of Harrison and Ahmed and (2000) and Harrison and Smith (2003), NSFs were interpreted by the GPs in my study as an attempt to reduce specialist medical knowledge into a set of bureaucratic guidelines to replace the exercise of their

knowledge, skills and experience in the diagnosis and treatment of patients. NSFs were recognised as a valuable reference point and a useful means of staying up to date with recent evidence-based developments in medicine. Some GPs also welcomed the definition of service levels for specific medical conditions because this takes the pressure off them having to justify their clinical decisions to patients. In spite of these perceived advantages, the GP participants resented the challenge that NSFs present to their professional autonomy and perceive NSFs to be an illegitimate attempt to control their work.

McColl and Roland (2000), Baker and Roland (2002), Campbell and Sweeney (2002), Marshall et al (2002), Sweeney et al 2002, and Onion and Roland (20000) in their studies of GP reactions to clinical governance identified the excessive time involved in implementing it. The GPs participating in my study similarly highlighted the time and intellectual energy involved in the reading and assimilating of the NSFs and NICE guidance and the regular updates on these. In addition, they suggested that NSFs result in a considerable increase in work associated with interpreting hospital test results and the clinical decision making associated with defining and regularly reviewing the treatment regimes of patients covered by NSFs. Whilst the more routine work may be delegated to practice nurses and other healthcare professionals the clinical decision making cannot be, and GPs remain accountable for everything that occurs in their practices. In addition, the GPs highlighted the increase in their workloads associated with seeing patients demanding new medication or referrals following the publication of new NSFs. GPs also have to input a lot of data to the computerised systems supporting clinical governance if it requires medical knowledge to do so. Now that the systems also support the 'Quality Outcomes Framework' in the new GMS contract, accurate reporting of patient information and clinical activity impacts directly on the income of the practice and so the GPs are keen to get this right.

Some of the GPs participants in my study questioned the genuineness of the 'independence' of the committee producing NSFs and guidance, suggesting that it may be more politically, managerially and financially focused than clinically focused. In line with Harrison and Ahmed's (2000) results, some of he GPs in my study perceived NSFs to be a tool for rationing healthcare services. Harrison and Ahmed (2000) suggested that prior to clinical governance, healthcare rationing was achieved via the autonomy of the medical profession, exercised within their clinical decision making, but now it is achieved via a set of bureaucratic protocols and guidelines. This point was similarly expressed by some GP participants in my study. Their response to this however was to accept it, on the basis that they no longer as individuals have to justify their medical decisions to patients, they can point to the NSF and NICE guidance as the authority for their actions. In effect this makes their life somewhat easier!

The GP participants in my study recognised that the application of NSFs and NICE guidance is still optional but suggested that they would think carefully before deviating from the guidance. They questioned their position if an adverse incident occurred and they had not followed national guidance. The GPs resented having to record their clinical decisions and to justify them if they deviated from national guidance. They perceived this to be an attack at the very root of their professional autonomy which they believed should provide them with the freedom to diagnose and prescribe treatment free from influences external to the medical profession (Coburn 1997). In line with Harrison and Dowswell's (2002) study, the routine recording of clinical actions and the medical audits associated with NSFs was also perceived to provide the information necessary for the managerial surveillance of their work. The GP participants also observed that a lot of the important work done in general practice does not have measurable outcomes and is therefore invisible to the clinical governance (and the new GMS 'Quality Outcomes Framework') systems.

Flynn (2002), drawing on the work of Lam (2000) argued that NSFs are an attempt to codify specialist medical knowledge facilitating managerial control of the medical

profession. It was also suggested by Flynn (2002) that NSFs would be unable to capture the tacit knowledge, skills and judgement of the medical profession which are individual, practical and context specific. Without exception, the GPs in my study suggested that whilst they felt constrained by NSFs and NICE guidance, they would not apply these if in their clinical opinion it was not in the best interest of their patient. The GPs observed that often patients do not fit neatly into the 'tick-box' framework of the NSFs. That application of tacit knowledge and experience might produce a different clinical decision than that dictated by NSFs. In this case they would follow their professional instinct rather than apply the guidance. This is in line with the findings of Armstrong (2002), who suggested that in the context of evidence-based medicine the prescribing practice of GPs maintained an individualistic approach to the varying needs of patients and to the idiosyncratic prescribing experiences of GPs.

Dopson et al (2003) suggested that whilst managers might perceive evidence-based medicine, and the resulting guidance as a means of creating a culture in which practitioners automatically think in an 'evidence-based' way, there may be an 'implementation gap'. Whilst evidence-based medicine and the production of guidance might have had clinical input and clinical support in the early stages, this is no guarantee that the medical profession will implement it in their every day practice. This 'implementation gap' was partly explained in terms of the power of the medical profession who may use their specialist knowledge to justify their action in applying *or not* applying guidance depending on the circumstances and their own objectives. Dopson et al (2003) suggested that acceptance or otherwise of national guidance depends on whether the medical professional perceives the guidance to be an authoritative and credible assistance to his/her clinical practice or a form of managerial control. In my study the GPs believed NSFs to be a managerial / political challenge to their professional autonomy and resented it. They did however perceive certain benefits associated with the implementation of the guidance. In the event of their doubting the validity of the guidance, or their perceiving it not to be in their own interest or in the interest of their patient in a particular situation, they would not

implement it. In line with the observations of Dopson et al (2003), they were confident that they would be able to justify such a decision in the context of their specialist knowledge, skills and experience. NSFs may be a direct attempt to control medical work, but the GP participants in my study demonstrated that they are able to successfully over-ride them if they choose to.

b.) GP Appraisal, Continuous Professional Development and Revalidation.

Chapter four of this thesis explains that knowledge monopolies are the major source of the medical profession's power because this facilitates control over how work is carried out, this in turn creates the necessity for professional self-regulation. (Becker 1962; Barber 1963; Hall 1968; Hughes 1971;Larkin 1983; Macdonald 1985; Abbott 1988 Halliday 1985; Friedson 1970a; 1970b;1986;Larson 1977). Both the managerial and professional participants in my study perceived compulsory performance appraisal, continuous professional development and revalidation to be a significant challenge to GP professional autonomy and self-regulation. This was also concluded by Salter (2000), Harrison and Dowswell (2002), Harrison and Smith (2003) and Harrison and Macdonald (2003).

The PCT Directors and managers, the practice nurses and the GP Medical Advisers perceived GP appraisal, CPD and revalidation to be an inevitable consequence of the GMC's tolerance of sometimes unacceptably low standards of performance. Some GPs have not kept up to date with advances in medicine or have merely pursued their interests within CPD rather than using the process to identify and overcome specific weaknesses. It was doubted whether in the longer term the public will be satisfied with the current professional model of peer review. Whilst this has been an appropriate way to introduce GP performance appraisal, CPD and revalidation to overcome initial resistance from GPs, it was perceived that the model is likely to become more performance management oriented in the future. A comparison was made with the more managerially focused appraisal of hospital consultants. It was suggested that as direct employees, hospital consultants come

within the managerial hierarchy of the hospital and are therefore automatically subject to formalised procedures in the event of under-performance being identified. The links between GP appraisal and local PCT procedures for dealing with under-performance were perceived to be ambiguous.

The GP Medical Advisers, two of whom were themselves trained GP appraisers, perceived they had a key role to play in encouraging GPs in the field to accept appraisal and CPD, to take it seriously as a vehicle for personal development, and not to view it as merely a paper exercise to satisfy a process of revalidation. There was thus a clear acceptance of the legitimacy of 'modernised professional self-regulation' with at the same time, an understanding of why GPs might seek to resist it.

Most of the GPs in the field strongly resented the challenge to their professional self-regulation posed by appraisal, CPD and revalidation, suggesting that it sanctions the probing of professionals which is unacceptable. Some GPs had refused to answer some questions and had made up responses to others to satisfy the appraisers. The GP participants did not believe that the appraisal process and CPD would change or improve their daily practice significantly, but would merely satisfy the requirements for revalidation. Two GPs had enjoyed the process, one was a GP appraiser himself, and a medical adviser to the PCT, and the other, the salaried GP attached to the PCT. There was concern in relation to the time and resources associated with the preparation for appraisal and the CPD resulting from it. Whilst it was appreciated that the PCT was funding this, it was perceived by most GP participants that the resources would be better spent directly on healthcare services for patients.

The PETS sessions, designed centrally by the PCT with input from the GP Medical Advisers, to support the professional development of both GPs and their practice teams were generally perceived to be pitched at too low a level. GPs also resented the use of these sessions to try to manipulate their prescribing habits. The multi-professional approach of

the PETS sessions was also criticised and was deemed inappropriate for the professional development of GPs. The PETS sessions, often led or introduced by the GP Medical Advisers, were seen to be a forum for the PCT to 'push' the clinical governance agenda, rather than as a genuine arena for professional development of primary care teams.

None of these responses are surprising given the difference in culture and underpinning values of traditional professional self-regulation and modernised self-regulation. Harrison and Dowswell (2002) Harrison and Macdonald (2003) and Harrison and Smith (2003) observe that professional autonomy and self-regulation is built on trust of independent professionals, motivated by the ownership of professional standards, whilst 'modernised self-regulation', is built on formalised bureaucratic procedures, measurement against centrally determined standards, and a belief in the surveillance of a directive body.

The GP participants demonstrated they would comply with the necessary rules and regulations to achieve revalidation and remain licensed to practice. They would, similarly continue to attend the PETS sessions while ever funding was attached to their attendance. At the same time they found direct and indirect ways to avoid co-operation with anything deemed to be an inappropriate managerial encroachment on their work or on the way they managed their practices. Examples of this are providing misleading responses, telling direct lies or simply refusing to answer certain questions during the appraisal process. There was no evidence to suggest that this had led to any adverse consequences. This might change in the future if the public demands even greater professional accountability of the medical profession. There may then be a 'tightening up' of the current self-regulatory procedures for GP appraisal making them more 'performance management' focused. The comparison of GPs with hospital consultant's experiences of performance appraisal also suggests that the independent contractor status of GPs plays an important role in supporting the self – regulatory approach to GP appraisal. This could also change if sufficient numbers of GPs take up the option of salaried status with the PCT.

c.) Commission for Health Care Audit and Inspection (CHAI).

Harrison and Smith (2003) argued that clinical governance is a form of 'neo-bureaucracy' in which clinical activity becomes subject to increased managerial surveillance. Rules and regulations 'govern' professional activity via regulatory agencies, such as CHAI, rather than by traditional bureaucratic hierarchies.

In my study, at the time of data collection, Utopian PCT was about to receive a CHAI inspection within the following few months but was unaware exactly when. The managerial participants were very focused on preparations for the visit. Because the Utopian PCT was newly formed at the time, the mangers anticipated the result of the CHAI visit to provide a useful baseline position for their future continuous improvement programme. There was concern, because as a new organisation the Utopian PCT lacked a history in the audit cycle. Not all systems and procedures were in place, and not all the necessary documentation was available. It was also perceived that a lot of work would need to be done to prepare PCT staff for the inspection. In particular, the managers were concerned that the auditors would wish to visit a sample of general practices as part of the inspection. GPs in the field were perceived not to have taken 'ownership' and responsibility for preparations for the CHAI visit in their practices. The PCT directors and managers were resigned to this, and hoped that if they could provide significant evidence that the PCT had made every possible effort to support the practices in the implementation of clinical governance, and had regularly communicated with them about the CHAI visit, any GP recalcitrance might not reflect badly on the PCT.

This response from the managerial participants is not surprising, given that in bureaucratic systems, it is managers who are primarily held responsible for poor performance. This is particularly the case with clinical governance where the CEO of the PCT has statutory accountability for its implementation, not just at the PCT but within all associated independent contractor organisations. The managerial participants stressed on many

occasions, the untenable position of having accountability and responsibility for clinical governance in independent contractor organisations, but no authority to direct and instruct its systematic implementation.

Rose (1999) observed that audit systems and procedures directly challenge trust in professionals and their expertise, which inevitably sets off a 'spiral of mistrust', resulting in the necessity to implement more and more complex systems of surveillance. In my study this was clearly illustrated. Whilst there was a degree of confidence in the policies, procedures and systems at the PCT, there was concern that these were not mirrored in the individual general practices. The PCT managers sought therefore to introduce further measures to assure compliance, but were frustrated because they could not gain access to records held in the practices.

As predicted by the managerial participants, the GPs in the field were mostly unaware, uninterested and unconcerned about the forthcoming CHAI visit believing it to have nothing to do with them. They were not willing to make advance preparations for the visit, suggesting that if the inspectors chose to visit the practices they should be allowed to see the pressures under which GPs and other primary healthcare professionals work. Whilst GPs should have had lots of knowledge and information about the CHAI visit from the PCT the practice managers had not always passed this on. The practice managers reported that anything from the PCT to do with clinical governance was either sent directly to them by the PCT or, more likely, was passed to them to deal with by the GPs who they believed wanted as little to do with the bureaucracy of clinical governance as possible.

There are clear differences in attitude between the managerial and professional participants in my study to the CHAI inspection. Whilst the managerial participants recognised the monitoring and inspection role of CHAI as legitimate and felt under pressure to conform to the significant bureaucratic procedures in preparation for a visit, this was not the case with professional participants, whose main concern was the frontline delivery of care. The

response of GPs also suggests that whilst they have been confederated to the PCG/T since 1999, they still think independently as small business owners, rather than 'corporately' in terms of 'collaboration' and 'partnership'. (DofH 1998b).

d.) Risk Management

Risk management has been subsumed into the clinical governance agenda. Within the clinical governance agenda, risk management strategies seek to record, report, analyse and facilitate learning from 'adverse events' or 'near misses' as well as setting up controls procedures (Donaldson 2002). For this to be done effectively in general practice, the managerial participants perceived that it requires GPs to take ownership of the implementation of the PCT's risk management strategies in their practices. To maximise benefits, GPs are asked to share information about adverse incidents, and to disseminate good practice between practices as well as within their own practice (Swage 2002).

The PCT has a set of policies, procedures and systems in place for identifying, assessing and controlling risk which the managerial participants in my study perceived GPs should take ownership of and apply them in their practices. At the time of data collection, it was perceived that the implementation of risk management in the practices had not been very successful. The managers suggested that this is because the risk management procedures require GPs to behave in more open and transparent ways, particularly in relation to information sharing, which they are generally unwilling to do. The Risk Manager also believed that GPs misunderstand the purpose of risk management seeing it as a managerial tool rather than a benefit to the practice and a means of ensuring safe practice and minimising the chance of litigation. The Risk Manager stressed the problem of having to 'sell' risk management to GPs, like a sort of product, rather than merely directing them to implement it. Some of the managerial participants were also concerned that subsuming risk management, itself a large and significant area of work, into the enormous clinical

governance agenda, had caused it to lose focus, particularly in its application in the independent contractor practices.

In the field the practice managers suggested that they deal with the administrative elements of risk management whilst the GPs deal with the clinical aspects of this. Contrary to the perception of most of the managerial participants, the GP participants were very much aware of risk management as a concept. They did in fact emphasise risk management more than quality improvement in their definitions of clinical governance. Most of the GP participants were not however aware of the detailed risk management strategies of the PCT. They perceived this to be a basically bureaucratic process which they had delegated to their practice managers. The GPs were however, clear about their ultimate accountability for everything that goes on in their practices including the work of the other primary healthcare professionals working with them. They expected to be consulted and kept informed about everything of a clinical nature that happened in the practices on a day to day basis.

The GP Chair of the PCT Professional Executive Committee and the GP Medical Advisers stressed that part of the normal professional practice of a GP is to examine positive and negative outcomes of clinical activity in their practices and to take this into account in future situations. They perceived that the managerial language associated with risk management, 'significant event analysis', 'adverse incidents' and 'near misses' for example, would irritate 'rank and file' GPs, who would see this as already a part of everyday professional practice and nothing to do with managers at the PCT.

The GP participants in my study stated that whilst they would discuss 'adverse incidents' as primary care teams within the practices, they were not happy to share information about these with other practices in a 'learning environment'. They perceived this to be a form of 'washing dirty linen in public' and saw no benefits to be gained from doing this. Whilst complying with the compulsory bureaucratic requirements of the PCT for risk management

via their practice managers, they themselves assumed responsibility for clinical risk management in their own practices. They would merely report serious cases to the PCT.

It appears that GP's understanding of implementing risk management is different from that of the PCT managers. The GP participants see the role of the PCT in relation to risk management in terms of health and safety and meeting the requirements of external regulatory bodies on a whole range of issues. On the other hand, PCT managers perceive a much greater involvement of the PCT in the management of adverse incidents and the learning process surrounding them within the individual practices. The GP participants were not happy to comply with this, preferring to deal with 'adverse incidents' in the context of their own professional culture and codes of ethics, valuing their own reputations and the reputations of their practices more highly than the collective reputation of the PCT.

7.2.2 What are the Requirements for and the Barriers to the Effective Implementation of Clinical Governance in General Practice?

a.) Time and Resources, Policies, Procedures, Systems

A number of studies have been conducted tracking the progress of the implementation of clinical governance in primary care (McColl and Roland 2001; Baker and Roland 2002; Campbell and Sweeney 2002; Marshell et al 2002; and Sweeney et al 2002). The GP participants in these studies stressed the large amount of time and resources it takes to implement clinical governance effectively. This point was similarly emphasised by both the managerial and professional participants in my study. This was perceived to be a significant barrier to the implementation of clinical governance in general practice, particularly for 'single-handed' GPs. In Utopia almost half of the GPs are 'single-handed.' The managerial participants observed that if clinical governance is not adequately resourced it will lose

credibility with already sceptical GPs. The managers were not confident that the PCT is adequately funded to follow through on the implementation of NSFs, the professional development of GPs flowing from their appraisals, and preparations for the CHAI visit along with any subsequent actions identified by the auditors. It was suggested that a continuous improvement process is resource intensive, and the department of Health may not be able to pay the bills.

In line with NHS guidance (DoH 1998), and Scally and Donaldson (1998), both the managerial and professional participants in my study identified the necessity for a clear framework of policies, procedures and systems to support clinical governance underpinned by a good communication strategy and information technology system. The managerial group clearly identified the areas where these will be required around seven key areas of work (seven pillars of clinical governance) including, clinical effectiveness, clinical audit, risk management, education and training, service user involvement, use of information and staff management. The managers were confident that most of the necessary systems and procedures are in place at the PCT, but were less confident that GPs in the field have taken ownership of these and are implementing them in their practices.

The GP participants in my study explained that to gain and maintain credibility with primary healthcare teams in general practice, clinical governance policies, procedures and systems need to be practical and simple to operate on a daily basis whilst working with patients. They also need to be relevant to the work of general practice, realistic in terms of the time and resources required to implement them, and practical and flexible, in line with the changing circumstances of day to day practice. Practice staff must be convinced of the value of clinical governance to patients and to the efficient running of the practice or else it will not gain their acceptance. Many of the systems presented by the PCT were not perceived to meet the criteria and were therefore openly ignored by some GPs and practice nurses.

b.) Systematic Quality Improvement.

The managerial group observed that a more systematic approach to clinical audit and quality improvement in general practice is required. Getting practices to gather information as an evidence base to underpin their practice was deemed to be a challenge, but for clinical governance to be effective as a continuous improvement process, it is necessary for practice teams to *use* the information gathered from multiple sources, including adverse incidents and complaints, to improve their practice. The managerial participants were concerned because many GPs appeared not to have taken this seriously and were not 'closing the loop'. The GP participants suggested that they had always engaged in reflective practice, and learnt from their experiences, though possibly not formally recording the outcomes of this. This was perceived to be part of behaving professionally, and not something necessary for PCT managers to be involved with.

c.) A New Culture.

Van Zwanenberg and Harrison (2004), report that clinical governance encourages a culture of excellence, partnership and accountability. Scally and Donaldson (1998) observe that this requires a working environment which is open and transparent, where ideas and good practice are shared and where 'blame allocation' is the exception.

The managerial participants in my study, except for one, who questioned whether managers could 'create' and 'manipulate' organisation culture, sought to change the existing culture of general practice which was perceived to be incompatible with clinical governance and in particular, stressed the need for many GPs to change their behaviour and to be less protective of their traditional professionalism, which was perceived to stand in the way of the continuous improvement process. The goal is to get everyone to engage with a quality culture, to internalise the values and beliefs of the culture and to automatically 'think quality' in everything they do.

The PCT had employed all aspects of the well established models of cultural change (Kotter and Schlesinger 1997), including strategies of education and communication, participation and involvement, facilitation and support, negotiation and the use of change agents. There is a detailed account of the strategies and structures used to implement clinical governance in Utopian PCT in chapter six of this thesis. The following is a summary.

Education and Communication

PCT managers perceived that they had provided a wide programme of education and communication to support clinical governance. There is the Protected Education Time (PETS) scheme which provides training and development for GPs and other healthcare professionals both individually and as practice teams. In addition there have been 'roadshows' and presentations aimed at preparing PCT staff, GPs and practice staff for the forthcoming CHAI visit. There have been various briefings, seminars, presentations and workshops targeting different groups of staff, focusing on different elements of clinical governance. For GPs these have often been designed and led or introduced by the GP Medical Advisers to the PCT. There has been a regular newsletter for PCT staff and posted out to the individual practices, reporting on the progress made in the implementation of clinical governance and highlighting 'success stories'. At the time of data collection for this study, the PCT was in the process of establishing an organisational intranet with up to date information and documentation about clinical governance. The independent contractor organisations associated with the PCT were also to have access to this once the information technology infrastructure was in place to support this.

Participation, Negotiation and Use of Change Agents..

The PCT managers perceived that individuals including GPs have been given many opportunities to participate in the decision making associated with the implementation of clinical governance. A key role in this context is perceived to be fulfilled by the GP

Medical Advisers to the PCT, who represent general practice on the PCT Board Professional Executive Committee (PEC), Clinical Governance and Risk management Committee and the sub group to this committee for general practice. These individuals were perceived by the directors and managers taking part in my study to be very important change agents in getting clinical governance accepted by GPs in the field. The role of these individuals is discussed in more detail in chapter six and further on in this chapter. In addition, GPs have taken the lead or have contributed as members of Local Implementation Teams (LITs) which are responsible for designing the local strategy for the implementation of the NSFs. These roles are largely filled by ex- Fundholders and are well known GPs to PCT managers. The managers suggested that these GPs are the 'trusted few' or the 'safe hands' in which to place such a significant task. GPs have the opportunity to undertake training to become GP appraisers. At the time of data collection there were six trained GP appraisers, these included two of the GP medical Advisers. All GPs in the field were required to complete self-assessment questionnaires to determine their practice's starting point in relation to clinical governance and the level of support that might be needed from the PCT in the future. GP Medical Advisers are required to make visits to the 'problem practices' to provide support and to help resolve issues and weaken GP resistance to clinical governance.

Facilitation and Support

The PCT managers outlined the support that had been provided for general practice in relation to the implementation of clinical governance. The Primary Care Directorate of the PCT employ a Clinical Governance Facilitation team, headed by a manager and staffed by a number of administrators and two clinical governance co-ordinators who go out into individual practices to provide general administrative support and staff development in relation to clinical governance. They also undertake some of the practical work associated with setting up clinical governance registers and systems. The Clinical Governance Facilitation Manger and the Director of Primary Care have visited every practice to explain

the PCT's approach to clinical governance, to answer GPs questions and concerns and to negotiate the support that each practice could expect from the PCT.

In spite of this extensive programme of cultural change, the managerial participants perceived there to be still a lot of work to be done to break down barriers with many of the GPs and to build trust between them and the PCT. The managers perceived that GPs still need to significantly change their behaviour. GPs need to be more open and willing to share information, to take a more team-based approach to the management of their practices and to communicate better with their practice staff and also with the staff at the PCT. They need to facilitate a 'learning culture' in their practices requiring a 'no-blame' climate. They also need to be more willing to implement PCT policies and procedures in their practices and to create the necessary evidence-base to support clinical governance and to actively use this information in the quality improvement process.

The managerial participants in my study had explanations for the perceived blockages in the cultural change process. They suggested that part of the difficulty is that each practice is an independent unit, and has its own organisation culture. For these to be melded into a single 'corporate culture' to support clinical governance was perceived to be a significant managerial task. The managers clearly believed however, that given time, GPs will see the benefits of clinical governance for their patients and practices and will 'buy-in' to the quality culture. The GP Medical Advisers are believed to be change agents in this context. Their role is to 'sell' clinical governance, like a product to GPs in the field. The GP medical Advisers themselves recognised this as part of their role.

A further problem was perceived to be an inherent contradiction between the 'blame-free', open, learning culture necessary to support continuous improvement and the control and accountability necessary for effective risk management, where individuals are required to report practice they consider to be unacceptable or questionable.

Some GP participants were unaware of all of the PCT's strategies to support the implementation of clinical governance in general practice and had not received the cultural communications of the PCT (identified above). The practice managers however, were all aware of the support available from the PCT for clinical governance. The information had not been passed on to GPs. The practice managers suggested that the GPs do not have time to be concerned with everything that arrives from the PCT. The practice managers are acting as a 'buffer' between GPs and the PCT. In their attempts to be efficient and supportive of GPs in the clinical governance implementation process, practice managers may be slowing down the progress of cultural change in general practice and the desired change in behaviour of GPs, associated with this.

Whilst there are significant differences in the cultures of professionals and managers, outlined in chapters two and four of this thesis (Horton and Farnham 1999; Flynn 2004; Aucoin 1990; Osbourne and Gaebler 1993; Mathiasen 1999; Holmes and Shand 1995 and Dunleavy and Hood 1994), to try to explain antagonistic relations between public sector managers and professionals in terms of these differences in culture is too simplistic. There is a complex interdependence between the two groups. For example, In the case of medicine, professional autonomy has played a key role in depoliticising and legitimising the management of demand for healthcare services in the NHS. Resource constraints appear acceptable to patients if they are expressed in terms of clinical decisions rather than managerial allocations (Aaron and Schwartz 1982; Johnson 1982; Flynn 2001; Light 1995). On the other hand, the medical profession relies on the state for its monopoly of service and for its right to self-regulation (Friedson 1970a; 1970b; Larson 1977). Nevertheless, the contrast between the professional and managerial cultures illustrates that the two groups may pursue the same objectives but use different means of achieving them which may often be incompatible (Harrison 2004).

d.) Multi-disciplinary teams.

The Department of Health (1998b) suggest that for clinical governance to be effective it will require better team working in healthcare organisations and between the various sectors of the NHS and at the interface between them (Scally and Donaldson 1998).

The managerial participants in my study suggested that there was effective teamwork within the PCT. There was however an area of conflict uncovered by my study between two key individuals in relation to the implementation of clinical governance at the PCT and in general practice. This is reported in full in chapter six and Appendix xxxx of this thesis. The problem was caused by a flaw in the PCT organisation structure supporting clinical governance. This had the potential to undermine the result of the forthcoming CHAI visit. In addition, other PCT directors were unclear what the boundaries were around each of their responsibilities for clinical governance. They were unsure where one person's responsibility stops and another's starts. At the time of data collection these problems were not being addressed.

All of the participants in my study perceived there to be weak team -working at the interface between primary and secondary care in the Utopian area. This was resulting in poor communication between hospital consultants and GPs in relation to patient hospital appointments, test results, and follow up care after discharge from hospital, detracting from the patient experience. This was explained in terms of a lack of mutual respect of hospital consultants and GPs and poor administration within some directorates at the hospital trust. Hospital consultants were perceived to be authoritarian with GPs in dictating 'pathways of care' for certain patients. This is led by secondary care, but has a significant impact on the work of GPs. Hospital consultants were also perceived to be uncooperative in the Local Implementation Teams (LITs) in relation to the local implementation of some of the NSFs which required a team-based approach between primary and secondary care.

The managerial participants identified the most serious weaknesses in team working to be within the general practices themselves.. The managers suggested that within many of the practices there is poor communication and team working between GPs and the other members of the primary care team. GPs were perceived to work closely with practice managers however, in relation to clinical governance. There were differences in the perceptions of practice nurses and GPs in relation to team-working.

The nurse participants in my study observed that even though their roles have expanded as a result of the 1990 GMS contract which has resulted in a lot of work previously undertaken by GPs being delegated to them, GPs are still the dominant actors in primary care teams. This was perceived to be because of the GPs historical professional autonomy and self-regulation (Friedson 1970a; 1970b); because the public, and to some extent NHS policies and structures 'reify' the medical profession (the nurses perceived that they will always be 'the handmaidens' of doctors), and most of all, because of the independent contractor status of GPs which makes them the employers of practice nurses and other healthcare professionals working in the practices. The nurses working in the 'single-handed' practices seemed to have higher status and greater self-esteem. They suggested they worked more in partnership with the GPs who rely heavily on them at all times in order to cope with their workloads. Amore hierarchical relationship was perceived in larger group practices and in health centres.

Clinical governance and the new 2004 GMS contract present even greater opportunities for nurses and other healthcare professionals to develop their skills and take on more of the work currently done by GPs .(Charleton 2005; Stokes et al 2005; Buckman and Snell2002). The practice nurse participants anticipated however, that clinical governance and the 2004 GMS contract will shift the workload downwards to them, but the control will remain with GPs. Interestingly the GPs felt similarly about their relationship with hospital consultants in relation to taking on responsibility from consultants for delivering 'enhanced services' within the framework of the new GMS contract.

The nurses explained that GPs firstly will have to agree to their taking on additional responsibilities from GPs, then GPs will have to sanction and support the nurses development of new skills, otherwise they will not be allowed to undertake the necessary training. Once qualified and experienced in their new roles, the nurses observed that they will still report to GPs as supervisors and employers. Clinical governance was not perceived therefore to break down the traditional boundaries between GPs and other healthcare professionals. GPs may be forced to make greater use of a more diverse workforce in general practice in order to cope with the additional workload associated with clinical governance, and in order to maximise their incomes within the Quality Outcomes framework of the new 2004 GMS contract, but they will not relinquish their overall control of the medical work undertaken by nurses.

The GP participants in my study had a different view of their approach to team-working, in every case believing themselves to be 'team-players'. The GPs believed that they had accepted the expanded role of other healthcare professionals in general practice, and had become more reliant on them. The GPs recognised that in some limited areas, for example, some aspects of chronic disease management and birth control, practice nurses know more than they do, so in those cases they would defer to the nurses greater experience. The GPs were happy for practice nurses to expand their skill further, taking on work previously done by them and most said that they would be willing to support the training and development the nurses required. The GPs agreed however, that they will maintain control over the work of practice nurses and other healthcare professionals working in their practices because they are professionally accountable for everything that occurs in their practices.

The shifting of professional boundaries in the context of clinical governance and the new 2004 GMS contract can be to some extent explained in terms of Abbott's (1988) 'system of professions' which seeks to understand inter-professional rivalry. As outlined in Chapter Four of this thesis, Abbott (1988) used the concept of 'jurisdiction' to describe the control a profession exercises over a specific area of work, the right to perform the work at the same time excluding others. Abbott (1988) argued that in the process of

'professionalisation', jurisdictions can be created, willingly vacated or shared and lost to other groups. Professions may attack each other, and external forces may open up or close jurisdictions. Clinical governance supported by the new GMS contract has, in effect, opened up a new 'jurisdiction' for practice nurses. Some GPs have agreed to willingly vacate these areas or at least to share them with the nurses whilst maintaining overall control of the medical work undertaken by them and so maintaining their own professional dominance. (Larkin 1983; Macdonald 1985)

Some of the managerial participants in my study suggested that the necessary skill mix to support clinical governance and the modernisation programme would be easier to develop in general practice if GPs became salaried employees of the PCT. If both nurses and GPs have the same employment status it will be easier to use the 'total medical resource' more flexibly. In spite of their heavy workloads however, none of the GPs I interviewed (except for the one already salaried GP) were interested in taking up salaried status. It was generally perceived that salaried status would impact even more negatively on their professional autonomy and would reduce the flexibility they currently exercise in the content and organisation of their own work.

The managerial and GP participants in my study believed that the role of the practice manager would expand under clinical governance and would become more 'professional'. It was envisaged that in the future, the practice managers will need some basic clinical knowledge to undertake the administration for clinical governance and the new GMS contract, and stronger leadership skills, as these individuals might become the line managers of other practice staff. Some of the PCT directors saw the practice managers as key change agents in getting clinical governance accepted by

GPs. The practice managers were perceived to know exactly what is going on in the practices and to have the 'ear' and support of the GPs. To get them 'on board' with the clinical governance agenda was believed to be essential.

The GPs similarly acknowledged their increasing reliance on practice managers for the bureaucratic elements of clinical governance, suggesting that if they had some basic medical knowledge in routine areas of work they would be able to relieve GPs of some of the paperwork they currently do. The GPs acknowledged that the practice managers 'sift' the information from the PCT for them, only passing on the really necessary documentation. The practice managers also undertake most of the clinical governance returns and reports for the PCT, as well as all of the bureaucratic elements of clinical governance, for example, the setting up and maintaining of chronic disease registers. The practice managers are also responsible for co-ordinating the work of the other primary healthcare specialists in general practice in relation to clinical governance.

The evidence from my study suggests that practice managers increasingly act in a 'boundary role' between the GPs and the PCT. The practice managers themselves perceived their role to be evolving as a result of clinical governance and becoming more influential. The practice managers recognised that often they are the only ones in the practice who are fully informed and involved with the PCT in relation to clinical governance. The evidence from my study suggests that the role of the practice manager is not only expanding in terms of workload but it is becoming a potentially very powerful role in general practice.

e.) Leadership.

Scally and Donaldson (1998) suggest that effective clinical governance requires strong leadership. The managerial participants in my study suggested that this is required both at the PCT and within the individual practices. The key role of the GP Medical Advisers was also stressed by the managerial participants. These individuals were perceived to be significant change agents in getting clinical governance accepted and implemented in general practice. The GP Medical Advisers to the PCT are practising GPs in the field, but work part time for the PCT, assisting in the interpretation of NHS policy and in developing

PCT procedures and systems to implement this locally. The Medical Advisers were described as a conduit of information between the PCT and general practice in relation to clinical governance. They are expected to 'sell' the clinical governance agenda to their professional colleagues. The Medical Advisers also represent GPs in the field in PCT decision making and then feedback information and decisions to GPs via Locality Group meetings (all primary healthcare professionals including GPs are divided into groups according to their geographic location in the Utopian area), informal local GP networks and sometimes, via the Local Medical Committee (where the Chair of the PCT Professional Executive Committee is also the Chairperson). The GP Medical Advisers have also been required to visit general practices having clinical problems, or presenting significant resistance in relation to implementing clinical governance, in an advisory/troubleshooting capacity, and to take part in the identification of training needs of practices and the design and delivery of PETS sessions to support clinical governance. The GP Medical Advisers were described by the managerial participants in my study as well known and well respected GPs in the local community and the key link between the PCT and GPs in the field. They were also described by one Director as managers in medicine.

Attempting to incorporate doctors into management is not new, it was a key theme of the Griffiths Report (1983), where hospital doctors were encouraged to take up full time general management posts. Also within the framework of the internal market hospital doctors were encouraged to take up part time Clinical Director posts where they became responsible and accountable for a specialist unit of care requiring them to deliver care within a fixed budget, engage in performance review of staff and undertake risk management. According to Fitzgerald (1994) large numbers of doctors accepted these part time managerial roles because they believed that medical professionals should have more of an influence on management decision making. Because the Clinical Director roles were part time, doctors could continue to practice in order not to lose their clinical skills, and to maintain the respect of their professional colleagues (Llewelyn (2001).

In my study, one of the directors compared the role of the GP Medical Adviser with the role of the Clinical Director. It was suggested that in the case of GP Medical Advisers however, both the role and the individuals fulfilling the role are under-developed in comparison. Clinical Directors were perceived to be more assertive in their representation of their professional colleagues on senior committees and on the Trust Board. It was suggested that this is partly because Utopian PCT was at the time, a new organisation (Utopian PCT only became a PCT in April 2002, when evolution from PCGs to PCTs became compulsory), and there has not yet been sufficient time for the role to become properly established. The independent contractor status of GPs was also identified as an explanatory factor in the problem. GP Medical Advisers do not represent a cohesive unit of professional colleagues, as in a specialist unit of a hospital trust. Instead GP Medical Advisers represent a diverse group of geographically dispersed professional small business owners, some of whom they may never have met. It was also perceived that many GPs refuse to attend Locality Group meetings, and so may never actually communicate with the Medical Advisers, contribute their ideas to PCT decision making, or hear the feedback provided by the Medical Advisers in relation to the decisions that have been made. This was contrasted with Clinical Directors, who know and work closely with the colleagues they represented on senior committees, and so they are able to speak with greater confidence, authority and assertiveness. It was suggested that it is very difficult for the GP Medical Advisers to represent such a large, diverse and fragmented group of general practitioners.

There was confusion between the PCT Directors about the exact nature of the GP Medical Adviser's role. Two of the directors saw the role as primarily one of professional representation, whilst a further two saw the GP Medical Advisers as firstly managers, with a corporate responsibility for the management decisions of the PCT. Interestingly, the Directors holding the former viewpoint have a clinical background, whilst the two expressing the second viewpoint are directly from industry.

The GP Chair of the Professional Executive Committee and the GP Medical Advisers themselves similarly believed that there was ambiguity about the nature of their role. This had led to many GPs accepting the role of Medical Adviser and then resigning from it very quickly. It has been very difficult to get replacements for these individuals. It appears that the PCT is not using the specialist skills, and abilities of the GP medical Advisers in achieving the objectives they employed them to fulfil, to communicate and negotiate with GPs in the field. Instead the GP Medical Advisers are burdened with excessive administrative work for which they have not been trained to do and have no wish to undertake. Sweeney et al (2002) reported similar difficulties experienced by GP representatives, who reported that this had led to feelings of powerlessness and a lack of control over workloads. The GP Medical Adviser participants in my study also experienced tensions between their managerial role at the PCT and working in practice. They suggested that knowledge of broader PCT issues and agendas impacted to some extent on their dealings with patients particularly in relation to use of resources.

The GP Chair of Utopian Professional Executive Committee (PEC) expressed reservations about the effectiveness of this senior committee. There is a lot of conflict between the full time managerial members of the committee and the part time GP Medical Advisers. The managers have a significant clinical governance agenda to deliver to tight timescales. The decisions have to be accepted by the PEC however, before they go to the PCT Board for ratification, only then can implementation take place. The GP Medical Advisers were perceived to slow things down in their attempts to consult with and represent GPs in the field on all key issues.

The GP Medical Advisers in my study, in line with the findings of Fitzgerald (1994) in relation to Clinical Directors, perceived a mixed response from professional GP colleagues in the field. From some there was support, from the majority there was indifference, and from a few, hostility. In line with the findings of other authors (Llewellyn 2001; North and Peckham 2001; Locock et al 2004 Sheaff et al 2003), the GP participants in the field were

keen that general practice should be properly represented at senior levels at the PCT. The implication of this is that medical expertise is necessary to the decision making of the PCT, generic management skill is not enough. Managers lack an understanding of medical practice, and they are not guided by the same professional code of ethics as doctors are. Can they be trusted therefore to make the right decisions in the best interest of patients, or will they be guided by short-term (financial) results oriented thinking?

Whilst wanting medical representation at the PCT, the GPs in the field questioned the desire of any GP wanting to undertake such a role. What would motivate them? There was concern that it might be because they are bored with general practice, or not so good at dealing with patients, or that these individuals might be self-centred careerists seeking to further their own objectives. It was also suggested that such individuals might 'sell out' to management and, in line with the observations of Coburn et al (1997), form mutually beneficial coalitions with PCT management. It was also perceived that since almost half of the GPs in the Utopian area are 'single-handed' and do not have the time or capacity within their practices to allow them to become GP Medical Advisers, the interests and problems of these GPs may not be adequately represented in PCT decision making.

The GP Medical Advisers have taken on management responsibilities in relation to the implementation of clinical governance in general practice. They recognise and accept that they are change agents and that they will need to win the 'hearts and minds' of GPs in the field, sometimes using strategies of persuasion and manipulation. They have accepted that, like Clinical Directors in hospital trusts, they operate in a boundary role between the PCT and GPs in the field (McCasky 1988; Fitzgerald 1994; Ferlie et al 1996; Llewellyn 2001; North and Peckham 2001; Sheaff et al 2003; Locock et al 2004; Dent 2005). The GP Medical Advisers address this however, in the context of a professional rather than a managerial culture. In line with the findings of Llewellyn (2001) and Sheaff et al (2003), the GP Medical Advisers in my study think about problems and present them to GPs in the field primarily in the context of 'professional objectives' and in the language of

'professionalism' rather than in the management language of rules, regulations, procedures, systems, targets, budgets and resources. In spite of the GP Medical Advisers being described as 'managers in medicine', my study suggests that although there is a complex interrelationship between NHS managers and the medical profession (Salter 2001) and the alignment of management and medicine promises to overcome the traditional antagonism and barriers between the two, medicine and management are still separate domains, at least culturally. March and Olsen (1976) suggested that doctors and managers have different logics. Doctors are guided by the 'logic of appropriateness', while managers are guided by the 'logic of consequences'. In line with the findings of Sheaff et al (2003) the GP Medical Advisers at Utopian PCT attempt to transmit managerial priorities from PCT managers to GPs in the field whilst at the same time conserving a degree of autonomy for professionals.

Llewellyn (2001) depicted the role of Clinical Director as a two-way window because Clinical Directors are able to acquire managerial knowledge and skills as well as having professional knowledge and skills. They have the ability therefore to control the interpretation of managerial ideas to other medical professionals, and to disseminate management information acceptably to them. Managers however, do not have access to, or control over medical professional knowledge and skills. Clinical Directors were perceived therefore to 'straddle' the whole organisation, whilst managers cannot. This situation was perceived to greatly increase the power base of these individuals. Whilst clinical governance may to some extent serve to make clinical practice more visible to managers, and to increase their influence over the way in which medical professionals perform their work, PCT managers are still heavily reliant on GP Medical Advisers to persuade independent contractors to conform to its principles. As in the case of Clinical Directors, only they have the trust and respect of the professional community. Managers do not have the same level of credibility. In the longer-term as GP Medical Advisers at the Utopian PCT become more confident in their role, and develop their management skills, the potential is there for them to become very powerful actors in the PCT.

f.) The New General Medical Services (GMS) Contract 2004.

A new GMS contract was implemented in general practice from April 2004 (Buckman and Snell (2002). As with the previous 1990 GMS contract, the new 2004 contract is based on a performance management model, but this time, rather than income being based on capitation and 'fee-for-service' payments (Warwicker 1998), it is based on the quality of care delivered to patients measured by centrally determined performance indicators (Moore 2004).

Both the managerial and professional participants in my study suggested that the new GMS contract aligns very closely with clinical governance. Most GP participants defined it as a financial incentive to manipulate them into implementing clinical governance in their practices.

The similarities between the new GMS contract and clinical governance are clear. The contract has a 'Quality Outcomes Framework' (QOF) which includes clinical, organisational and patient experience elements. In the case of the clinical area of work, this relates to the management of ten chronic disease groups which align with relevant NSFs. Clinical quality is measured on a sliding scale where practices are able to move up a range of criteria with rising standards of quality. There are organisational implications, since for example, this involves having accurate disease registers, internal clinical audit systems, and undertaking frequent disease reviews requiring efficient 'call' and 'recall' systems for patients. The focus is on improving the patient experience, determined by the use of patient questionnaires identifying areas where GPs and the primary healthcare team can improve their services. Income is based in part on the achievement of outcomes- based targets measured by performance indicators. This involves GPs and the primary health care teams in constantly examining their systems and procedures to identify blockages and to remove these (continuous improvement). Risk management is also central to the new contract. Practices have to ensure they comply with the requirements of a range of external

regulatory bodies. To maximise their income within the framework of the new contract GPs will have to delegate the considerable work involved to appropriate members of the healthcare team. This reduces the capacity for GPs to behave independently and territorially within the practices. In particular, the new GMS contract will make considerable demands on the practice manager.

The new GMS contract also opens up the opportunity for GPs to deliver 'enhanced services'. These are services that have previously been undertaken by hospital consultants. The GP participants in my study demonstrated a mixed response to 'enhanced services.' Some GPs perceived this to be an interesting way of developing their skills and interests whilst at the same time maximising their incomes. Other GPs believed that this was merely a way of redistributing work from secondary to primary care, further increasing their workloads.

Lindsay et al (2002) observe that up to one third of GP income is related to quality criteria under the new contract. The contract recognises the quality of existing work, including therefore all of the work GPs may have done towards implementing clinical governance, along with future work. Those who have delivered better patient outcomes and evidence-based medicine, including the implementation of NSFs and NICE guidance receive rewards for this. Both the practice manager and practice nurse participants in my study suggested that the GPs were becoming more interested in clinical governance now that they have seen the potential earnings that are available. GPs were also reported to be keen to check returns to the PCT in relation to the areas that attract the most income. Some of the GP participants were sceptical, suggesting that the level of funding will not be available to cover the number of quality points that GPs in the area will be claiming. The GP Chair of the Professional Executive Committee was concerned that if this is the case it will create a lot of ill-will among GPs and the positive work that has been done in relation to the implementation of clinical governance in general practice will be damaged.

The participants in my study identified a number of potential flaws in the new contract. The contract is to be monitored in non-expensive, non-intrusive ways using a model of high trust. (Buckman and Snell 2002). GPs will be responsible for making their own returns to PCTs. Similar to clinical governance, the system is self-reporting and self-regulatory. Some of the managerial and practice nurse participants suggested that clinical governance was open to manipulation by GPs.

The Practice Nurse participants highlighted that the pursuit of targets will fragment care, because GPs will seek to engage in activities that will enhance their incomes to the exclusion of everything else. This is in line with the observations of Moore (2004), who suggested that the management of 'soft' psychosocial issues previously dealt with by general practice, access to GPs for conditions not covered by the contract and the rigour of referral decisions and the associated healthcare demand management achieved by general practice might be undermined by the new contract.

The GP participants in my study were concerned about a variety of issues. To make the QOF work, it is essential to have appropriate information management systems and information technology infrastructure. Whilst the PCT is committed to achieving this in the longer term, there are short to medium terms problems with this, which might cost GPs money under the new contract. The GPs have access to disease management templates but the PCT had not at the time of data collection agreed a set of 'read codes'. This means that GPs might be inputting data using inaccurate read codes for the various disease groups and clinical activities associated this, and thereby missing out on income. GPs have to input the data (although in some cases practice nurses were able to help), because it is necessary to have medical knowledge to know which read codes are appropriate for the clinical activity that has taken place. This was perceived to be very time consuming, especially because many GPs are not IT literate, and especially for 'single-handed' GPs.

A further concern was in relation to the funding formula of the new contract. GPs receive a 'global sum' plus the income from the QOF and providing enhanced services. Practice expenses, plus the salaries of other practice staff and staff development costs are now to be paid out of the 'global sum' which is calculated on a complicated formula based on weighted patient list sizes. Previously, 70% of the cost of the salaries of practice staff and the full cost of staff development were reimbursed by the PCT (Gulland 2005). Some GPs particularly the 'single-handed' GPs in my study, perceived that despite the 'minimum practice investment guarantee' (put in place to ensure GPs are at least as well off under the new GMS contract as they would have been under the annual increase in the old 'red book' payment system) they would lose out under the global sum. Practice nurse participants suggested that GPs now have the perverse incentive to keep staffing levels low and to minimise staff development costs in order to maximise their own incomes. This was perceived to 'fly in the face' of the increased workloads and skills development necessary to make clinical governance work for patients.

Participation in the QOF aspect of the new contract is voluntary. In the case of the practices that have not been progressive in organisation development and have not already made good progress in implementing clinical governance, and for many of the 'single-handed' GPs it is likely to cost more in terms of finance and effort to do the necessary work to achieve the quality points within the QOF than the rewards associated with them. These GPs will therefore be unlikely to participate in the QOF. Concern was expressed that these practices will become very visible to the PCT as potential quality problem areas and will attract undesired attention as a result.

Many GPs perceived the new GMS contract to go even further in challenging their professional autonomy than the previous controversial 1990 contract had done. The 1990 contract had defined precisely *what* work GPs must do, what information they had to get from patients and what they had to do with this in terms of preventative work, clinical action and prescription control. The GP participants in my study perceived the 2004

contract to go even further, in dictating also *how* the work must be undertaken.The new GMS contract, on the surface appears to support and reinforce the clinical governance agenda. This is not least of all because it provides financial incentive for GPs to bury their indignation at challenges to their professional autonomy and self-regulation in order to significantly increase their incomes, and at the same time increase the quality of services for patients. The evidence in my study raises the following questions. Does the new GMS contract (which is in effect clinical governance), actually improve the quality of care for patients? Alternatively, does it merely satisfy a set of 'tick-box' criteria facilitating the manipulation of performance related outcomes, to enable GPs to maximise their incomes, PCTs to achieve high 'star ratings' in league tables, and the government to be seen to be raising quality standards of care, managing resources more efficiently and curbing the autonomy and self-regulation of the medical profession? Is the new GMS contract (clinical governance) an unarticulated collusion of the government represented by NHS managers and GPs to regain the confidence and trust of the public?

g.) Increased Public Expectations.

Scally and Donaldson (1998) argued that part of the new continuous improvement culture of clinical governance is the need to view healthcare services through the 'eyes of the patient' in order to enhance the patient experience. The increased availability of information about disease and healthcare services via publications, the television, and the internet, along with increased levels of general education and a society where individuals 'know their rights' leads the public to demand a greater input into their diagnosis and treatment and the healthcare services offered to them. This has an impact on the way medical professionals need to interact with patients and how they practice medicine (Haug 1973; 1975). Patients are to be viewed as consumers able to make choices and exercise preferences and the right to evaluate and comment on the quality of the services they receive.

The managerial participants in my study emphasised the challenge of getting some GPs and healthcare professionals to recognise and respond appropriately to the increased demands and expectations of the general public in relation to the nature and quality of healthcare services. It was suggested that the new GMS contract might assist because it requires GPs and other healthcare professionals working in general practice to engage much more with patient groups and to seek their views directly about how the services of general practice can be improved. The GP participants in my study were opposed to describing patients as 'customers'. It was accepted and understood that the general levels of education of the population have increased and patients may desire more information about their medical conditions and available treatment, but that they were still not qualified to make a free choice, as they would be if they went into a shop to purchase consumer goods. The GPs and other healthcare professionals participating in my study believed that there is still a significant knowledge gap between the medical profession and the general public.

h.) Independent Contractor Status of GPs.

The evidence from my study suggests that the most significant barrier to the implementation of clinical governance was perceived by both managerial and professional participants to be the independent contractor status of GPs. As outlined in chapter two of this thesis, GPs have always fought to maintain their independent contractor status believing salaried status to potentially reduce their clinical freedom and their ability to organise their own work.

The independent contractor status of GPs was considerably reinforced by GP Fundholding which effectively turned GPs into entrepreneurial, small business owners (Harrison and Pollitt 1994). 'Third way' policies under the present Labour government however, abolished fundholding and replaced it with Primary Care Groups (PCGs) which by 2002 had evolved into Primary Care Trusts (PCTs). Although maintaining their independent contractor status, it was mandatory for general practices to attach themselves to a PCG/T.

These organisations co-ordinate local healthcare organisations including general practice in the provision of local healthcare services, manage a budget which represents 80% of expenditure on local hospital and community healthcare services including GP prescribing costs, and are responsible and accountable for the implementation of healthcare policy (including clinical governance) in independent contractor organisations (North et al 1999).

North and Peckham (2001) suggested that the implementation of PCG/Ts represents a significant attempt to extend control over the work of independent contractors. Mahmood (2001) observed that concessions were made to GPs who had been allowed to be in the majority on PCG Boards and to opt to have a GP Chairperson. By April 2002 however, all PCGs had evolved into PCTs where the structure of the Board is different. Although GPs have representation on PCT Boards, they are no longer in the majority which reduces their influence therefore over PCT management decisions.

The PCT managers in my study were concerned and frustrated that they are now responsible and accountable for the implementation of clinical governance in independent contractor organisations, but have no authority to 'direct' and 'manage' the process. Instead, in their dealings with GPs they have to use tactics of reason and persuasion. The managerial participants hoped that the new GMS contract 2004 will provide significant financial incentive for GPs to comply with clinical governance. In spite of this, the managers participating in my study felt it important to treat the GPs with extreme care and to make life as easy as possible for them, by for example, merging the systems and procedures for the implementation of both clinical governance and the new contract. It makes managerial sense not to duplicate work, but the implications are clear, PCT managers perceive that GPs must be treated carefully and any requirements made of them must be as non-time consuming and as non-threatening as possible. PCT managers must respect the independent contractor status, professional autonomy and self-regulation of GPs in order to achieve and maintain their co-operation. Both clinical governance and the new GMS contract are thus monitored with a 'high trust' model via self-reporting and self-

regulation with a minimum of bureaucracy. This was however, perceived by many managerial and practice nurse participants to leave the system open for manipulation by GPs. This might serve to reduce the quality of services rather than improve them.

One of the Directors participating in my study was extremely concerned about the PCTs lack of control over independent contractors including GPs. She compared the situation with consultants in hospital who are salaried employees of hospital trusts. She observed that whilst hospital consultants are directly managed by Clinical Directors, who are fellow professionals, in the event of serious under-performance or non-compliance with hospital trust policies and procedures, consultants fall under the sanctions which may be imposed via the bureaucratic, managerial and organisational structures of the hospital. It was perceived that in comparison, PCTs are powerless to control GPs.

Sheaff et al (2003) analysed the 'governance' of GPs within PCTs using Courpasson's (2000) concept of 'soft governance.' Sheaff et al (2003) suggested that general practice is a professional network lodged within a larger governance structure, the PCT. The PCT was perceived to be a 'soft bureaucracy' because it has a rigid exterior symbolising the managerial control stakeholders (including the public) expect to see, but it has 'loosely-coupled' interior practices (Jermier et al 1991). PCTs combine both hard and soft forms of governance. For non-professionals, PCT managers can still obtain obedience through hierarchical supervision, standardisation of working procedures, and through rewards and penalties above those stipulated in contracts of employment. For independent contractor professional workers however, fellow professionals are employed to provide an alternative leadership (Dopson and Waddington 1996).

Sheaff et al (2003) suggested that clinical governance and the GP Professional Advisers acting in their boundary role between GPs in the field and the PCT represent the 'soft governance' of GPs. (This is referred to as 'flexible corporatism' by Courpasson 2000)

GPs in the field are encouraged by GP Professional Representatives to comply with clinical governance using three forms of tactics. Firstly, GP Professional Representatives represent clinical governance policy, procedures and systems in technical medical problem solving terms, using the language of medical professionals rather than managerial language. In addition, GPs are encouraged to set their own targets and to define their own clinical audits to support these. GPs are also encouraged to take the lead on major projects relating to the implementation of clinical governance in general practice.). This is referred to as 'instrumental legitimation' by Courpasson 2000)

Secondly, GP Professional Representatives regularly visit the practices, encouraging GPs to comply with clinical governance suggesting that it is scientifically and clinically unacceptable not to do so. (This is referred to as 'liberal legitimation' and 'soft coercion' by Courpasson 2000)

Finally, GPs are encouraged to willingly share information and decision making with PCT managers. (This is referred to as 'political legitimation' by Courpasson 2000) Sheaff et al (2003) suggested that this was the weakest form of legitimation in their study because GPs in the field refused to comply with this.

Utopian PCT was a newly formed PCT at the time of data collection for my study. Some of the PCTs in Sheaff et al's (2003) study appeared more advanced in their organisational development and in their progress towards the implementation of clinical governance, than Utopian PCT, so a direct comparison of findings is not appropriate. There are however, signs that GP Medical Advisers at Utopian PCT are starting to employ similar tactics.

During the data collection period for my study I observed the GP Medical Advisers and the PCT managers at the Clinical Governance and Risk Management Committee meetings and at the meetings of the General Practice Sub-group. A lot of the discussions focused on how

best to communicate clinical governance policies, procedures and systems to GPs in the field in a way they would be comfortable with and accept. The GP Medical Advisers re-wrote or re-worded much of the formal documentation about clinical governance going out to the practices. The GP Medical Advisers often explained to PCT managers how GPs would perceive certain issues and problems, and advised on how best to present management solutions and decisions to minimise GP resistance.

PCT managers encouraged GPs to undertake a self-assessment of starting position in relation to clinical governance, and to produce an action plan, including targets with timescales and management responsibilities attached. The GP Medical Advisers were asked to visit the practices that were resistant or experiencing problems in relation to clinical governance. Their remit was to persuade and encourage compliance, making use of their technical medical knowledge in the process.GPs were encouraged to lead projects relating to aspects of clinical governance. The PCT managers suggested however, that always the same GPs volunteered. These were ex-Fundholders and had always been active in similar ways prior to the PCG?T being formed. The GP Medical Advisers were asked to design and deliver some of the PETS sessions in support of clinical governance because PCT managers hoped that this would add to the credibility of the sessions 'in the eyes of' the GPs. The Medical Advisers were also encouraged to become GP appraisers.In line with the findings of Sheaff et al (2003), the GPs at Utopia also refused to willingly share information and decision making with PCT managers or GP Medical Advisers.

Although at an early stage in the development of their role, the GP Medical Advisers at Utopia are using similar tactics to those displayed by the GP professional Representatives participating in the study of Sheaff et al (2003) in the implementation of clinical governance, and similar conclusions can be drawn in relation to this. Although GP Medical Advisers at Utopia have no formal hierarchical authority over

their professional colleagues in independent practice, they are a part of a policy making leadership at the PCT and have started to exercise forms of 'soft governance' over GPs in the field.

In line also with the findings of Dowswell et al (2000), Harrison and Dowswell (2002) and Mahmood (2003), the GPs at Utopian PCT demonstrate a reluctant acceptance of clinical governance. They apply those aspects perceived to be in their own interest or in the interest of their patients, whilst circumventing many of the less palatable elements, justifying this in terms of their specialist medical knowledge and skills. At this stage the GP Medical Advisers at Utopian PCT have not achieved the compliance of GPs in the field with all of the clinical governance policies, procedures and systems of Utopian PCT. In line with the findings of Sheaff et al (2003), Utopian GPs continue to subscribe to a professional sub-culture which is quite different from the official 'clinical governance culture' encouraged by PCT managers. This professional sub-culture appears to remain impenetrable by clinical governance activities.

The managerial and practice nurse participants in my study generally believed that the only way to effectively implement clinical governance (or any other centrally defined initiative) in general practice is by changing the employment status of GPs. Only when GPs become direct employees of the PCT will it be possible to gain full compliance with PCT policies and procedures.

The longer-term effects of GP Medical Adviser leadership of clinical governance in PCTs and the impact of GP salaried employment on clinical governance in general practice may present interesting areas for future research (That is assuming sufficient numbers of GPs take up salaried employment in the future to make such research a viable prospect!)

Part One of this chapter has discussed clinical governance, the requirements for and the barriers to its effective implementation at Utopian PCT. It suggests that GPs have generally demonstrated a resigned, unenthusiastic compliance with clinical governance and its associated policies, procedures and systems (Dowswell et al 2002; Harrison and Dowswell 2002; and Mahmood 2003). The GPs at Utopian PCT identify with the objectives of clinical governance, but seek to achieve these within a professional rather than a 'neo-bureaucratic' culture (Harrison and Smith 2003). This has created barriers to the effective implementation of clinical governance in general practice. Drawing on the discussion in Part one of this chapter, Part two considers the impact of clinical governance on the professional autonomy of GPs at Utopian PCT in the context of the theories of deprofessionalisation (Haug 1973; 1975; 1988), proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; Coburn 1992; Coburn et al 1997) and restratification (Friedson 1984; 1985; 1986; 1994)

7.3 Part Two: The Impact of Clinical Governance on the Professional Autonomy and Self-regulation of GPs.

In Chapter four of this thesis I suggested that in the sociological literature, professional autonomy and professional self-regulation are at the very centre of what it means to be a professional (Friedson 1970a; 1970b; Johnson 1972).

Harrison and Smith (2003) defined professional autonomy as a medically qualified professional having,

> '....*control over diagnosis and treatment*, including what tests and examinations to order, what drugs and procedures to prescribe, to whom to refer; *control over evaluation of care*, including the appropriateness of care for particular patients; and *control over the nature and volume of medical tasks*, including determination of own movements, priorities, time and workloads.' (Harrison and Smith 2003:245)

There is an ongoing debate about the impact of clinical governance on the professional autonomy and self-regulation of the medical profession including general practitioners, and it is to this body of knowledge I am seeking to contribute with this thesis. The debate centres around whether clinical governance is contributing to a decline in professional autonomy of GPs, conceptualised by two overlapping theories of deprofessionalisation (Haug 1973; 1975; 1977; 1988) and proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; McKinlay and Stoeckle 2002; Coburn 1992; Coburn et al 1997) or whether it is leading to a redistribution of power within the profession, referred to as restratification (Friedson 1975; 1983; 1984; 1985; 1986).Chapter four of my thesis explores these theories in detail and reviews the findings of recent studies examining the impact of clinical governance on the professional autonomy of GPs in the context of these competing theoretical explanations. The remainder of this chapter attempts to locate my study in the context of this literature.

7.3.1 Deprofessionalisation and the Professional Autonomy of GPs.

'Deprofessionalisation' was posed by (Haug 1973) as an explanation of the erosion of professional legitimacy, and monopolies of knowledge resulting from the improved levels of general education and a less deferential society. Deprofessionalisation suggests that doctors are in effect, technicians producing medicine for the consumer according to standard protocols. This implies that the doctor's monopoly of knowledge is easily eroded so that less well qualified para- professionals could do the job. Deprofessionalisation also implies that medical performance can be more easily monitored by managers. Professionals are perceived to be losing their cultural authority in terms of status and trust (Exworthy and Halford 2002)

a.) A more highly educated and less deferential public.

There is limited evidence in my study of the 'deprofessionalisation' of GPs within the Utopian PCT. The managers and directors at Utopian PCT suggested that patients do desire more information and involvement in their treatment. The increase in the availability of healthcare books, TV programmes and the internet providing up to date information about medical conditions and healthcare options was cited as an explanations for this. Improved standards of general education enable the public (patients) to understand these sources, providing the opportunity for a degree of participation in medical decision-making.

The managers at Utopia suggested that getting some GPs and other healthcare professionals at Utopia to recognise these increased public expectations and to respond to them appropriately in their clinical practice is a challenge. It seems that increased public expectations present more of a challenge to the implementation of clinical governance, than to the professional autonomy of GPs. The GPs at Utopia recognised that some patients expect to have more information about their medical conditions than in the past but were not aware of any failure on their part to respond to these increased patient expectations. The GPs at Utopia had no perceptions of a narrowing 'knowledge gap' between themselves and their patients. In the context of the new GMS contract, the opportunity for GPs to develop their skills and to provide 'enhanced services' will *increase* any such knowledge gap.

b.) Computerisation

Haug (1973; 1975) identified computer technology as a threat to professional knowledge monopolies. The concern is that if medical knowledge can be codified and input into a computer, it has the potential to replace medical judgement, making it possible for individuals with a lesser medical training to replace members of the medical profession. There is little evidence of this in my study. The GPs at Utopia resented NSFs and NICE guidance as a set of codified rules and procedures challenging their knowledge and skills

and freedom to diagnose and treat patients, but they recognised that these were developed by a committee largely comprising members of the medical profession. At the time of data collection the GPs at Utopia were not receiving the NICE guidance in electronic form. This was perceived to be part of the problem of accessing NSFs for use in daily practice. Some GP participants revealed a preference for other computer assisted diagnostic aids like 'Mentor' and 'Prodigy', although it was conceded that these are not so up to date forms of guidance as NSFs. They are however available electronically, and easy to use when patients are in the surgeries. Computer technology appears to be assisting GPs at Utopia in their clinical decision making, rather than usurping it.

My study reveals that computer technology and information systems are an essential requirement for the effective implementation of clinical governance in general practice, facilitating the necessary policies, procedures, and systems. They are also necessary to provide the data to implement the Quality Outcomes framework (QOF) in the new GMS contract. Whilst practice managers tend to be responsible for setting up and maintaining these systems, and making the returns to the PCT, a lot of what is input to the electronic systems has to be done by the GPs themselves because medical knowledge is required in the process. This seems to suggest that computerised systems are making work for GPs rather than taking it away from them. Whilst in some surgeries practice nurses help with the input of certain data in relation to the chronic disease management in which they have specialised, they are not able to do it all. There is no evidence in my study that computerised information systems are facilitating the replacement of GPs by lesser qualified medical professionals in the practices. The PCT managers expressed concern at the shortage of GPs and their lack of ability to recruit GPs, but there was no discussion of this being solved by using lesser qualified individuals to do the job. The PCT directors did suggest that they would like to employ GPs directly in the PCT because if GPs shared the same employment status as nurses, the workforce overall could be used more flexibly. This however, would serve to proletarianise GPs rather than to deprofessionalise them.

c.) New divisions of labour

This leads to the third strand of the deprofessionalisation thesis, which is the threat to medical professional autonomy from the emergence of new divisions of labour. There is evidence in my study to suggest that in recent years there has been an increase in the significance of the role of practice nurses and other allied health professionals in general practice. The 1990 GMS contract was the catalyst for routine medical work previously done by GPs to be passed to practice nurses in relation to for example, the management of chronic diseases, immunisation and cervical smear tests (Lewis 1998), to enable GPs to maximise their potential income under the contract. Clinical governance, reinforced by the Quality Outcomes Framework (QOF) in the new 2004 GMS contract appears set to continue this trend. The GPs in my study recognised that they will not be able to manage the increased workload associated with implementing clinical governance and the QOF in the new 2004 contract without this support.

The new 2004 contract also allows GPs to undertake further training and to specialise in areas of work currently undertaken by hospital consultants in the secondary care sector of the NHS. The progressive delegation of routine medical work to practice nurses will be essential to free up the time of GPs to take up this new opportunity. The results of my study demonstrate that whilst some GPs at Utopia have for many years accepted a team-based approach to healthcare delivery in general practice, others have been less progressive. This is likely to change if GPs wish to maximise their incomes within the new GMS contract. GPs however, are still independent contractors and the employers of practice nurses and ultimately accountable for what happens in their practices. Whilst some of the work previously done by GPs might be done by practice nurses, GPs will still control and supervise their work. This suggests that rather than deprofessionalisation occurring, in general practice, GPs maintain their professional dominance. (Friedson (1970a; 1970b).

Whilst there is some evidence of GP perception of their deprofessionalisation in my study, this is explained more in the context of wider social trends and previous NHS policy, than as a direct result of the implementation of clinical governance. The findings of my study in relation to the deprofessionalisation thesis are broadly in line with the conclusions drawn in other similar studies. (Harrison and Dowswell 2002; Sheaff et al 2002; 2003;2004)

7.3.2 Proletarianisation and the Professional Autonomy of GPs

According to McKinlay and Stoeckle (1988), proletarianisation is a process which reduces medicine's control over,

> 'the location, content and essentiality of its task activities thereby subordinating it to the broader requirements of production under advanced capitalism' (Mckinlay and Stoeckle 1988:200).

This theory suggests that professionals are losing their traditional defining characteristics and are becoming like any other workers in a capitalist system. The key strands in the argument are that in advanced capitalist societies professionals are increasingly dependent on salaried employment in bureaucratic organisations (Oppenheimer 1973). Professionals then work to achieve the goals of the organisation rather than to serve clients. Regulation and inspection impose on their professional autonomy and reduce their freedom to practice and they become subject to the rules of management. Whilst they continue to receive high rewards, surplus value is extracted from their labour. (Mckinlay and Stoeckle1988).

a.) The Employment Status of GPs.

GPs are independent contractors and are not therefore employed in large bureaucratic organisations like for example, hospital consultants. GP fundholding reinforced the independence of GPs and established them as small business entrepreneurs within the NHS. Since 1999 however, GPs have been required to confederate themselves to PCGs, all of which became PCTs by 2002. PCTs are able to employ GPs directly, but this has not proved to be an attractive option with GPs at Utopian PCT. At the time of data collection there were only two salaried GPs. none of the other GPs participating in my study planned to take up the option of salaried employment. They perceived salaried employment to allow PCT managers to have too great an influence on their work which would significantly erode their professional autonomy. The PCT directors and manager however, hoped that salaried employment of GPs would be the solution to many of the problems they have in relation to the implementation of clinical governance (and other NHS initiatives)in general practice. GPs would then come under the managerial hierarchy of the PCT and could therefore be 'directed' to implement clinical governance and other NHS initiatives. The GP Chair and GP Medical Advisers doubted whether salaried status would be attractive even to newly qualified GPs, many of whom are entering the profession because of the clinical freedom and flexibility that goes with independent contractor status. The practice nurse and practice manager participants similarly doubted that large numbers of GPs would take up the option of salaried employment, emphasising that GPs carefully guard their independence.

b.) Organisation Structures

Mahmood (2001) argued that the evolution from PCGs to PCTs represents an extension of management control over general practice. GPs were in the majority on the PCG Boards, but this is not the case on PCT Boards. In this sense, the ability of GPs at Utopian PCT (as in the case of any PCT), to influence medical decision making has been reduced (Mahmood

2001; North and Peckham 2001). The relationship between GPs in the field and the PCT is not hierarchical however, although the PCT does hold prescribing budgets, and until the new GMS contract was introduced in April 2004, it reimbursed 70% of the salaries of other primary healthcare professionals working in the practices and maintained some of the infrastructure of the surgeries (Mahmood 2001; Sheaff et al 2004). Until the new GMS contract was implemented in 2004, the PCT mainly influenced GPs and monitored their practice through clinical governance procedures themselves, and through the GP Medical Advisers, in the role of Professional Representatives.

c.) GP Employment Contract

A new GMS contract which aligns very closely with clinical governance was agreed and implemented in April 2004. The details of the contract were discussed previously in this chapter, where it was explained that up to one third of GP remuneration under the new contract depends on GP compliance with what are effectively clinical governance policies and procedures. This can be interpreted as a very powerful financial incentive to conform to the Government's clinical governance agenda. Participation in the Quality Outcomes Framework (QOF) within the new contract is optional for independent GPs, not to participate however, suggests there are serious quality problems within a practice. There is then the threat that this will attract unwanted managerial attention from the PCT. The contract, in this sense, represents both an incentive and a potential sanction in relation to the implementation of clinical governance. Whilst the previous 1990 GMS contract was perceived to play only a minor role in ensuring GPs fulfil their responsibility to implement clinical governance in their practices in the work of Sheaff et al (2002; 2003; 2004), my study demonstrates that the new 2004 GMS contract, is on the contrary, a very significant and influential factor in the process.

It has been argued that the whole process of clinical governance including the implementation of NSFs, GP appraisal, formalised CPD, GP revalidation, external audit and inspection by CHAI and the use of GPs in quasi managerial roles in PCTs serves to proletarianise the general practice (Harrison and Dowswell 2002; Harrison and Smith 2003). Both managerial and professional perceptions of the various elements of clinical governance in my study have been discussed at length in the previous section of this chapter.

d.) Clinical Governance

In the case of NSFs and NICE guidance, in line with the findings of Harrison and Ahmed (2000), Harrison and Smith (2003), Harrison and Dowswell (2002), and Flynn (2002), the GPs in my study recognised clinical guidelines to be a set of bureaucratic rules to be routinely applied, which challenge their control over treatment and referral decisions, and their right to determine the appropriateness of care for particular patients. The GPs also perceived NSFs and the associated clinical audits and performance indicators to provide management information about their clinical activity which facilitates management surveillance of their work and facilitates performance management within a managerial rather than a professional framework (Flynn 2002; Harrison and Smith).

Some of the GPs expressed concern that not all patients fitted neatly within the context of NSFs and guidance, then independent clinical decisions have to be made. The problem was perceived that newly qualified GPs who are being trained to work with guidance may not be developing the knowledge, skills and experience to solve medical problems without guidance. Harrison and Smith (2003) similarly questioned the technical capacity of bureaucratic rules to deal with every situation that medical professional's encounters on a day to day basis, and McKinlay and Marceau (2002), asked whether it is desirable to make doctors rules oriented and narrowly focused.

In line with Salter (2000), Harrison and Dowswell (2002), Harrison and Smith (2003) and Harrison and Macdonald (2003) the GPs in my study similarly perceived the other features of clinical governance, including compulsory GP appraisal, CPD and revalidation, along with external monitoring by CHAI to be significant challenges to their right to professional self regulation. These are clear examples of features of clinical governance, which act to proletarianise general practice (McKinlay and Stoeckle 1988; McKinlay and Arches 1985).

e.) GP Medical Advisers: Professional Representatives or PCT Managers?

There was disagreement within the PCT directorate about the nature of the GP Medical Advisers role at Utopia. Two directors (previously nurses) believed that the role should be primarily one of professional representation. As well as using their specialist medical knowledge to help PCT managers to interpret NHS policy and to develop local systems and procedures to implement this, the GPs should be the channel of communication between the PCT and GPs in the field. They should represent GP views in medical decision making, and then communicate the decisions back to the GPs using Locality Groups and other informal GP networks as the vehicle for this. The GP Medical Advisers should then work to 'sell' clinical governance to GPs in the field, educating, encouraging, and supporting them in the process of its implementation. It was perceived that the Medical Advisers should not use overt managerial tactics to achieve this. They should instead use their professional leadership skills to 'win hearts and minds' and effect longer term cultural change in general practice.

Two other directors, previously from industry, perceived the GP Medical Adviser role differently. To them it is primarily a part time management role. The GP Medical Advisers should work with the PCT directors and managers, presenting a professional perspective in problem solving and decision making. Thereafter the GP Medical Advisers should present

these solutions and decisions to GPs in the field using negotiation, communication, manipulation, whatever tactics are necessary to get clinical governance implemented.

Coburn et al (1997) argued that state co-option of the medical profession has always been a key element of government strategy. Examples of this at 'mesa-level' (Harrison and Ahmed 2000), are the collaboration between professional associations and the state to implement NHS policy. The medical profession receives legal licence to practice, a monopoly of service provision, and the right to self-regulation. The government gains the compliance of rank and file medical practitioners with NHS policy, and assurance of the quality of service provided by them regulated by the profession itself. Similarly, professional associations and members of the medical profession have played a key role in the development of NSFs and NICE guidance, which the medical profession are then required to implement. The guidance has been evaluated not just on the basis of its clinical effectiveness but also on the basis of its cost effectiveness, in that sense the guidance is a healthcare rationing device. At 'micro-level' (Harrison and Ahmed 2000), in line with Coburn et al's (1997) argument, it has been suggested that GP Medical Advisers are similarly drawn into *controlling* their professional colleagues and ensuring that they comply with national policy. Although medically qualified and practising professionals themselves, once exposed to a managerial agenda, these individuals are more likely to behave like managers than professionals (Coburn et al 1997).The ambiguity surrounding the GP Medical Advisers role at Uopian PCT typifies this issue, are they in the first place professional representatives, or are they part time PCT managers?

There is evidence in my study that clinical governance does indeed serve to 'routinise' the medical labour process (Harrison and Dowswell 2002). Professional action is more rule constrained (Harrison and Smith (2003) and is potentially more open to managerial surveillance (Flynn 2002). The rules are enforced not through traditional bureaucratic hierarchy (McKinlay and Stoeckle 1988; McKinlay and Arches 1985), but through regulatory agencies such as NICE and CHAI (Harrison and Smith 2003). My study

demonstrates in addition, that the new GMS contract is a significant example of the simultaneous use of incentives and sanctions to achieve professional compliance with clinical governance procedures.

In line with the findings of Sheaff et al (2003), whilst there are features of the proletarianisation of GPs in my study, as a direct result of the implementation of clinical governance in general practice, and whilst GPs perceive their professional autonomy and self-regulation to have been significantly eroded, GPs have by no means been reduced to the status of production line workers as suggested by the theory of proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988). GPs still have high professional and social status, they remain highly paid and are considered a 'significant force' to deal with by PCT directors and managers. In line with the findings of Sheaff et al(2002; 2003; 2004), Mahmood (2001) and Locock et al (2004), the GPs in my study found it desirable to resist aspects of clinical governance, justifying this resistance on the basis of their specialist knowledge and skills, and had not experienced any adverse consequences for their non-conformance. They were concerned about the erosion of their professional autonomy but this may be more of an anticipated threat than an actual threat (Locock et al 2004).

7.3.3 Restratification and the Professional Autonomy of GPs

Whilst the theories of deprofessionalisation (Haug 1973; 1975 1977 1988) and proletarianisation (McKinlay and Arches 1985; McKinlay and Stoecle 1988) interpret the impact of clinical governance as a reduction in the power and autonomy of the medical profession, the theory of restratification (Friedson 1984; 1985; 1986; 1994) suggests that this is better understood as a redistribution of power and autonomy *within* the profession.

Friedson (1994) argues that the medical profession maintains its overall power and control through restratification. Rank and file professionals lose power and autonomy to newly emerging medical elites who accept management responsibilities and supervise other fully qualified professionals. Friedson (1994) argues that professionalism is being 'reborn' in a hierarchical form (Mahmood 2001).

Whilst individual professionals might lose power and autonomy, the profession as a whole continues to exercise authority over the content of its work. The profession maintains autonomy at 'macro level' (Harrison and Ahmed 2000) because the 'biomedical model' (Mishler 1989) continues to defines needs and how to meet them; and at 'mesa level' (Harrison and Ahmed 2000) because professional associations continue to play an important role in determining NHS policy, for example, in determining standards of clinical performance through NSFs and NICE guidance, and by evaluating the performance of medical professionals within the profession; and at 'micro-level' (Harrison and Ahmed 2000), via medical professionals being drawn into managerial roles where they supervise other fully qualified professionals. This has the effect of dividing a previously cohesive profession into a 'knowledge elite', a 'supervisory stratum' and rank-and-file professionals (Friedson 1994; Sheaff et al 2004)

As discussed in the first part of this chapter, restratification is perceived to have already occurred in secondary care, as hospital consultants have taken on the role of Clinical Director. Since the implementation of PCG/Ts in 1999 it may have started to occur in primary care. In the case of general practice, this is via GP Professional Representatives participating on PCT Boards and/or Professional Executive Committees. These individuals are referred to at Utopian PCT as GP Medical Advisers. These individuals fulfil this role on a part time basis, continuing to work in independent general practice the rest of the time. They assist PCT managers in the interpretation of NHS policy and in the development of local systems and procedures for its implementation, including for clinical governance.

As previously discussed, there is confusion at Utopian PCT about the nature and purpose of the Medical Adviser role. Some PCT directors perceive the role to be primarily a professional representative role, others believe it to be a management role. As suggested by Coburn et al (1997), whichever is the case has significant implications for the power and autonomy of general practice. If GP Medical Advisers are professional representatives, then, in line with Friedson's (1994) argument, they may serve to maintain the power and autonomy of general practice as a profession in the Utopian area. If they are primarily PCT managers, then it is more likely that they will weaken the power of the profession locally through co-option. Whilst they might present a professional perspective in decision making at the PCT, they will behave more like managers than professionals, forming a coalition with PCT managers in the implementation of clinical governance, accepting rather than challenging the managerial agenda.

The perception of the directors in my study has already been discussed, but perhaps more important, are the perceptions of the GP Medical Advisers themselves, and GPs in the field. Key questions are: Whose agenda is being followed? What is the effect of the strategies that are pursued to implement clinical governance?

The GP Medical Advisers at Utopian PCT genuinely perceive their role to be one of professional representation. The tensions within the PCT Professional Executive Committee exist largely because GP Medical Advisers are perceived to be slowing down managerial progress towards meeting externally defined deadlines in relation to the implementation of clinical governance. This is because the GP Medical Advisers are genuinely attempting to consult with, and gain the advice and participation of the GPs in the field who are willing to acknowledge their role, and to take part in discussions within the local informal GP networks and the newly formed Locality Groups. The GP Chairperson of the PCT Professional Executive Committee is also the Chairperson of the Local Medical Council (LMC) and has tabled clinical governance as a fixed agenda item for LMC meetings.

My observations of the GP Medical Advisers in the PCT Clinical Governance and Risk Management Committee, and the General Practice Sub-group meetings however, suggest that whilst the GP Medical Advisers see their role as that of professional representative, they accept the PCTs clinical governance agenda. They rarely challenge the legitimacy of this. The GP Chair of the PEC, and the other GP Medical Advisers recognise and accept clinical governance to be an inevitable consequence of the previously lax standards of their professional associations, leading to cases like the Bristol Heart Surgry Inquiry, mistaken diagnosis in breast cancer screening services at Canterbury Hospital and the unauthorised use of children's organs at Alder Hey Hospital. The GP Medical Advisers continue to work closely with PCT managers at Utopia to present clinical governance in ways that will be acceptable to GPs in the field, and they engage in implementation tactics aimed at minimising GP resistance to PCT policies, procedures and systems, which they themselves have had a key role in developing.

The GP Medical Advisers at Utopian PCT resent being burdened with routine administrative work associated with clinical governance, believing this to be a waste of their time and talent. Instead they wish to use their specialist knowledge and skills to communicate and negotiate with GPs in the field to gain their acceptance of the Government's clinical governance agenda.

GPs in the field demonstrated that they are largely confused by the exact role of the GP Medical Advisers at the PCT. They do however perceive it to be a professional representative role, believing it essential for general practice to be properly represented as a profession in PCT decision making, by individuals who are practising GPs themselves, and therefore understand the pressures faced in day to day work of GPs and other practice staff.

In line with the findings of Locock et al (2004), the strategies used by GP Medical Advisers to encourage GPs in the field to engage with the clinical governance policies of the PCT, so far appear to have had only a weak impact on the attitudes and activities of GPs

in the field. As discussed in the first part of this chapter, the GPs in the field demonstrated an unenthusiastic compliance with NSFs and NICE guidance, recognising that some benefits accrue from conformance with these for themselves and their patients (Dowswell et al 2002; Harrison and Dowswell 2002; Mahmood 2003). Similarly, the GPs were resigned to participation in appraisal and CPD in order to achieve revalidation and remain licensed to practice. The GPs were not however co-operating fully with GP Appraisers if they perceived the process or the Appraiser's approach to be too intrusive. The GPs were attending the PETS training sessions for which they were receiving funding to do so, but they were finding alternative professional development sources in line with their own particular interests, which satisfied the conditions for CPD but were not necessarily directly related to clinical governance. The GPs were not fully complying with the PCTs risk management strategies and were not engaging in any way with the forthcoming CHAI visit to the PCT. Despite the best efforts of PCT managers and the GP Medical Advisers, in line with the observations of Dopson (2003) there is an 'implementation gap.'

In line with the findings of Fitzgerald (1994) and Llweellyn (2001), in relation to Clinical Directors in hospital trusts, and with Sheaff et al (2002) in relation to GP Professional Representatives in PCTs, the GP Medical Advisers participating in my study seek to take the initiative in shaping and influencing PCT policy in relation to clinical governance, assisting and reinforcing PCT managers in their decision making (Coburn et al 1997). The perceptions of the PCT managers and the GP Medical Advisers is that whilst there is still work to be done in 'winning the hearts and minds' of GPs in the field, considerable progress has been made in implementing clinical governance in general practice. In line with Sheaff et al's (2002) results, GPs in the field however, seem to have divided themselves into two groups. One group is willing to co-operate to an extent with PCT managers and the GP Medical Advisers, taking the lead in significant clinical governance projects, but focusing on a professional agenda rather than a managerial agenda. The second group are more resistant to clinical governance, complying only with what they have to in order to remain licensed to practice.

Concurring with North and Peckham (2001), Sheaff et al (2002; 2003; 2004), and Locock et al (2004), the results of my study suggest that restratification of general practice is starting to occurr in the Utopian area. Sheaff et al (2004), in their application of Courpasson's (2000) theory of 'soft governance' to the situation in general practice, concluded that whilst restratification of general practice is occurring, the effect of this is not to sharply divide the profession into three separate areas of work, a 'knowledge elite' (those GPs contributing to the construction of guidance and healthcare policy), a 'supervisory stratum' (those GPs supervising other fully qualified GPs) and 'rank and file professionals' (GPs in the field) as suggested by Friedson (1984; 1985; 1986; 1994). Instead, Sheaff et al (2004) argue that knowledge management, and supervision are two aspect of the same role fulfilled by GP Professional Representatives. The results of my study support Sheaff et al's (2004) conclusion as the GP Medical Advisers at Utopian PCT shape and influence policy on the basis of their specialist medical knowledge, and seek to lead GPs in the field in implementing it. Presently, at Utopian PCT however, the former aspect of the role is more fully developed than the latter.

The Utopian PCT is a newly formed organisation and the PCT directors and managers and the GP Medical Advisers are all seeking to clarify their roles. Llewellyn (2001) in her analysis of the role of Clinical Directors in hospital trusts, defined them as 'two-way windows' because they have access to both medical knowledge and the managerial agenda, and are the channel of communication therefore between general hospital managers and professional hospital consultants. Their ability to access *both* clinical *and* managerial knowledge (whilst managers could not access clinical knowledge at all) was perceived to strengthen their power-base considerably, and to advantage the professional agenda in hospital trust decision making. At Utopia, whilst there is evidence of the start of the restratification of general practice, with GP Medical Advisers fulfilling a knowledge management and a supervisory role (Courpasson 2000), their influence over GPs in the field is presently very weak. GPs in the field, as independent contractors continue to pursue their own separate agendas. The longer-term question remains: who benefits most from

restratification? Is it the profession of general practice which maintains its overall power (Friedson 1985; 1986; 1994), or, the state, as GP Medical Advisers become co-opted into political/managerial decision making? (Coburn et al 1997).

It is too early in the organisation development of the Utopia PCT, and in the personal development of the GP Medical Advisers to draw a firm conclusion about this. The signs are there however, that as in the case of Clinical Directors at hospital trusts, the GP Medical Advisers to a PCT are 'two-way windows' and could become very powerful actors at the PCT in their own right rather than merely as professional reinforcement of PCT directors and managers. This is likely to be in relation to the interpretation of NHS policy and the development of PCT policy, procedures and systems however, rather than in the supervisory aspect of their role. The GPs in the field, no doubt will comply with PCT procedures for clinical governance, but, as independent contractors, it seems more likely that this will result from the considerable financial incentives presented by the new GMS contract 2004 than from the supervision of GP Medical Advisers. If in the future however, significant numbers of GPs take up the option of salaried employment with the PCT this situation might change dramatically.

7.4 Conclusion

This chapter has discussed the results of my study in the context of other recent studies of the impact of clinical governance on the autonomy and self-regulation of the medical profession. Part one of the chapter discussed the perceptions of managerial and professional participants in my study of the nature of clinical governance, and the requirements for, and barriers to its effective implementation in general practice. Part two discussed the impact of clinical governance on the professional autonomy and self-regulation of GPs in the Utopean area in the context

of the theories of deprofessionalisation (Haug 1973; 1975; 1977; 1988), proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; McKinlay and Stoeckle 2002; Coburn 1992; Coburn et al 1997) and, restratification (Friedson 1975; 1983; 1984; 1985; 1986). The next and final chapter presents the conclusions of my study, outlines the contribution of my study to the ongoing debate about the impact of clinical governance on the professional autonomy and self-regulation of GPs, identifies the strengths and limitations of my study and concludes with a personal reflection on my personal development resulting from the research process.

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2006

Chapter Eight

Conclusions.

'Clinical governance is really summed up in doing your job properly, nothing more, nothing less. It's about professionalism, something which is on the wane.' (GP 12; Interview 18; Page1; Paragraph 4)

8.1 Introduction

As a single-site exploratory case study my research seeks to particularise rather than to generalise, and to highlight areas for further research. My study presents a rich and detailed picture of the 'human-side' of Utopian PCT. The conclusions drawn are based on that which has been studied, the perceptions of the managers, GPs, practice nurses and practice managers at the Utopian PCT, of the nature of clinical governance and how this impacts on the professional autonomy and self-regulation of GPs. This concluding chapter is structured in relation to the three research objectives of my study. Within each section it 'draws the threads together' from chapters six and seven, by briefly summarizing the main findings of the study and explaining the position of my research in relation to other similar studies, and then outlining the conclusion reached. The chapter goes on to identify the contribution made by my study to the existing body of knowledge in the field of inquiry and highlights the areas identified for future research. The chapter concludes with reflections on the strengths and limitations of my study and of my own personal development as a result of undertaking the research project.

The aim of this study is to examine the impact of clinical governance on the professional autonomy and self-regulation of general practitioners (GPs) in a Primary Care Trust (PCT) in the Northwest of England from the perspectives of Primary Care Trust directors and managers, and medical healthcare professionals working in general practice.

The objectives of this research are:

- To explore clinical governance in the context of general practice and to identify the requirements for and the barriers to its implementation.
- To examine the role of GP Medical Representatives on the Primary Care Trust (PCT) Board and Professional Executive Committee (PEC) in the implementation of clinical governance in general practice.
- To analyse the impact of clinical governance on the professional autonomy and self-regulation of GPs to determine whether this is contributing to the deprofessionalisation, proletarianisation or restratification of general practice.

8.2 What is Clinical Governance in General Practice?

The managers, practice nurses and GPs at Utopia had a clear understanding of the Government's stated purpose of clinical governance, that it is a vehicle to improve the equality of access to healthcare services, and a continuous quality improvement mechanism in the NHS including general practice. Both groups similarly recognized that clinical governance is a more holistic rigorous and integrated approach than previous quality assurance initiatives in the NHS, working across primary, secondary and tertiary sectors and at the interface between them. The GPs however, believed clinical governance to be

more politically and financially motivated than quality improvement motivated. Both managers and professionals shared the same understanding of the elements of clinical governance, defining these as National Service Frameworks (NSFs) and NICE guidance, GP appraisal, formalized continuous professional development (CPD) and revalidation, risk management and external audit and inspection by CHAI.

There was a difference in the focus of the definitions of clinical governance between PCT managers and the practice nurse participants who stressed the new open, supportive and continuous improvement culture in their discussions of clinical governance. The GP participants on the other hand, stressed risk management and suggested that clinical governance is primarily about the performance management of the medical profession including independent contractors.

Throughout my study the perceptions of PCT managers and practice nurses were very often in line but very different from those of the GP participants. Interestingly, the practice managers were able to see both the managerial and the professional viewpoint but tended more often to support the GPs viewpoint. The nursing profession however is more used to working within a bureaucratic framework of protocols and guidance, and has always been supervised by the medical profession. In line with Dent's (2005) observations, the practice nurses at Utopian PCT recognized that clinical governance and the new GMS contract present them with further opportunities to develop their skills, rather than limiting their autonomy as is the case for the GPs.

The PCT managers, practice nurses and GPs all shared the same goals, to improve equality of access to services for patients, and to improve the quality of healthcare services. There was a totally different perception of how this should be achieved however. The managerial

participants and practice nurses were convinced that clinical governance is an effective vehicle, whilst GPs stressed that quality of service can only be improved via their own professionalism.

In line with most other recent studies dealing with the impact of clinical governance on the autonomy and self-regulation of the medical profession (Harrison and Ahmed 2000; Harrison and Dowswell 2002; Harrison and Smith 2003; North and Peckham 2001; Flynn 2002; Dent 2005), both the managerial and professional participants at Utopia agreed that clinical governance represents an overt challenge to the professional autonomy and self-regulation of GPs. Whilst resenting this, the GPs at Utopia, identified benefits accruing from the implementation of NSFs, for example that NSFs are a useful reference point in practice, they are an easy way to stay up to date with medical advancements, NSFs can be used to justify unpopular medical decisions with patients. Although under pressure to conform to clinical governance, the GPs at Utopia were able to employ strategies to circumvent less popular aspects of clinical governance if they believed this was to be in the best interest of patients or themselves. These decisions were justified on the basis of specialist medical knowledge, skills and experience. The GPs also refused to engage in some clinical governance activities, for example, refusing to fully engage with GP appraisers and answer all of their questions, refusing to implement some of the PCT procedures for risk management and refusing to make preparations in their practices for the CHAI inspection. This is in line with the findings of other researchers, who similarly observed resistance on the part of the medical profession resulting in the successful avoidance of some aspects of NHS policy. (Armstrong 2002; Dopson et al 2003; Sheaff et al 2002; 2003;2004; Locock et al 2004)

8.2.1 Unenthusiastically compliant but not helpless victims.

The participants at Utopia recognized that Clinical governance does represent an attempt to standardise access to healthcare services and to improve the quality of services for large numbers of people. This is achieved within the context of a bureaucratic rules-oriented framework rather than a professional framework (Harrison and Smith 2003), which inevitably serves to reduce the professional autonomy of GPs, and erodes their self-regulation. However, many of the GPs at Utopia also recognized that there is a complex interrelationship between the government, the medical profession and the public (Salter 2000). The government must be seen to be taking action to regulate the medical profession given that recent adverse medical incidents like the Bristol Heart Surgery Inquiry, the unauthorised use of children's organs at Alder Hey hospital, mistaken diagnosis in breast cancer screening services at Canterbury Hospital and the murder of numerous patients by GP Harold Shipman suggest that the profession has been lax in its self-regulation. Clinical governance along with its 'modernised self-regulation' seeks to achieve this objective (Flynn 2002). The relationship between the government and the medical profession is subject to ongoing change and renegotiation however, and the GPs at Utopia recognized that clinical governance does reduce the ability of the government to 'hide behind' the clinical decisions of the medical profession in relation to resource allocation and demand management decisions (Harrison and Ahmed 2000), it maybe therefore, that the government may revise aspects of clinical governance in the future.

My study demonstrates that despite the structural constraints imposed by clinical governance on general practice, and despite the perceptions that these are eroding the professional autonomy and self-regulation of GPs (Harrison and Ahmed 2000; Flynn 2002; Harrison and Doweswell 2002; Harrison and Smith 2003; Harrison and McDonald 2003), the GPs at Utopia are by no means helpless victims of government policy. Where possible

they use clinical governance to their own advantage and to the advantage of their patients, they unenthusiastically implement those aspects of clinical governance they dislike but cannot avoid, for example, GP appraisal and formalised CPD, in order to achieve revalidation and remain licensed to practice and they rely on their specialist medical knowledge to circumvent the rest (Sheaff et al 2002; 2003; 2004; Locock et al 2004).

8.3 What are requirements for and the barriers to effective clinical governance in General Practice?

The managers and practice nurses at Utopia suggested that clinical governance requires a clear framework of procedures and systems underpinned by an effective communication strategy and an appropriate information technology infrastructure. Also, that it requires an open, supportive, 'no-blame' organisation culture with effective team-working and strong leadership at the PCT and in the individual practices. It was stressed that this would require a complete change in culture within the practices, and GPs would need to change their behaviour and the ways in which they managed their practices. As discussed in chapter seven, to achieve this the Utopian PCT is engaging in a process of cultural change, employing tactics of education, communication, participation, negotiation, facilitation and support, along with the use of change agents. (Kotter and Schlesinger 1979).

The Utopian managers believed the main barriers to the effective implementation of clinical governance in general practice to be the resistance of GPs in the field and their independent contractor status. The GPs were perceived by many Utopian managers to unrealistically adhere to an antiquated set of professional values and codes of conduct, which are 'protectionist' and stand in the way of the efficient delivery of modern medical services to large numbers of patients. Other challenges, for example, the time it takes to

implement clinical governance, resource problems and issues with organization structures, systems and procedures were perceived to be within the control of managers, the attitudes and actions of professionals in the field however are not.

The Utopian managers believed the new GMS contract 2004 with its strong links with clinical governance to be the key to GP compliance with PCT policies and procedures. The contract was perceived to provide the financial incentive necessary to motivate GPs to implement what is in effect clinical governance in their practices. The Utopian GPs similarly believed this to be the case, but some GPs perceived the new contract to be merely rewarding them for the existing quality of the work of their practices rather than for the current and future implementation of clinical governance. Whilst Sheaff et al (2004) in their study of how clinical governance is affecting governmentality and discipline in general practice concluded that the previous GMS contract played a small part in this, my study suggests that the new GMS contract will be very influential in the future. The 'Quality Outcomes Framework' aspect of the new contract is voluntary however, so GPs may choose not to be constrained by its demands. Most GPs at Utopia were determined to earn as many quality points as possible to maximize their incomes.

The GP Medical Advisers were perceived by Utopian managers to be very important change agents in the process of implementing clinical governance in general practice and to play a key role in assisting them with the interpretation of NHS policy and in shaping local procedures and systems for its implementation. The GP Medical Advisers, because of their professional status were perceived to have the necessary credibility to encourage, persuade, and manipulate GPs in the field into compliance. This is a clear attempt to draw practicing GPs into the supervision of their fully qualified professional colleagues and is similar to what has already occurred in hospital trusts, where consultants were drawn in as clinical directors to provide professional leadership for hospital consultants. (Dopson 1994; Fitzgerald 1994; Stewart 1996; Llewellyn 2001)

The GP participants at Utopia accept the goals of clinical governance, to improve access to healthcare, and to improve the quality of healthcare services, without question, but they perceived clinical governance itself to be the main barrier rather than the vehicle for achieving these goals. The GPs perceived their own professionalism and freedom to carry out their work according to their own professionally determined standards, values, and ethics to be the only way to improve the quality of healthcare services. To them, clinical governance is a time consuming, resource hungry, bureaucratic process, which seeks to turn them into rule-following supporters of centrally defined healthcare policy. For the GPs at Utopia, clinical governance has the potential to detract from the quality of healthcare services rather than facilitating it.

8.3.1 A clash of cultures.

The evidence from my study suggests that GPs and PCT managers at Utopia both demonstrate a clear commitment to improving access to healthcare services and improving the quality of those services for patients. Utopian managers and practice nurse participants have 'bought into' the clinical governance agenda as the means to achieve this. GP participants have not, believing their own professionalism to be the key to achieving better quality services. PCT managers, and to some extent practice nurse participants, perceive the 'protectionist' professionalism of GPs and their independent contractor status to be the main barrier to achieving the goals. On the other hand, GPs perceive managerialism as represented by the bureaucratic procedures of clinical governance to be interfering and prohibiting them from progressing towards improved healthcare services.

The managerial and professional participants in my study accept the same goals, but not the means for achieving them. GPs have been socialised into a professional culture where they use their expert medical knowledge, skills and tacit judgement on a daily basis, where they have control over their work, operate independently of colleagues and where standards of

work are set by independent professional associations. GPs are oriented to the interests of their patients and have a high trust relationship with them. They are socially controlled through a code of ethics, which has been internalised via their medical education, training and work socialisation (Barber 1963; Marshall 1963; Hall 1968; Friedson 1983). Clinical governance, on the other hand, with its roots in Total Quality Management (Flynn 2002) absorbed into the New Public Management (NPM) of the NHS (Gray and Jenkins 1993; Clarke et al 1994; Hood 1995a; 1995b), stems from a bureaucratic culture which seeks to make clinical activity more rule governed, and in which medical work has become the subject of surveillance by managers or professional leaders and subject to incentives and sanction to secure professional compliance (Harrison and Ahmed 2000; Harrison and Dowswell 2002; Flynn 2002; Harrison and Smith 2003). As concluded above, my study suggests that the new GMS contract 2004 is the most recent financial incentive used to secure GP compliance with clinical governance and has the potential to be a very powerful motivator. It does significantly challenge the autonomy of GPs however, because it not only dictates *what* work they should do, as in the case of the 1990 GMS contract, but it also stipulates and seeks to reinforce *how* they should carry out their work.

My study demonstrates that clinical governance has significantly challenged the professional autonomy and right to self-regulation of GPs (Harrison and Dowswell 2002; Harrison and Smith 2003 Mahmood 2003). Reinforced by the new GMS contract 2004, most of the GPs participating in my study are resigned to clinical governance and sought to get the best out of it for themselves and their patients. In spite of this however, the GPs demonstrated that they object to managerial interference, and continue to strongly adhere to a professional rather than a 'neo-bureaucratic' culture (Harrison and Smith 2003). In line with the findings of Locock et al (2004) and Sheaff et al (2002; 2003; 2004) whilst clinical governance and the use of GP Medical Advisers as change agents has eroded the professional autonomy and self-regulation of GPs because they are now subject to guidelines and protocols, surveillance of professional leaders and GP appraisers and

external monitoring by CHAI, it has not significantly eroded or even penetrated their professional values, beliefs and code of conduct. GPs at Utopia still find it possible to resist aspects of clinical governance on the basis of their medical knowledge and expertise if they perceive it desirable to do so.

8.4 The Role of the GP Medical Adviser in the implementation of Clinical Governance.

As in the case of any PCT, there is no formal hierarchical relationship between Utopian PCT managers and independent contractor GPs, yet the CEO of the PCT is accountable for the implementation of clinical governance in the independent contractor organisations including general practice. This was perceived to be one of the most significant barriers to the implementation of clinical governance in general practice by Utopian managers. It has already been concluded that many Utopian GPs are resistant to clinical governance, and most have not engaged with the bureaucratic process of clinical governance. Professionally qualified GP Medical Advisers to the PCT, working part time for the PCT and the rest of the time in independent practice, are perceived by the directors and managers of the PCT to have the professional credibility to be key change agents in getting clinical governance accepted and implemented by GPs in the field.

In the first instance GP Medical Advisers assist PCT directors and managers in interpreting NHS policy (in this case in relation to clinical governance), and then help to shape and develop local policies, procedures and systems for its implementation in general practice. The strategies employed by the GP Medical Advisers at Utopia are outlined in detail in chapter seven of this thesis, and are similar to those employed by Clinical Governance Lead GPs in Sheaff et al's (2002; 2003; 2004) study. In effect, the GP Medical Advisers at Utopia are participating in a cultural change programme, designed to change the attitudes

and behaviour of GPs in the field to be accepting of clinical governance activities. GP Medical Advisers act in a hybrid advisory/supervisory role, exercising 'soft governance' over GPs in the field (Courpasson 2000; Sheaff et al 2002; 2003; 2004). Unlike the situation described by Sheaff et al (2003; 2004) however, at Utopia, the supervisory aspect of the GP Medical Adviser's role has had only limited success. This may be because the Utopian PCT is a newly formed organisation and as already explained, has not yet adequately defined the role of the GP Medical Adviser. The GPs in the Utopian area were generally 'open minded' but largely confused about the role of the GP Medical Advisers. As a result the GP Medical Advisers have not so far significantly influenced the attitudes and behaviour of the GPs. Given that GPs in the field are very keen that general practice should be properly represented in PCT decision making, by qualified GPs in practice themselves and therefore aware of the pressures faced by GPs in their day to day work, it appears that the GP Medical Advisers at Utopia have the potential to become very influential in the future.

8.4.1 Professional representatives or PCT managers?

There is confusion amongst the directors of the PCT about the role of the GP Medical Advisers. Are they principally professional representatives advising PCT managers in their decision making, or are they principally managers? The GP Medical Advisers themselves are similarly confused and perceive there to be considerable ambiguity about their role. The evidence in my study suggests that the GP Medical Advisers see themselves in the first place as professional representatives. They consult with and encourage the participation of those GPs in the field who will recognize and engage with them. The behaviour of the GP Medical Advisers in PCT committees however suggests that whilst they see themselves as principally professional representatives to the PCT, they readily accept rather than challenge the managerial agenda. Presently, the GP Medical Advisers of Utopian PCT are 'professional reinforcers' of the decisions of PCT directors and managers.

This situation could change considerably in the future, as the GP Medical Advisers become more experienced in their roles, become more familiar with the managerial agenda, further develop their management knowledge and skills and gain confidence in dealing with their professional colleagues in the field. In line with the findings of Llewellyn et al (2001) in relation to the role of Clinical Directors in hospital trusts, GP Medical Advisers have the potential to become very powerful actors within PCTs. Unless medically qualified themselves, PCT directors and managers cannot access the specialist medical knowledge and skills of the GP Medical Advisers, whilst, because of its generic nature, it is possible for GP Medical Advisers to develop managerial knowledge and skills. This greatly increases the potential power-base of GP Medical Advisers.

8.5 The impact of clinical governance on the professional autonomy and self-regulation of GPs

As discussed in chapters two and four of this thesis and reiterated in chapter seven, recent changes in the public sector including the NHS have resulted in rapid change for the professionals employed in it. New Public Management (Newman and Clark 1994; Farnham and Horton 1996) has embraced private sector 'managerialism' which has changed the culture of public services from one of 'professional bureaucracy' to one resembling 'machine bureaucracy'. In traditional 'professional bureaucracies' professionals acquire knowledge and skills through formal education and training and have a high degree of autonomy in their work, applying their knowledge in their specialist areas. Any standardization is experienced through external professional bodies. On the other hand, in 'machine bureaucracies' there is a clear division of labour, close supervision, and a continuous effort to codify knowledge and skills, use of tacit knowledge is kept at a minimum and mistakes are corrected through performance monitoring (Mintzberg 1983; Lam 2000; Flynn 2002). This is the backdrop to the ongoing debate about the changing nature of professionalism. As discussed in chapter four of this thesis, three main schools of

thought have emerged, that deprofessionalisation (Haug 1973; 1975; 1977; 1988), proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; McKinlay and Stoeckle 2002; Coburn 1992; Coburn et al 1997), or restratification (Friedson 1984; 1985; 1986; 1994) is taking place. The results of my study were discussed in the context of each of these theories in chapter seven of this thesis the following presents the conclusions from that discussion.

8.5.1 Deprofessionalisation

There are three strands to the theory of deprofessionalisation. Which suggests that professionals are losing their power and trust through firstly, increasing consumerism and increased levels of general education which reduces the 'knowledge gap' between professionals and their clients; secondly, the expansion of computer systems increasing the possibility of the codification of the work of professionals making it possible for this to be done by lesser qualified individuals and finally, linked to the second of these strands, that professionals lose power to newly emerging divisions of labour.

As discussed in chapter seven of this thesis and in line with the findings of Harrison and Dowswell (2002) and Sheaff et al (2002; 2003;2004), there is limited evidence of the deprofessionalisation of GPs in Utopia. Whilst patients are generally better educated, more demanding and less deferential towards GPs, and do have access to authoritative information from books and the internet, this is the result of general social trends not the result of the implementation of clinical governance in general practice. Utopian GPs did not perceive a reducing 'knowledge gap' between themselves and their patients. Whilst clinical governance reinforced by the new GMS contract 2004, does present the opportunity for nurses and other primary healthcare professionals to expand their knowledge and skills, GPs as medical professionals and employers of these staff are still the dominant profession in general practice. Whilst computerisation does increase the possibility of management

surveillance of professional work, the Utopian GPs were very much in control of what data is input into systems and what is made available to managers at the PCT. GPs are also the ones who have to interpret data stored in computer systems and make the necessary clinical decisions relating to this.

8.5.2 Proletarianisation

In line with the observations of Harrison and Ahmed (2000), Harrison and Dowswell (2002), Flynn (2002), Harrison and Smith (2003) Harrison and McDonald (2003) and Locock et al (2004), my study demonstrates that clinical governance does serve to proletarianise GPs in some ways. McKinlay and Arches (1985) suggested that proletarianisation of the medical profession involves loss of control over the criteria for entering the profession, the content of training for professionals, autonomy regarding the terms and content of work, loss of control over clients , loss of control over the tools and means of labour and the amount and rate of remuneration. Though the medical profession has so far not lost control of most of these features, clinical governance now reinforced by the new GMS contract 2004 has impacted on the terms and content of the work of GPs. As previously discussed in chapters three and seven of this thesis, NSFs represent a challenge to the professional autonomy of GPs because they seek to direct a GP in the diagnosis, treatment and referral of patients. GPs are required to follow a set of centrally defined, pre-determined rules in relation to these functions, and to record their reasons for any deviation from these. GP appraisal and formalized CPD, although still based on peer assessment by professional colleague, is now a compulsory requirement for GPs to gain revalidation and remain licensed to practice. GP practices via the PCT are subject also to external inspections via CHAI. The new GMS contract is a powerful means of achieving GP compliance via financial incentive. It was recognized that the contract could work as a sanction against non-conformance, because although participation in the Quality Outcomes Framework in the new contract is optional, not to participate is likely to identify a practice

as a potential quality problem area and attract unwanted managerial attention from the PCT.

In line with the findings of Sheaff et al (2003), whilst there are the above features of the proletarianisation of GPs in my study, and whilst Utopian GPs perceive their professional autonomy and self-regulation to have been significantly eroded by clinical governance, the GPs have by no means been reduced to the status of production line workers as suggested by the theory of proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988). GPs still have high professional and social status, they remain highly paid and are considered a 'significant force' to deal with by PCT directors and managers. In line with the findings of Sheaff et al(2002; 2003; 2004), Mahmood (2001) and Locock et al (2004), the GPs in my study found it desirable to resist aspects of clinical governance, justifying this resistance on the basis of their specialist knowledge and skills, and had not experienced any adverse consequences for their non-conformance. They were concerned about the erosion of their professional autonomy but, in line with the findings of Locock et al (2004), this was more of an anticipated threat than an actual threat. The situation could change however, if significant numbers of GPs take up salaried employment with the PCT in the future because this would bring them within the bureaucratic structure of the PCT subordinating them to formal managerial control.

8.5.3 Restratification.

Friedson (1984; 1985; 1986; 1994) argued that bureaucratisation, rather than causing a decline in the overall power and autonomy of the medical profession, results in a redistribution of power and autonomy *within* the profession. This divides the profession into distinct and separate groups, a 'knowledge management' group, for example medical professionals who serve on senior committees to produce medical protocols and guideleines; a 'supervisory stratum' for example, members of the medical profession who

are drawn into management and supervise their fully qualified professional colleagues; finally, 'rank and file' professionals in the field. Friedson (1984; 1985; 1986; 1994) argued that 'rank and file' professionals may lose power and autonomy, but they do not lose it to managers they lose it to elite groups of professional colleagues. Overall therefore, whilst the profession might fragment it does not lose its overall power and autonomy.

In line with the findings of North and Peckham (2001), Sheaff et al (2002; 2003; 2004) and Locock et al (2004), there is evidence in my study that the restratification of general practice is starting to occur in the Utopian area.

Whilst Friedson (1985; 1986; 1994) argued that the result of restratification is to divide the profession into three *distinct* occupational groups undertaking *different* roles, a 'knowledge elite', a 'supervisory stratum' and 'rank and file' GPs in practice; Sheaff et al (2004) drawing on the work of Courpasson (2000), argue that GP Medical Advisers fulfil all three functions within the *same* role. As shown by the discussion in chapter seven of this thesis, my study supports Sheaff et al's (2004) conclusion. GP Medical Advisers at Utopia are acting in an advisory capacity at the PCT in relation to the interpretation of NHS policy and the development of local procedures and systems to implement it. They are a channel of communication between the PCT managers and GPs in the field and are starting to exercise 'soft governance' over GPs in the field. GP Medical Advisers are also practicing GPs themselves. The GP Medical Advisers have a part time hybrid advisory/supervisory role, whilst still remaining in practice.

Presently, the Utopian PCT organization structure is under-developed and so are the roles within it, including the GP Medical Advisor role. As a result the 'soft governance' (Sheaff et al 2004) exercised by GP Medical Advisers over GP's in the field is very weak. The

Utopian GPs are not very aware of the GP Medical Adviser role, or responsive to it. It is possible that the GP Medical Advisers themselves could change this in the future. In line with the findings of Llewellyn (2001) in relation to hospital consultants, my study shows that GP Medical Advisers are potentially very powerful individuals because they already have specialist medical knowledge and skills (which PCT managers may not have), and they can easily develop generic management knowledge and skills. They have the potential therefore, to shape their role in the direction they wish.

As outlined in chapter four of this thesis, Coburn (1992) contended that restratification may have occurred but that this advantages the managerial agenda more than the professional agenda because professional elites become co-opted, working for and developing the goals of management rather than the profession. From this persepective, whilst GP Medical Advisers are professional leaders, the profession itself becomes 'corporatised' through them. The profession's knowledge base, work practices and organization are compromised through them. This is interesting in the context of the Utopian PCT because the GP Medical Adviser role is still developing. It has already been concluded that GP Medical Advisers are potentially powerful actors at the PCT because they have professional knowledge and skills and can easily access management knowledge and skills, and may shape the role in the direction they prefer. At the time of data collection, the GP Medical Advisers perceived themselves as principally professional advisers, but their behaviour on senior committees suggested they had accepted the managerial agenda without challenge. If in the future the GP Medical Advisers focus their role on professional representation, it is likely that this will strengthen the power and autonomy of general practice in the Utopian area (Friedson 1994). However, if the GPs continue to readily accept the managerial agenda, behaving more like co-opted professionals (Coburn 1992) they will weaken the power and autonomy of general practice locally. It is too early in the organisational development of the Utopia PCT, and in the personal development of the GP Medical Advisers to draw a firm conclusion about this. The signs are there however, that as in the case of Clinical Directors

at hospital trusts, the GP Medical Advisers to the Utopian PCT could become more than mere 'professional reinforcers' of PCT management decisions, they could become very powerful in their own right.

8.6 Contribution to knowledge and areas for future research.

Whilst there are a small number of other studies examining the impact of clinical governance on the professional autonomy and self-regulation of GPs (Sheaff et al 2002; 2003; 2004; Locock et al 2004) my study focuses on the whole process of clinical governance whilst the others focus on the implementation of NSFs. My study is the only one to employ a single site exploratory case study methodology. Rather than to draw general conclusions about the field of inquiry my study sought to particularise and to paint a rich and detailed picture of the 'human-side' of the Utopian PCT and the associated general practices. In the discussion of my research results in chapter seven, and here in the concluding chapter of the thesis, useful comparisons and contrasts are made with the findings of the other studies. This suggests that the findings of my research could be inferred to a wider research domain. Future research could develop the findings of my study, in conjunction with those of others, adding further insights to the existing body of knowledge.

Whilst never intending to be generalisable, the results of my study add to the growing body of evidence that the restratification of general practice has begun in England through GP Professional Representatives (referred to as GP Medical Advisers at Utopian PCT), employed in hybrid advisory/supervisory roles within PCTs. Other researchers indicating this are Mahmood (2003), Sheaff et al (2002; 2003; 2004) and Locock et al (2004). My study also supports Sheaff et al's (2004) findings, suggesting that in the case of general practice, restratification does not divide the profession into separate occupational groups

(Friedson 1984). Instead, knowledge management, supervision and general practice are different aspects of the same role (Sheaff et al 2004; Courpasson 2000).

An interesting future investigation at Utopian PCT might be to examine the development of the GP Medical Adviser's role in the context of Friedson's (1984; 1986; 1994) theory of restratification and Coburn's (1992) concept of co-optation. More generally a fruitful area of research may be to compare the GP Professional Adviser's role with the Clinical Director's role in hospital trusts in the context of the implementation of clinical governance.

My study also suggests that some aspects of clinical governance impact negatively on the autonomy of GPs to control the content of their work (Harrison and Dowswell 2002; Harrison and Smith 2003), in this limited sense clinical governance contributes to the proletarianisation of GPs. My study highlights the significance of the new GMS contract 2004 in reinforcing Utopian GP compliance with clinical governance. The contract is significant in that it goes beyond merely identifying the work GPs are required to carry out, as was the case with the previous 1990 contract, and defines how the work of GPs should be carried out. The close alignment of the Quality Outcomes Framework in the new contract with clinical governance may in the future provide a powerful financial incentive to motivate GPs to comply with rather than to resist what is in effect, clinical governance. The impact of the new GMS contract on the implementation of clinical governance and the resulting implications for the professional autonomy of GPs will be an interesting area for future research.

In addition to these contributions, my study identifies an agenda of issues particular to the Utopian case, but which may be generalisable to other PCTs in England. A different research methodology, for example a survey, could be applied to define whether these issues are present on a regional or a national level. Alternatively, a similar methodology

might be employed to make in depth studies of single issues. The areas highlighted by my study for further investigation are outlined in the following paragraphs.

The changing role of the practice manager is evident in my study. The role of practice manager is evolving from a routine administrative role to a higher profile, higher status role in general practice. The practice manager is likely to become increasingly important to GPs as the systems and procedures for clinical governance are aligned with those for the implementation of the new GMS contract, potentially impacting on the income of the practice. Practice managers are also highly valued by PCT managers who see them as potential change agents in the practices because they have the trust of the GPs and because they know the workings of the practices. In the future practice managers may have some basic medical knowledge and may become the line manager of some members of the primary care team. The changing nature of the practice manager's role in the context of clinical governance and the implementation of the new GMS contract could be a further area for future investigation.

My study highlights the contradiction of subsuming risk management into the broader clinical governance agenda. In particular, the issues associated with implementing a supportive, developmental, 'no-blame' culture to facilitate the continuous improvement associated with clinical governance v. the vigilant 'whistle-blowing' culture associated with risk management was highlighted by PCT managers. It might be interesting to define whether other PCTs perceive there to be such a contradiction, and if so, the impact of this on the effective implementation of clinical governance in general practice.

The Utopian directors indicated that direct employment of GPs by the PCT would give GPs the same employment status as nurses and other healthcare professionals employed directly by the PCT. It was suggested that this would enable all healthcare professionals including GPs to be used more flexibly in the provision of primary healthcare services. If sufficient

numbers of GPs accept direct employment with PCTs in the future, an interesting area for future research might be to investigate the changing nature of work undertaken by GPs and other primary healthcare professionals employed directly by PCTs and how this impacts on the traditionally dominant relationships between GPs and other primary healthcare professionals.

Some of the Utopian GPs were concerned that the training currently given to GPs including implementation of NSFs and NICE guidance may be detracting from their developing the necessary knowledge and skills to be able to work effectively without this guidance. There was doubt expressed that newly trained GPs would have the opportunity to develop the tacit knowledge necessary to be able to define and solve clinical problems independently from guidance when patients do not fit neatly into the tick-box mentality of NSFs and NICE guidance. The longer term impact of the use of NSFs and NICE guidance and the associated training of GPs on the clinical performance of GPs could also be an interesting research project.

8.7 Strengths and limitations of the research project.

The strength of my study is the detailed picture it paints of Utopian PCT. The study explores the subjective meanings motivating the actions of the participants. My study demonstrates that people interact with their environments and make sense of this through their interpretation of events and the meaning they extract from these. My aim through out the study has been to try to understand the subjective reality of the participants. Like any research however, mine also has its boundaries and limitations. It is not possible to generalise from the results of a single-site qualitative study. Supporters of qualitative research argue however, that since the social world is changing all of the time and every set of circumstances is unique the inability to generalise from a study is unimportant (Saunders et al 2003). In the case of Utopia for example, the PCT is just about to merge with another,

changing all of the geographic boundaries of the newly proposed PCT and changing therefore the general practices that will be associated with the new PCT. It is also likely that there will be changes in the job descriptions of senior managers and in the people holding these posts in the new PCT. Things will move on very quickly from the scenario painted by my study.

There are also limitations on research imposed by the restrictions of part time PhD registration. These are in relation to the time and resources available for the research process and the implications of this for the research methods employed. There is a lot of difference undertaking a project such as this in isolation, than for example in a research team with funding available to support research on a full time basis. It took a very long time for me to complete the fieldwork and the transcription of the interviews and focus groups alongside having a full time teaching job and a family. As illustrated by the previous paragraph organizational life moves on and results become quickly dated. In chapter five of this thesis, I stated that a more ethnographic approach could have been usefully employed in my study. Again, my circumstances as a part time PhD student and full time lecturer excludes participant observation as a sensible research strategy. Finally, I would have liked to have used purposive sampling to select the GP participants in my study rather than the mixture of self-selection and snowball sampling employed. This would have ensured that the single-handed GPs who make up almost half of the practices in the Utopian area could have been better represented in my study. Despite my efforts however, this was not possible given the busy nature of general practice, particularly for single-handed GPs and the time constraints on me to complete the study within my registration period.

8.8 A personal reflection on my development as a result of the research process.

Undertaking a part time PhD is a very long process extending over several years and there are many challenges and pressures along the way. Perhaps an appropriate way to identify the personal development that has occurred is to identify changes in thinking and behaviour as a result of the research process. Of course, life does not 'freeze' around the research process and so it is not possible or desirable to be specific about 'cause and effect'.

8.8.1 Background information.

My starting point was that I was already in my early forties, with a university education, several years experience as a sales manager in the paper industry, followed by fifteen years experience as a lecturer in Higher Education. I was married and had a family. During the research process I was divorced and remarried, had supported my ex-husband through a very serious legal prosecution and more recently his death. These have been significant challenges to face whilst completing my PhD, but they are all part of making me who I am.

8.8.2 Planning the research

The background to my interest in general practice and clinical governance has already been outlined in chapters one and five of this thesis. Defining the specific research objectives and the research design was the result of a lot of time spent in literature searching, reading and critical reflection on the surrounding issues and debates. I gained a lot of new knowledge about sociological perspectives, and about the professions as a distinct occupational group which I had never studied before. I also enhanced my existing

knowledge of research methodology. Prior to setting up my research project, I had never given any thought to what my own ontological and epistemological position might be. Creswell (2002) suggested that the purpose of research, the nature of its central inquiry, along with the worldview, education, experience and personal attributes influence researcher philosophy and design. No doubt this is true also in my case. I have come to understand that I believe reality to be largely socially constructed and subjective. This is why I have been interested to discover the individual perceptions of my participants in relation to clinical governance and its impact on the work and professional autonomy of GPs. I do not believe I am (or was) independent of the participants in my study although I was careful to report and make sense of their responses as accurately and honestly as possible. My life experiences including the research process leads me to believe that life is 'open' and emergent and subject to change all of the time. Given this, I am comfortable with the risks associated with qualitative research methodology and will continue to use this approach to my research in the future.

8.8.3 The Literature Review.

Whilst completing the literature review I gained knowledge and developed or enhanced many skills. I further developed my ability to use electronic data bases and now find myself using these more readily in preparing lectures for my students. I developed my ability to speed read and to identify key points and issues in an argument. I enhanced my ability to critically reflect on what I was reading and to draw boundaries around what was or was not relevant to my own work. I also started to look for evidence of the theoretical perspectives and research methodologies of the authors and to think about the implications of these for the conclusions drawn. I began to disrespect authors who use impenetrable language but say very little in their work. A challenge for me at the start was to separate out contextual and theoretical literature, and to make decisions about the relevance of material and where to locate it in my own work. A key development for me was learning how to structure the

literature review, narrowing down from a broad overview of the literature to the specific debates and issues relevant to my own study.

8.8.4 Data Collection.

This part of the research process was where I developed the most in relation to planning and organizing and the inter-personal skills necessary for successfully implementing interviews and focus groups. Arranging and conducting interviews and focus groups with very busy managers and medical professionals (when you yourself are also a very busy professional), over an extended period of time requires careful planning, organising, time management, flexibility and a huge amounts of tact and diplomacy. The way the interviews and focus groups were conducted has already been outlined in chapter five of this thesis. Building trust and encouraging people to communicate freely and openly, and at the same time managing the information technology used to record interviews and focus groups stands out as a key learning point for me. The 'grind' of transcribing following the process builds determination and tenacity! Observation at senior committees develops concentration, sensitivity to important issues and political awareness.

8.8.5 Data Analysis

The approach used to analyse the data in my study is explained in chapter five of this thesis. This was a very challenging process for me. Reducing the huge mass of data I had collected and structuring it into appropriate categories, influenced by my initial literature review but which also allowed additional themes to emerge, and then making sense of these, required extreme patience, concentration, discernment, sensitivity to meaning and a willingness to challenge assumptions and cross reference thoughts and ideas.

8.8.6 Writing Up

I had been encouraged to write my ideas and findings throughout the research process. Looking back over early drafts makes me realise that I have developed my writing skills and style considerably over the years. This will now be an ongoing process for me. I have tried very hard to develop the ability to effectively structure my work to enhance its communication value. I have found it very difficult in this thesis to separate the reporting of my results from the discussion of them to avoid unnecessary repetition. I have written and re-written these chapters and sections within them and have literally lost sleep over this problem. I have improved but there is still room for development in this respect.

8.8.7 Transferability of learning

A key lesson I have learnt from my study is that whilst people may share the same goals their perceptions of how best to achieve them are shaped by their individuality and socialisation and may therefore be very different. This is a simple lesson but I see this now everywhere around me and it helps me to understand situations that develop and the behaviour people demonstrate in professional, social and personal life.

Before doing this research I was never convinced that you need to be a researcher to be an effective teacher in Higher Education. I have now revised this viewpoint. Having regular contact with the world outside of education has improved both the content and the style of my teaching. I can also relate much more fully with the difficulties and experiences of my students in the learning process. I believe I am also more realistic and effective in my dissertation supervision of both undergraduate and Masters students as a result of my PhD experience.

The skills I have developed or enhanced, as outlined in this section are transferable to any situation and whilst skills development is an ongoing process throughout life, the research

process has been very valuable in this respect. I have enjoyed the research process and it is my intention to continue to engage in research.

8.8.8 Final Comment.

When I reached my final conclusion, I thought, so much time, so much effort, so many words and I have added only a little to what is already known. Perhaps this is the most important lesson.

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Appendix One

Samples of Interview Schedules.

Interview Schedule: Director of Clinical Services

Biographical details

- Could you briefly outline your main roles and responsibilities as Director of Clinical Services, particularly in relation to the implementation of clinical governance?
- Could you provide brief outline of previous posts held?.
- Could you briefly outline any positions of responsibility held outside of Utopian PCT?

Theme One: Clinical governance in general practice

- What do you believe to be the main features of clinical governance?
- How is this approach different to previous quality initiatives in the NHS?
- What are the key strengths and weaknesses of this approach to quality assurance?
- What do you believe to be the most important factors in making clinical governance work in general practice?
- What do you think will be the main barriers to making clinical governance work in general practice?

- Will the new GMS contract impact on the implementation of clinical governance in general practice? How?

Theme Two: Implementing Clinical Governance in general practice at Utopia?

- Could you give me a brief overview of the strategies adopted for implementing clinical governance within general practice within Utopia? (Structures / systems / processes / culture)
- What do you anticipate to be the most significant managerial challenges in implementing clinical governance in general practice?

Theme Three: The Impact of Clinical Governance on the Work of Managers and General Practitioners

Managers at the PCT

- What impact does legal accountability for quality have on the work of the CEO and other managers at the PCT?
- As Director of Clinical services you have the 'lead' responsibility for clinical governance. How does clinical governance impact on the work of senior managers at the PCT? Does it impact on the dynamics of the team? How?

GPs and GP Medical Advisers

- How does clinical governance impact on the work of GPs in practice?
- How are GPs reacting to NSFs and NICE guidance, the requirement to be appraised and to undertake CPD; revalidation, increased government interest in professional self-regulation; CHAI monitoring?
- What impact do you think clinical governance will have on the way in which GPs work with other healthcare professionals in general practice?
- How will clinical governance impact on the work of practice managers?
- What role do you perceive GP Medical Advisers to have in the implementation of clinical governance in general practice?
- How do you think GPs in the field view/relate to GP Medical Advisers?

- How do you think the GP Medical Advisers perceive their own roles?

Conclusion.

- You are anticipating a CHAI visit during the year, what do you see as the main challenges associated with this?
- What is your vision of clinical governance? Will it still be here in five years time?

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Interview Schedule: GP in Practice.

Biographical details

- Could you briefly outline your role as a GP in the Utopian area?
- Could you provide details of any previous posts held?
- Do you hold any other professional roles/responsibilities in the Utopian area or outside Utopia?

Theme One: Clinical governance in general practice

- What do you believe to be the main features of clinical governance?
- How is this approach different to previous quality initiatives in the NHS?
- What are the key strengths and weaknesses of this approach to quality assurance?
- What do you believe to be the most important factors in making clinical governance work in general practice?
- What do you think will be the main barriers to making clinical governance work in general practice?

Theme Two: Implementing Clinical Governance in general practice at Utopia?

- What strategies have the PCT put in place to support the implementation of clinical governance in general practice?
- What are the key strengths and weaknesses of this approach? What changes would you like to see made? How would you like to see this developing in the future?
- How would you assess the support provided by the PCT to general practice in relation to the implementation of clinical governance?
- How would you describe the relationship between PCT managers and GPs in the field in the Utopian area?

Theme Three: The Impact of Clinical Governance on the Work of Managers and General Practitioners

Managers at the PCT

- What do you think are the priorities and key challenges faced by PCT managers in getting clinical governance implemented in general practice?

GPs and GP Medical Advisers

- How do the following features of clinical governance impact on the day to day work of GPs in practice? NSFs and NICE guidance? The requirement to be appraised and to undertake CPD? Revalidation? Increased government intervention in professional self-regulation?
- What do you think GPs welcome and dread the most about clinical governance? How do GPs react to this?
- Will clinical governance impact on the way in which GPs work with other healthcare professionals in general practice? How?
- Will clinical governance impact on the role of the practice manager? How?
- Will the new GMS contract impact on the implementation of clinical governance in general practice? How?
- What is the role and responsibilities of GP Medical Advisers to the PCT? How do you perceive these individuals?

Conclusion.

- The Utopian PCT is expecting a CHAI visit this year, what do you believe to be the role of GPs in preparing for the visit?
- What is your vision of the future for clinical governance? Will it still be here in five years?

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Interview Schedule: GP Medical Advisers.

Biographical details

- Could you briefly outline your role as a GP Medical Adviser in the Utopian area?
- Why did you decide to become a GP Medical Adviser?
- Could you provide details of any previous posts held?
- Do you hold any other professional roles/responsibilities in the utopian area or outside Utopia?

Theme One: Clinical governance in general practice

- What do you believe to be the main features of clinical governance?
- How is this approach different to previous quality initiatives in the NHS?
- What are the key strengths and weaknesses of this approach to quality assurance?
- What do you believe to be the most important factors in making clinical governance work in general practice?
- What do you think will be the main barriers to making clinical governance work in general practice?

Theme Two: Implementing Clinical Governance in general practice at Utopia?

- What strategies have the PCT put in place to support the implementation of clinical governance in general practice?
- What are the key strengths and weaknesses of this approach? What changes would you like to see made? How would you like to see this developing in the future?
- How would you assess the support provided by the PCT to general practice in relation to the implementation of clinical governance?

- How would you describe the relationship between PCT managers and GPs in the field in the Utopian area?

Theme Three: The Impact of Clinical Governance on the Work of Managers and General Practitioners

Managers at the PCT

- What do you think are the priorities and key challenges faced by PCT managers in getting clinical governance implemented in general practice?

GPs and GP Medical Advisers

- How do the following features of clinical governance impact on the day to day work of GPs in practice? NSFs and NICE guidance? The requirement to be appraised and to undertake CPD? Revalidation? Increased government intervention in professional self-regulation?
- What do you think GPs welcome and dread the most about clinical governance? How do GPs react to this?
- Will clinical governance impact on the way in which GPs work with other healthcare professionals in general practice? How?
- Will clinical governance impact on the role of the practice manager? How?
- Will the new GMS contract impact on the implementation of clinical governance in general practice? How?
- How do you perceive the role of GP Medical Adviser in the implementation of clinical governance in general practice?
- What advantage do you as a GP Medical Adviser provide for the PCT / GPs in the field in relation to the implementation of clinical governance?
- What do you find to be the most rewarding and challenging about the role of GP Medical Adviser?
- How do you see the role of GP Medical Adviser developing in the future?
- How do you think GPs in the field perceive the GP Medical Adviser's role?

Conclusion.

- The Utopian PCT is expecting a CHAI visit this year, what do you believe to be the role of GPs in preparing for the visit?
- What is your vision of the future for clinical governance? Will it still be here in five years?

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Appendix Two

Framework of Analysis Derived from the Initial Literature Review.

Key Themes:

From the Clinical Governance / NPM literature:

- Clinical Governance
- National Service Frameworks/NICE
- Evidence-based medicine
- Appraisal
- Continuous Professional Development
- Revalidation
- CHAI
- Leadership
- Team working
- Culture
- Continuous improvement
- Key Performance Indicators
- Benchmarking
- Statutory responsibility for quality

From the literature on the professions:

- Professional autonomy
- Professional self-regulation
- Professional dominance

- Use of IT
- Changing roles of healthcare professionals in general practice
- Training and education
- Employment status
- Increasing bureaucracy
- Increasing standardisation
- Increased public expectation
- Reduced public trust in professionals
- Codifying of medical knowledge and skills
- Use of GPs as managers / professional representatives

Additional Themes Emerging During Data Analysis

- GP Independent contractor status
- The new GMS contract
- Management styles
- Organisation strategies, structures and processes
- Single-handed GPs
- Size and complexity of general practice
- Time and workloads
- Funding and resources
- Performance management and control
- Roles and relationships at the PCT and within the practices

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