Clinical governance in primary care

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The government's stated top priority for the NHS is the quality of care of patients and there now exists a new duty of quality on all those providing care, accompanied by a drive for greater accountability to the public of clinical decision making. The process which governs these initiatives is termed clinical governance.

Clinical governance is not new. In the same way that the Royal College of General Practitioners term 'primary care', invented in the 1950s, was only discovered by NHS management in the late 1980s, so clinical governance — or its component parts — has been with us far longer than management would have the non-medical public believe.

THE QUALITY AGENDA

The term clinical governance first appeared in the white paper *The New NHS, Modern Dependable* (Department of Health, 1997) in December 1997, shortly after the general election. In its document *A First Class Service*, the government defined the term for the first time as:

> **'A framework 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 will flourish (Department of Health, 1998).'**

The government was driven by the need to restore confidence in the NHS, especially after the cardiac surgery inquiry in Bristol, as well as the need to deliver a higher quality service across the country, and be seen to do so in its first term.

Essentially, the government was announcing to the profession that it wished to see greater accountability to the public for clinical decisions, and that a regulatory framework would be established across the NHS to see that this was done.

HOW WILL CLINICAL GOVERNANCE OPERATE?

The framework rests on four pillars, which are now part of British law following the Royal Assent of the Health Act 1999 on June 30. These are:

A duty of quality

Every practitioner and organization within the NHS now has a statutory duty to ensure that they strive to provide the highest quality of care. GPs and their practices are now accountable to their primary care group (PCG) boards (through the clinical governance lead member — the primary care equivalent to clinical director), and PCGs are in turn accountable to health authorities. The chief executive of the health authority is accountable direct to parliament, and therefore has a strong interest in ensuring that the clinical governance framework is firmly bedded in.

NICE

The National Institute for Clinical Excellence has been established to 'even out' differences across the country by pronouncing on the plethora of guidelines, and on controversial issues such as the use of interferon B.

CHImp

The Commission for Health Improvement (CHImp) has the powers to carry out investigations in GP practices, PCGs and trusts, to determine whether or not there is or has been unsatisfactory practice.

Self-regulation

The government has enhanced the powers of local medical committees and has invited the General Medical Council (GMC) to submit proposals for more rigorous sanctions for aberrant doctors.

WHAT IS HAPPENING RIGHT NOW?

In the meantime, across the UK, and differently in each of the four countries, GPs, nurses, local authorities and the public have

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been learning about working together in the spirit of partnership set out in the new NHS. Clinical governance has naturally been high on their list of priorities, but until now most PCGs have been too concerned with establishing their own internal structures and with understanding how to make their new budgetary arrangements work.

This is somewhat fortuitous as the Health Act 1999 had not yet appeared, very little guidance had been forthcoming from the NHS Executive on how to implement clinical governance, and very few authors had yet produced anything concrete for general consumption. However, PCGs are beginning to get on top of these affairs, and are now turning their attention to the detail of clinical governance. They are examining how to make it effective, yet retain the confidence of individual practitioners.

Pulling this off will be tricky. GP and nurse morale continues to remain low, while cynicism about resources is high. *A First Class Service* goes to great lengths to reassure practitioners that clinical governance is about the pursuit of excellence, and not about naming and shaming, yet the media continue to pander unabated to the public's apparent desire for the latter. It will be a very special PCG board which can successfully manage that triangle.

Most boards are approaching the challenge by acknowledging that most of the fabric of clinical governance already exists, and that good governance can be demonstrated by highlighting the building blocks, resourcing them, making them more widely available so that they reach out to all, and then focusing down on one or two priorities which fit with the PCG's needs in terms of their Health Improvement Programme (HimP), prescribing, or other areas of interest/concern.

The building blocks available to them are:

Clinical audit

Medical audit advisory groups (MAAGs), or similar, have been firmly established across the country for over 10 years. Funded on a shoestring by Family Practitioner Committees (FPCs), Family Health Services Authorities (FHSAs) and subsequently health authorities, they have been treated with enthusiasm by the vast majority of GPs. Organized by GPs for GPs, they have positively facilitated audit within practices and demonstrate that there is a firm base for clinical audit within primary care.

Two key adjustments will need to happen if MAAGs or their successors are to fit in with the new NHS. First they will need to be more inclusive and involve other primary care health professionals, especially nurses, and second they will need to coordinate audit work and focus on the priorities of the PCG, and not the preferences of the individual GP — in other words, they must become service orientated as opposed to academically orientated.

Continuing professional development

Current education and training arrangements will also need to adapt, if they are to meet the service-linked requirements of the new NHS. Continuing medical education, until now for most GPs a non-directed exercise incentivised through the postgraduate education allowance, will become more directed and will incorporate service-based training — an element which has long been the Cinderella of the NHS, and for post vocational training scheme GPs practically non-existent.

Training will need to reflect both the needs of the doctor and the demands of the service. It will also increasingly need to be seen to be coordinated in a multidisciplinary fashion. If it is to succeed, this new approach will need to command the confidence of GPs. Care will be needed to ensure that existing good practice is not sacrificed in pursuit of unachievable perfection. Service-based education and training requires substantial investment by the service in the protected learning time for its participants. The track record of the NHS in this field is appalling.

Research and development

NHS Executive investment in research and development in primary care is growing, and will require ongoing resourcing if it is to deliver solutions to the many dilemmas facing a service confronting the need to minimize waiting lists and length of hospital stays.

Clinical risk management

No clinical management plan is without risk: health outcome risk for patients, and medicolegal risk for practitioners. In general practice, GPs as independent contractors are not protected by a trust or health authority from medicolegal risk. As the traditionally low-risk nature of primary care becomes more complex, so too does the level and variety of that risk. The new quality-led, cash-limited NHS can no longer tolerate avoidable errors, and needs to minimize the impact of unavoidable errors.

For some disease processes, protocols and guidelines, when adequately evaluated, may go some way to lowering risk, but the generalist

nature of British general practice does not readily lend itself to the protocol approach, and is itself at risk if such an approach is too rigorously or too innocently pursued. Much more research needs to be urgently done in this field. GPs and patients will need to come to terms with a potential loss of some of the arguably softer psychosocial aspects of a visit to the surgery — so often an integral part of continuity of care so unique to British general practice and the envy of most other nations — in pursuit of a more outpatient styled and purist medical model of consultation.

Poor performance

In 1996, legislation enabled the GMC to institute proceedings in cases of poorly performing doctors. Serious cases which cause a GP's registration to be in question are dealt with through the GMC's performance procedures. The GMC advises that other cases are normally resolved locally in accordance with the School of Health and Related Research (SCHARR) report (Rotherham et al, 1997) aimed at identifying underlying causes and proposing remedies. Clinical governance at PCG level provides a mechanism for such local resolution to take place at an earlier stage, freeing up the local SCHARR procedures to manage the more complex cases.

The complaints procedures

The Wilson report (Department of Health, 1994) led to a radical revision of the NHS complaints procedures. Separation of investigation from discipline has resulted in successful local resolution of the vast majority of complaints at practice level, with very few cases ending up at independent review. As part of clinical governance, data from the complaints process will provide a useful adjunct to the enhancement of quality and risk management.

APPLYING CLINICAL GOVERNANCE IN PRIMARY CARE

In practical terms, PCG clinical governance lead members have now been appointed. Their role is to ensure that processes exist within practices for GPs and nurses to meet their duty of quality obligations, to determine what resources might be needed to operate those arrangements, and to begin to identify areas of concern which might need addressing.

As a start, they will encourage GPs and nurses to ensure that the education and training in which they participate is relevant to their needs, and to focus on one or two areas which are priorities for the PCG, such as diabetes management and prescribing costs. With the very limited resources available to them, these should fully occupy their time in the first year. The more enthusiastic PCGs will attempt to deal with a wider range of issues, but will need to maintain the confidence of their GPs and nurses as they progress their agenda.

PCG boards will be looking to their clinical governance leads and support staff to ensure constant improvement in their organizations' clinical quality, prescribing practices and budgetary control. They will increasingly use financial levers to encourage compliance with the PCG's needs, and they will be performance-managed on their results.

NEXT STEPS

Primary Care Trust status — thought by many to be the precursors of American-style Health Maintenance Organizations in Britain — will certainly depend on the demonstration of good clinical governance, and there will therefore be some considerable variation in the style and nature of clinical governance delivery, depending on how much the PCG covets trust status. But if the experience of the previous NHS reforms is anything to go by, we can expect widescale Primary Care Trust status to be achieved sooner rather than later. We will then be able to assess the impact of clinical governance if not in terms of outcomes for patients, then certainly in terms of the structure of the service, well ahead of the government's original 10-year agenda.

Whether primary care will be any better at meeting patients' expectations remains to be seen. HM

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KEY POINTS

- Clinical governance seeks to make clinical decision-making accountable to the public.
- There is a new duty of quality on all working in the NHS.
- Many elements of clinical governance already flourish in practice.
- Attention should be paid to developing systems to manage clinical risk.
- A bottom-up approach to clinical governance is more likely to succeed.