# What do specialist registrars know about clinical governance?

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***Clinical governance is an essential part of quality assurance for everyday clinical practice. It is part of the generic curriculum for all specialist registrars (SpRs) training in medical specialities. The authors of this update undertook a survey of SpRs training in geriatric medicine to determine their perceived knowledge of clinical governance and whether they had received training in this area.***

## INTRODUCTION

Clinical governance is defined by Scally and Donaldson (1998) as:

> **'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish'.**

It covers all areas of medical practice and includes risk assessment and management, clinical effectiveness, development of guidelines and care pathways, research governance, critical appraisal of evidence, audit and complaints management. It also has links with managing 'poor performance' and with this revalidation.

Unfortunately many clinicians view clinical governance negatively as being more about government driven targets and an associated increase in paperwork and meetings, rather than improving the quality of health care. Hospital trusts have clinical governance committees to oversee their clinical governance strategy, with consultants often taking the lead. Medical involvement and support is essential if improvements in medical care are to be achieved. As the future consultants, specialist registrars (SpRs) need to be well informed and educated about the systems of clinical governance.

The authors of this article undertook a questionnaire survey of SpRs training in geriatric medicine during 2004 to determine how much knowledge SpRs had of clinical governance and whether they had received any training in this subject.

## METHODOLOGY

The generic curriculum for SpRs training in medical specialties is based on the General Medical Council's *Good Medical Practice* (2001) and defines the generic knowledge, skills and attitudes that all SpRs in medical specialties need to acquire during their training. One of the key objectives of generic training is clinical governance.

The clinical governance section of the generic curriculum was used to develop a questionnaire composed of a series of 22 closed questions requiring either a 'yes' or 'no' response (*Table 1*). Questions covered all aspects of clinical governance (*Table 2*) and were framed to determine what knowledge SpRs had in these areas and whether they could undertake specific tasks relating to clinical governance. At the end of the questionnaire there was a free text section where SpRs could describe what training they had received to date in clinical governance.

The questionnaire relied on SpRs' perceived knowledge and no attempt was made to objectively assess this knowledge. Questionnaires were anonymous but trainees were asked to record their year of training and deanery. The questionnaire was piloted in one deanery and questions modified slightly to avoid ambiguity, before being distributed further.

Questionnaires were distributed by the regional SpR representative at a single geriatric medicine SpR training day within six regions (North West, Mersey, West Midlands, South West, Wales, East Anglia), and also to SpRs (who had not previously completed the questionnaire) attending the trainees' meeting of the British Geriatrics Society in October 2004.

In total, 106 SpRs completed the questionnaire, representing 19.3% of all SpRs in training in geriatric medicine in the UK and included respondents from 16 of the 18 UK deaneries.

Returns were higher in the six

**TABLE 1. Example questions from questionnaire**

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|---|
| Are you confident that you can do a comprehensive literature search accessing appropriate resources? |
| Would you be able to undertake a risk assessment of a clinical scenario? |

**TABLE 2. Components of clinical governance**

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|---|
| Clinical effectiveness |
| Audit |
| Research governance |
| Evidence-based medicine |
| Risk assessment and management |
| Adverse event reporting |
| Performance assessment and revalidation |
| Care pathways and guidance |
| Complaints management |

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**TABLE 3.**
**Response rates by deanery**

| Deanery | Total number of specialist registrars (By Deanery) | Number attending training day and completing questionnaire (% of total) |
|---|---|---|
| North West | 36 | 26 (72%) |
| Wales | 26 | 17 (65%) |
| Mersey | 22 | 12 (55%) |
| West Midlands | 35 | 17 (49%)) |
| South West | 21 | 9 (43%) |
| East Anglia | 26 | 10 (38%) |

deaneries where the questionnaire was distributed at a single training day. All trainees (100%) who attended these regional training days completed a questionnaire (*Table 3*).

## RESULTS

One hundred and six questionnaires were returned and analysed. Responses were obtained from SpRs in all 5 years of training in geriatric medicine although only 9% of SpRs were in their final year. Thirty eight percent of registrars had received some form of training in clinical governance and 27% had received training in clinical effectiveness (*Table 4*).

Of all the aspects of clinical governance, SpRs had most experience in the practice of audit. Seventy-seven percent said they knew how to identify audit standards, 79% had undertaken an audit project, however only 56% of the respondents had completed a full audit cycle. Only 10% were aware of Caldicott guidelines (Department of Health, 1997). Seventy percent stated that they could undertake a comprehensive literature search, 66% stated they could define key search terms and 82% stated that they could critically appraise an article.

SpRs knew much less about risk assessment (only 37% claimed to have knowledge of this), risk management policies (22%) and investigating critical incidents (36%). Only 24% had received risk management training. Eighty-two percent reported that they would know what to do if a colleague became unfit to practise.

Fifty-seven percent were aware of their hospital's policy on handling complaints, but were less knowledgeable about the process, which occurs when local resolution is not possible, such as independent review panels (29%).

Forty-one percent of registrars had been involved with developing clinical guidelines and 50% with developing care pathways. Encouragingly, 88% of participants believed that they should receive formal training in clinical effectiveness and clinical governance.

## DISCUSSION

This survey shows that the majority of specialist registrars in geriatric medicine have experience in literature review, critical appraisal of scientific papers, audit and clinical guidelines. However, it also demonstrated that they have an inadequate knowledge of most other areas of clinical governance despite this being part of the generic curriculum for all medical specialities.

This was an opportunist survey and only SpRs from six deaneries who attended a specific training day or those who attended the trainees meeting at the British Geriatrics Society were represented in the survey. This may have introduced an element of bias into the study, possibly favouring trainees who were more enthusiastic about formal teaching or had access to study leave.

However, all deaneries included in the survey have a policy whereby SpRs are expected to attend training days unless on leave or precluded from doing so by service commitments. Those included in the survey would therefore be very likely to accurately represent SpRs training in geriatric medicine as a whole and the subjective nature of this survey is more likely to lead to an overestimation of SpR's abilities in this area.

Although the survey is confined to only one medical speciality, the authors have little doubt that similar results would be found in other specialities.

The fact that SpRs have more exposure to audit and critical appraisal of literature rather than other aspects of clinical governance probably reflects that these are the areas of clinical governance in which their consultant supervisors are most involved.

The results of this survey are similar to those obtained from a survey carried out in a single trust in the south east of England (Nettleton and Ireland, 2000), which showed most junior doctors had some experience of audit, but had a variable understanding of clinical governance.

The general feeling in the medical profession is that clinical governance has been driven by a management focused on financial issues and activity targets rather than by clinicians as part of quality assurance. It has been suggested by Degeling et al (2004) that this:

**TABLE 4.**
**SUMMARY OF RESULTS**

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|---|
| Good experience of audit, but few had completed an audit cycle |
| Majority had experience of critical appraisal of literature |
| Poor experience in risk management and assessment |
| Lack of awareness of Caldicott guidelines |
| Inadequate knowledge of management of complaints |

**TABLE 5.**
**RECOMMENDATIONS**

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| Clinical Governance training should be included in SpR regional training days and deanery courses. |
| Knowledge of Clinical Governance should be assessed at annual RITA assessments. |
| The benefits of clinical governance to patient care should be promoted. |
| SpRs should shadow clinicians involved with clinical governance. |