The role of clinical governance as a strategy for quality improvement in primary care

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SUMMARY

This paper considers the process of implementing clinical governance in primary care and its impact on quality improvement. It discusses how clinical governance is being implemented both at the level of Primary Care Organisations and general practices, and the challenges to implementing clinical governance. It also suggests a model for promoting the factors that will help clinical governance improve quality of care. The experience of implementing clinical governance is broadly positive to date. However, the government needs to match its commitment to a ten-year programme of change with realistic timetables to secure the cultural and organisational changes needed to improve quality of care.

Keywords: *clinical governance; quality improvement; primary care organisation; primary care team.*

Introduction

A VARIETY of approaches have been used to improve the quality of health care in England and Wales, culminating in clinical governance, which is part of the Government's overall strategy for quality improvement in the National Health Service (NHS). Clinical governance is part of a ten-year 'framework through which NHS organisations are accountable for continually improving the quality of their services, safeguarding high standards by creating an environment in which excellence in clinical care will flourish'.[1] It places attention equally upon accountability for existing care and improving future care.[2-3] The concept seeks to combine and codify previous approaches to measuring and improving quality of care.[4-9] The framework is unique in that it represents the first coherent and compulsory strategy for improving quality within the NHS as a systems-based model.[4]

There is evidence to suggest that considerable progress has been made in terms of establishing the infrastructure for clinical governance in primary care.[10-14] This progress has been influenced by Department of Health directives, Regional Office guidance, Primary Care Organisations' (PCOs') interpretations and guidelines, 'levers' from all levels, and a personal 'willingness'.[8,10-11,15] Progress is important as there is a need to improve the efficiency, effectiveness, and safety of patient care; to enhance accountability; and because there is evidence of significant variation in care,[16] medical errors,[17-19] and poor care.[20]

This paper considers the process of implementing clinical governance in primary care and its impact on quality improvement. It also suggests a model for promoting the factors that will help clinical governance improve quality of care.

What are the most effective quality improvement strategies?

Much previous research concentrated on individual components of quality improvement, such as significant event auditing (SEA),[21-23] conventional auditing,[24-25] and patient feedback.[26-27] However, multi-level strategies for change that *combine* continuing education, audit, research, and clinical effectiveness in unified multi-professional educational strategies, lead to the changes in behaviour that enhance quality improvement.[28-30] The developmental approaches currently being used by PCOs,[12,13,31] which focus on team and corporate learning, are therefore founded on a sound basis. For example, successful team building and leadership/management have been found to be important catalysts for quality improvement in first-wave PMS sites.[32]

Successful implementation of clinical governance will require an understanding of the need for multi-level approaches to change, at the individual (e.g. general practitioner), the group or team (e.g. primary health care team), the overall organisation (e.g. the PCO), and the larger system (e.g. the NHS), in which individuals and organisations are embedded.[28] While recognising the independence of each level, quality improvement strategies need also to consider the interdependence of various levels.

How is clinical governance being implemented at a PCO level?

A myriad of approaches have been used to implement clinical governance, including audit (the dominant approach to quality improvement in the last decade), SEA, team-based education and training events, sharing comparative data, personal and practice learning plans, the setting and monitoring of standards, and the use of quality indicators.[11-12] In particular, facilitative, developmental, and supportive processes are being advocated by many PCO clinical governance teams, to nurture a sense of ownership, trust and voluntary engagement by practice staff (Box 1).[10-13,15,33] Clinical governance is seen as requiring implementation on a long-term bottom-up 'softly-softly' basis, as opposed to 'quick fixes'.

Primary care organisations are advocating collaborative and corporate learning (all practices learning together) and team-

based learning (all staff within a practice learning together). Asking independent contractor primary care practitioners to work within a corporate philosophy is a significant departure from previous policy and cannot be simply imposed by government. Common approaches have included the RCGP Quality Team Development initiative, which encourages practices to identify their own priorities for improvement. Such strategies, highlighting the concept of learning organisations, are appropriate, as quality improvement requires fundamental changes in organisational and behavioural (professional) cultures, which are far from straightforward and take time to achieve.[34-35]

It is important to foster a sense of ownership and engagement among health staff, as many are wary that clinical governance will be used to monitor poor performance, rather than foster quality improvement,[10,13] aggravated by fears relating to the introduction of GP revalidation and appraisal. Many health professionals are still not engaged with the quality improvement agenda,[36] partly because it is seen as being imposed and as 'policing' their performance, rather than supporting quality improvement.

Only 3% of clinical governance leads have employed the withdrawal of resources from poor performers and only 9% have established any formal disciplinary procedures.[12] As Primary Care Groups (PCGs) become Primary Care Teams (PCTs) — and with the recent abolition of health authorities — PCOs will have to deal with poor performers. Not surprisingly, therefore, given that clinical governance also incorporates systems to ensure minimum standards, PCOs are also engaged in developing mechanisms for dealing with poor performers, although these are, as yet, less well developed.[13] Early in the process of developing clinical governance, PCO clinical governance staff were unsure of the 'carrots and sticks' at their disposal to monitor and improve quality of care, in terms of identifying and dealing with incidences of substandard care and in 'encouraging' resistant colleagues to develop the process on the ground. Many clinical governance leads lacked clarity about the levers (for example, financial incentives, publication of league tables) that they have the authority to use, but these have tended to become clearer as PCGs have moved to PCT status. Some have therefore relied on the goodwill of their 'independent contractor' colleagues to move the process forward.[10-11,13,33] Facilitative and developmental approaches were often the only possible option available to the PCO leads themselves, as workload and shortage of protected time meant that they were unable to chase up practice members on a continuous basis.

Almost three years into the process, clinical governance in primary care is viewed predominantly as a positive and welcome process, but it remains under-resourced and a challenge to implement.[10-13] The clinical governance leads who initially grappled with the relatively theoretical concept and definition of clinical governance have begun to grasp its inherent clinical and managerial challenges. At a PCO level, clinical governance is seen as a process that will grow and develop over several years, facilitated by reflection, access to information, and adequate resources.

How is clinical governance being implemented at practice level?

A progressive, developmental and accumulative process of implementation:

Use of tools

Education
Audit
Information management
National and local guidelines

Use of strategies

Peer pressure and professional pride
Mentoring and supervision
Involving others
Sharing experiences and knowledge

Ethos/approach

Encouraging, facilitating, supporting, engaging, Inspiring, reflecting
Arm-twisting!
Being a resource, an advocate

'Moving slowly — a step at a time'

Box 1. The process of implementing clinical governance being advocated by PCOs.[11]

Evidence suggests that many staff at practice level have a good basic knowledge of clinical governance, although their focus tends to be slightly narrower (more practice-orientated) than that expressed by PCO-level clinical governance leads.[37-38] At practice level, clinical governance is seen as being composed of three components: culture, accountability, and tools within an overall patient-focused, whole-team approach to quality improvement. It is beginning to become embedded in the day-to-day working lives of practice staff as a routine, positive, and shared multidisciplinary team activity.[37-38] For example, many practices have made a start with National Service Frameworks-based audits, SEA, complaints systems, personal learning plans, practice development plans, appraisals, and practice 'awaydays'.

There are a number of difficulties with clinical governance at practice level;[37-38] in particular, lack of time and support (administrative, information technology) and logistical difficulties. With the advent of large PCOs, some primary care staff reported feeling 'disconnected' from the organisation. Single-handed practices feel vulnerable and exposed at the comparison of their data to data generated by larger practices, feeling that there was room for distortion and exposure. Some practice staff feel that clinical governance had the potential to become 'a paper exercise', characterised by 'ticking boxes' and doing the minimum amount of work. Three components of clinical governance caused particular difficulties in practices: dealing with slight under-performance, GP appraisal, and meaningful patient participation.[37-38]

What challenges face clinical governance in primary care?

There are reasons to be hopeful that clinical governance will lead to meaningful improvements in primary care, including the dedication of staff, emerging clinical leadership, evidence-based developmental approaches by PCOs, the fact that national clinical priority areas (e.g. heart disease) are aligned to health professionals' own priorities, and the emphasis on a systems-based strategy. Moreover, real improvement comes

from changing systems,[39] which is the government's current approach to the NHS.

There are also significant barriers.[11-12] These include concerns about the pace of change and volume of work involved, problems associated with moving from PCG to PCT, a perceived blame culture that undermines attempts to foster openness and shared learning, too few staff, limited dedicated resources to implement clinical governance, and the continued disengagement by some practices and staff.[12-13] In addition, the fact that practices offer different levels of care and vary in terms of information technology skills and financial resources, can hinder corporate approaches. These barriers have left many clinical governance leads feeling beleaguered, already faced with a steep learning curve, long working hours, and lack of time to absorb and understand multiple initiatives. It has also had an impact on them personally, especially in terms of relationships at home and work (Box 2). It is important therefore that mechanisms are put in place that support clinical governance leads and their teams.

Clinical governance leads have experienced many difficulties during the development of their role; for example, they have not always been clear about their level of responsibility for the development of clinical governance within their own organisation.[11] Other concerns include ambiguity in the role of clinical governance leads, long-term uncertainty, and the emotional impact of the role.[33] In terms of emotional impact, some leads have felt 'powerless' and 'out of control' with the volume of work and shortage of resources. The early lack of direction and the paucity of volunteers for the role of clinical governance leads has served to create a sense of powerlessness among some clinical governance leads, forcing many to resign their positions.[11,37]

In addition, despite PCO staff being committed to the involvement and influence of users in clinical governance priority setting and implementation, as stipulated in government directives,[40] so far there is little evidence that this has occurred in any meaningful way.[41] Meaningful engagement of service users has been highlighted as a major difficulty for both practices and PCOs.[10-11] There is also, as yet, little evidence of improved outcomes for patients as the emphasis has been mostly on quality assessment.[12]

There are also a number of inherent contradictions within the implementation of clinical governance that need to be reconciled. For example, transformational leadership and quality improvement focused on fostering change at the local (PCO) level may be incompatible with performance management and quality assurance at the national (government) level. It may generate hostility from above (e.g. government timetable) and hostility from below (perceived blame culture within practices). Moreover, different stakeholders (e.g. professionals and patients) have different perceptions about what constitutes quality improvement. For example, research has shown that some first-wave Personal Medical Services sites have advocated longitudinal continuity of care (delivered by teams), rather than personal continuity of care (delivered by individuals) as a catalyst for quality improvement, but that their patients do not value such a shift.[32] In addition, high-profile media cases of medical error risk overshadowing improvements in care within the NHS in the perception of the general public.

What factors will make clinical governance improve quality of care?

There are three overlapping sets of issues, which, if addressed successfully, will enhance the successful implementation of clinical governance in primary care (Boxes 3, 4, and 5):

1. The architects of clinical governance and the context under which it is being implemented (the environment of change);
2. The people responsible for implementing clinical governance (the leaders of change), and
3. The people who will make clinical governance part of their daily routine (the implementers and users of change).

Not all healthcare staff can (or need to be) leaders of change and clinical governance. However, all staff must be users of clinical governance and all patients must be beneficiaries of the process. Finally, we must be patient and allow time for the process to become embedded and for the new culture to develop.

Clinical governance seeks to foster an environment under which excellence can flourish. However, standards and targets (for both organisations and individual practitioners) must be

Practicalities of implementation

Speed and volume
Lack of funding
Lack of adequate direction
Doctor-dominated
Multiplicity of employers

Role of the lead

Appointed by 'accident/default'
Steep learning curve — initial lack of confidence
Lack of clarity about 'carrots and sticks'
Time to 'absorb, understand, translate and convey'

Relationship

Consequences
Partners/colleagues in practice
Marriage/home/social
Patients
'Rowing upstream…'

Emotional impact

Increased personal stress, decreased personal achievements
Feeling exposed, vulnerable
Feeling isolated (an 'outsider')
Sense of powerlessness

Long-term uncertainty

Transition from PCG to PCT
Succession and lack of continuity
League tables/'Ofdoc' inspectors
Accountability and responsibility
Penalties

The wider agenda

Short-term (political) gains
External scrutiny
Loss of GP independent contractor status
Clinical governance 'set up to fail' (external control)

Box 2. Concerns about clinical governance.[11]

- Clarity of roles (e.g. PCO, health authority)
- Effective (clinical) leadership
- Multi-professional teamwork and team learning
- Power of sanction
- Power of reward
- Facilitation and developmental approaches to quality improvement
- Protected time for reflection and to undertake quality improvement
- Adequate resources and infrastructure
- No-blame culture
- Adequate resources and support at meso-level (PCG) and micro-level (practice), in terms of skills, advice, etc.
- Time-sensitive and realistic timetables/outcomes

Box 3. The context of clinical governance: creating the environment of change.

- Clarity of roles and responsibilities (e.g. clinical governance team, clinical governance lead, practice clinical governance lead)
- Clinical governance teams including joint leads (GP and non-GP)
- National guidelines on the 'carrots' and 'sticks' available to clinical governance teams
- Recompense to practices where clinical governance leads practice
- Dedicated and adequate clinical governance budgets at PCO level
- Adequate career structure for clinical governance leads/facilitators
- Making clinical governance part of the everyday routine of PCG/Ts: the 'glue' or 'oil'.
- Multi-professional team approach with managerial support

Box 4. Leaders of clinical governance: facilitating effective leaders of change.

realistic and practice-specific,[42] showing that sustained improvement longitudinally (and laterally) is what counts year on year. Moreover, clinical governance, correctly, gives greatest emphasis to supportive and developmental quality improvement. Indeed, the tide has perhaps turned too far in the direction of checking on, and not trusting, health professionals.[43] Clinical governance leaders must recognise and deal accordingly with poor care and those who, despite adequate support, prove themselves incapable of quality improvement. The recipients of clinical governance (patients and carers), as well as all users of clinical governance in the health service, must not feel threatened by the use of penalties (including, where appropriate, suspension or termination of contracts); rather, they should support it where this is warranted. Continuous quality un-improvement must not be tolerated in the National Health Service. In addition, the system of payment within general practice that advocates financial reward based on capitation, needs replacing by a system that encourages and rewards high quality care. It is to be hoped that this will be facilitated by the introduction of the new core contract.

Conclusions

The vagueness of the initial definition of clinical governance serves both as a problem and an opportunity, in terms of its successful implementation. It encourages flexibility and local ownership as well as facilitating the organic growth of the process. However, it also provides limited criteria against which to judge the success or failure of clinical governance

- Protected time for reflection and to undertake quality improvement will encourage a sense of ownership and engagement with the process.
- Adequate funds and staff to implement initiatives (e.g. audit).
- Developmental and facilitative approaches based on the perceived needs of the practice, according to the staff (e.g. Quality Team Development).
- Multi-professional teamwork and team learning.
- Aligning national clinical governance agenda to local needs (e.g. heart disease).
- Practices would benefit by having half a day per month protected for clinical governance activities, in addition to half day a month for PCG/T multi-professional training events.

Box 5. Users of clinical governance: developing a climate under which health staff will implement change.

and has led to uncertainty within PCOs. Clinical governance is not a unitary phenomenon but a myriad of local and national initiatives. It is therefore unhelpful to consider whether 'clinical governance will work or fail'. It is likely that some components will work and some will fail. However, because clinical governance is a systems-based model it is likely to be judged as a single entity, which will mask examples of both success and failure.

The experience of implementing clinical governance is broadly positive to date. There have been no systems-based schemes of this size and scope in England and Wales before, backed up with Government commitment and substantial resources (e.g. NHS Clinical Governance Support Team). Considerable progress has been made in transforming the rhetoric of clinical governance into reality, and a recognisable (and more open and transparent) continuous quality improvement agenda is emerging as a result. Patients will benefit from these improvements and practitioners will improve the care they provide. In addition, practitioners will reap the benefits of working in a safer, more supportive system. However, to become genuinely embedded in our culture, it is necessary that the process meets the needs of professionals as well as patients. A considerable body of evidence suggests that there are real concerns about the time, effort, and personal sacrifices involved in developing the process at a local level. The government needs to match its commitment to a ten-year programme of change with realistic timetables to secure the cultural and organisational changes needed to improve quality of care. A focus on short-termism must not be allowed to deter from longer-term objectives.

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