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A model for clinical governance in primary care groups

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Clinical governance is the core component of the new quality programme for the NHS (see box on next page) announced in the consultation document *A First Class Service*.[1] It is described 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." It will be the central focus for assuring the quality of care and addressing the issue of providing accountability through the Commission for Health Improvement.[2] The activities of the commission will reflect national and local priorities as identified by the National Institute of Clinical Excellence and health improvement programmes respectively. Although *A First Class Service* included details about the structure and functioning of clinical governance in health service trusts, arrangements for primary care groups were not specified. In this paper, we suggest a possible model for clinical governance in primary care groups.

Summary points

Clinical governance is central to the NHS quality programme, but how it will operate in primary care groups remains unclear

Although many activities included in the new concept of clinical governance are already being undertaken, these need to be coordinated

A model of governance that addresses the core tasks of defining, accounting for, and improving quality and incorporates evidence on effective methods of changing performance is suggested

This model can improve professional, practice, and primary care group performance

It shows how groups can introduce and develop clinical governance and how health authorities and the Commission for Health Improvement can monitor progress

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Model precepts

The model is based on three underlying precepts:

- Clinical governance encompasses both quality improvement and accountability—systems for both must be developed fully if the highest levels of quality of care and professional performance are to be shown to have been achieved;
- Quality improvement and accountability depend on effective methods of changing performance—without these, clinicians and primary care groups cannot improve quality or account for it. Fortunately, there is growing evidence about the effectiveness of methods of changing performance that can be used to guide arrangements for clinical governance[3–5];

Table 1 Examples of current quality improvement activities in primary care in relation to the principles of clinical governance[6]

Examples of current activities/organisations involved	Strengths	Weaknesses	Opportunities in governance
Quality improvement processes are in place and integrated			
Clinical audit led by primary care audit groups (or equivalents)	High levels of participation by practices[14]	Quality of some audits could be improved	Integrate with evidence based practice and continuing professional development
	Can lead to demonstrable improvements in care	Audits often not linked to evidence[14] or to continuing professional development	Use of a wider range of implementation methods[3]
			PCG-wide policy for clinical data recording
Evidence based practice, innovative practice, and research and development			
Clinical effectiveness not actively managed[16]	Increasing examples of evidence based health care through guidelines[17] and/or audit protocols[18]	Lack of local support and infrastructure	Systematise and actively manage evidence based practice in primary care groups
Research practice networks and individual research practices; university departments		Lack of training and skills in evidence based practice	Research practices/research groups
Professional development programmes			
Hospital based teaching, pharmaceutical companies	Self directed learning groups	Not actively managed or systematic	Multidisciplinary practice professional development plan[20]
Departments of general practice/nursing, etc	Vocational training and trainers[19]	Failure of traditional continuing medical education to change practice[5]	Needs based or practice based life long learning
Practice based educational programmes	Clinical supervision (nursing)	Not needs based learning	
	Systems for recertification being developed	Not multidisciplinary	
Complaints, adverse events, and clinical risk reduction			
Practice based complaints procedure	Resolution of complaints locally	Not actively managed or systematic	Integrate with other quality improvement processes, collation of data at primary care group level
Poor clinical performance			
No requirement routinely to monitor clinical performance	Clinical supervision (nursing)	Often not actively managed or systematic	Actively manage a process to identify, support, and rectify poor performance at individual and team levels.
GMC/UKCC procedures; health authority procedures	Tool available to monitor and enhance performance[21]	Current procedures rely on extreme cases	Develop occupational health[22]

GMC=General Medical Council; UKCC=United Kingdom Central Council for Nursing, Midwifery, and Health Visiting; PCG=primary care group

• Primary care groups can be regarded as organisations. Though most will be little more than loose affiliations of representatives of primary health care teams at first, many groups will become increasingly integrated, with comprehensive systems of communication and decision making. Therefore, to be fully effective, governance must meet the needs not only of the organisation as a whole but also the teams and individuals associated with it. Governance can draw on the experience of quality management systems in other organisations.

Clinical governance and primary care groups

- From April 1999 all general practices will be brought into local primary care groups, each serving around 100 000 patients
- Groups will be responsible for improving the health of their community by developing primary and community health services and commissioning high quality secondary care services
- Clinical governance will be a local system for quality improvement and accountability
- Each group will be required to appoint a lead clinician to be responsible for clinical governance, and there will be a lead in each practice. Every health professional is expected to take part
- The key components of clinical governance are a comprehensive quality improvement programme, arrangements for continuing professional development, policies for managing risk and tackling poor performance, and clear lines of accountability for the quality of care

Current governance activities

The NHS Executive has outlined several components (referred to as "principles") of clinical governance in primary care,[6] although many related activities were already being undertaken (table 1). One approach to clinical governance would be to link these activities through a unified management structure such as a clinical governance committee, which would have representatives from each activity. A more integrated model of governance would bring all the component activities together to meet the joint objectives of a primary care group, its patients, and the local health authority. In addition, it would determine not only the relation between the component activities, but also when the use of each is appropriate. The challenge is to bring the components together in such a way that the impact of the "whole is greater than the sum of the parts."

The model

The model relates the activities that may be undertaken as part of clinical governance to the tasks of defining, accounting for, and improving quality at three levels—the health professional, the primary healthcare team, and the primary care group (table 2).[3] To account for and improve quality, a group must first define quality in respect of any particular professional activity. Although there are numerous definitions of quality, most are too elaborate to be of direct practical use to primary care groups. Nevertheless, some explicit features of quality have been articulated. These include

Table 2 A model of clinical governance at different levels (1 to 4) in the development of primary care groups*

Level of clinical governance[3]	Defining quality	Defining accountability	Defining quality improvement
Individual healthcare professionals	1 General Medical Council and United Kingdom Central Council for Nursing, Midwifery, and Health Visiting standards, GP's terms of service	1 Information given to health authority about training received, complaints, and participation in audit. Persistent poor performance dealt with	1 Assessment and enhancement of consultation performance
	2 Criteria of consultation competence[21]	2 Summary of audit findings provided	2 Clinical audit
	3 Professional development, eg Royal College of General Practitioners fellowship by assessment	3 Relevant anonymised audits reported to patients	3 Personal appraisal with use of a limited range of implementation methods
	4 Patients' views, evidence based practice	4 Patients involved in choosing audit topics/assessing performance	4 Personal development plans. Full range of implementation methods available
Practice teams	1 NICE annual topics	1 Publication to health authority of extent of practice accreditation	1 Multidisciplinary protocols in use
	2 Local NHS priorities–health improvement programme	2 Participation in audits	2 Multidisciplinary audit taking place
	3 Health needs assessment	3 Publication of results of clinical audits within health service	3 Practice professional development plan
	4 Patient involvement, evidence based practice	4 Relevant anonymised results of audits available to patients	4 Team has fully implemented continuous quality improvement, including systems to identify obstacles to change
Primary care group	1 One or two NICE, national service framework, or health improvement programme topics	1 Performance data reported to health authority. Persistently poorly performing teams and individuals assisted to improve	1 Findings of audits on topics fed back to practice teams and plans for improvement made
	2 More NICE, national service framework, and health improvement topics	2 Annual report on quality of care issued to Commission for Health Improvement and local health and social services	2 Audit findings compared with those of other groups; obstacles to improvement identified
	3 Comprehensive population health needs assessment, with explicit group objectives agreed	3 Annual quality report available to the public. Participation in accreditation schemes for groups	3 Wide range of methods used to overcome obstacles to change
	4 Patient involvement, systematic evidence based practice	4 Patient involvement in assessing quality of services	4 Comprehensive quality management system in place throughout the group

NICE=National Institute for Clinical Excellence.
*Activities in each cell of the model illustrate but do not define what should be expected of primary care groups at each stage of their development to trust status.

the duties of a doctor as set out by the General Medical Council,[7] the code of professional conduct for nurses, health visitors, and midwives,[8] the terms of service for general practitioners,[9] and the requirements for summative assessment.[10] Quality also involves eliminating inequalities in access to effective care between different patient groups in the same practice or between patients of different practices in the group.[1] To these will be added the provision of information about performance at the request of the Commission for Health Improvement[1] and audit of one of the four national topics to be selected each year.[6]

Beyond the minimum level, two factors become more important. The first is improvement, with quality being regarded as part of a process of improvement rather than an end point. The second factor is the patient or user, who is given a greater, or even predominant, role in defining and judging quality. The balance between these two factors will vary because of different perceptions of quality. Thus, a primary care group which is fully committed to quality of care will have accepted that quality is not a static goal, but a condition of continuing and sequential improvement.[11] It will also have involved patients in defining quality from a lay perspective.

Once quality has been defined, the group is accountable for ensuring that its constituent healthcare professionals and teams are providing it. After the recent case in Bristol, the argument for improved and transparent accountability is irrefutable.[12] It has been made plain that corrective action is mandatory when unacceptable levels of performance have been identified. In consequence, groups must establish systems for accountability that ensure that poor performance, however identified, is reported and corrected. In addition to correcting poor performance, accountability means that evidence confirming acceptable performance needs to be gathered and transmitted to a health authority, the Commission for Health Improvement, patients, and health professionals themselves. This would facilitate any discussion on performance between these groups and the primary care group.

However, the system of accountability must also include rules about the need for confidentiality and the point at which it becomes permissible, or even obligatory, to break confidentiality to protect patients. The arrangements must make clear that individual health professionals are accountable for their own performance, but teams and the primary care group are also accountable, not only for performance but its improvement. For example, a primary care group is accountable to its health authority and the community it serves. Furthermore, it is probable that primary care groups operating at more advanced levels will introduce systems for reporting on and accounting for quality improvement activities to their patients.

Although clinical audit is likely to be the principal tool for monitoring the quality of clinical care, it needs to be used in conjunction with a wide variety of methods of implementing change if it is to have maximum impact.[5] Methods of identifying obstacles to change are also needed. These enable informed choice of the most effective way of overcoming the particular obstacles facing individual general practitioners, practice teams, or the primary care group.[3] If clinical audit reveals deficiencies in performance, an analysis of the underlying reasons should indicate the most appropriate corrective actions such as training in consultation skills, reminder systems, targeted education, or restructured healthcare teams. To be fully effective, those responsible for clinical governance will need to be able to access and apply any or all of these interventions as required.

Furthermore, health professionals sometimes experience stresses in their working lives that can cause depression or other illness, and thus impair performance.[22] Primary care groups which value their

Table 3 Examples of clinical governance in a primary care group

Level	Quality problem	Possible solution: quality improvement process	Accountability—including accountability to patients
Individual healthcare professional	GP returning to work after prolonged absence—concerns about consultation competence	Arrange direct observation and assessment of consultation performance with provision of supportive feedback to identify practical approaches, enhance strengths, and correct weaknesses. Follow up as required	Clinical governor can report to the group that no further action is required. Patients can be reassured that a mechanism is in place to monitor and enhance clinical competence
Practice	Assessments of patient satisfaction show problems in securing appointments, complaints in relation to access, and difficulty getting through on the telephone	Evidence based audit of appointments process, rigorous analysis of problem; practical solutions identified and implemented. Further review planned after a reasonable interval	Agree with patients' group the standards for appointments accessibility. Share audit results with patients' group. Report to clinical governor and group board
Primary care group	A few health professionals and practice(s) refuse to participate in clinical governance activity, particularly audit. This is associated with evidence of problems in care, eg failure to reach clinical targets, patient complaints	Group clinical governance team visits the practice(s) to undertake detailed appraisal and identify obstacles to change. Comprehensive package of support offered, including team building, help with organisational development, and practical assistance in responding to the practice's heavy workload	Report to group board and health authority. Persistent failure reported to relevant local or central organisations, eg local medical committee, regional office, or Commission for Health Improvement

members will have a system of governance that includes means of identifying and supporting colleagues who are experiencing such problems.

Since groups will include a variety of professional disciplines working in teams and with other agencies, methods of improving quality that promote collaboration will be needed. These should improve communication and support teamwork and joint decision making. Methods of continuous quality improvement offer such an approach.[13]

The model of governance (table 2) brings together the three elements of defining quality, assuring accountability, and improving quality. It also shows how a group can develop its activities in stages, as it progresses towards becoming a primary care trust.[23] However, the activities indicated in the model at each stage are illustrative rather than prescriptive, and an excessively bureaucratic approach must be avoided. Different primary care groups may choose different activities to meet local needs (see case studies in table 3). However, we recommend that each group should be able to describe its own approach to the tasks of clinical governance identified in the model.

It should also be remembered that clinical governance is not just about making poor practice better, it is also about making good practice even better. The balance between the systems of accountability and quality improvement will be critical to the impact of clinical governance. If the balance is tipped towards quality improvement, many activities may be introduced, but at the risk of poor coordination with the objectives of the group and local or national health service priorities. If the balance is tipped towards accountability, clinicians will find their performance under close scrutiny, but have few resources available to help them improve. Consequently, they will comply only to a limited extent with the demands of clinical governance. Achieving a balance will require agreement on the system of governance between the primary care group, its member professionals, the health authority, and the Commission for Health Improvement.

Implementing clinical governance

The agenda for clinical governance is ambitious, and the resources required to underpin it must not be underestimated or it will be programmed for failure from the outset. For example, the adoption of evidence based practice by a primary care group is a major undertaking. Many clinical and other staff will require education and training, but the group itself is unlikely to contain people with the skills and time to deliver all that is required. Furthermore, the planning and completion of systematic evidence based audit requires expertise that will not often be available within a group.[15] Particular methods of changing performance such as educational outreach and marketing techniques also rely on skills that will not be available in most groups. The information systems needed to support quality improvement and accountability must also be developed.

Therefore, primary care groups will need considerable external support, which is likely to come from audit groups, educational agencies, and health authorities. The creation of regional and national centres with expertise in clinical governance should also be considered in order to provide those elements of support that cannot be provided locally. Since there will be several hundred primary care groups, many of whose problems and experiences are likely to be similar, these centres should also disseminate information about successful approaches to clinical governance in primary care.

Use of the model

Because clinical governance will have such an important role, it must be firmly established in all primary care groups.[2] Practices represented in the group, the health authority, and patients should all have confidence that their own group has an acceptable and effective system of governance. The model may be used by groups to plan and monitor their introduction of clinical governance, and it shows how this may be done in stages. Since the introduction of clinical governance will take time, groups can plan their development at a speed that takes local circumstances into account. This process is in keeping with the proposed development of groups through four stages, leading to the emergence of primary care trusts.[23] However, the activities at each stage in the model are illustrative and intended to promote the development of clinical governance. Although they are not detailed statements of what must occur at each stage, the model does enable groups to identify those aspects of governance that they have implemented, and those that they have yet to implement.

The model could also be used by health authorities or the Commission for Health Improvement to assess the progress of clinical governance in primary care groups. Some groups may face particular problems in introducing governance, and these must be identified so that additional guidance and support can be made available.

Clinical governance in the context of primary care groups has the potential to improve the quality of health care for patients and the working lives of health professionals. The model we have proposed offers a practical framework for interlinking the various activities. It emphasises improving performance, and shows how groups can gradually develop their own system of governance. It offers a feasible approach to the introduction and monitoring of clinical governance in primary care groups, and its wide adoption would be likely to help promote both quality improvement and accountability.

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Towards primary care groups

Managing the future in Bradford

S R Proctor, J L Campbell

This paper describes the processes and experiences of key players in Bradford, West Yorkshire, of setting up primary care groups (PCGs)—from initial reactions to the government's white paper,[1] through configuration and establishing the boards, to planning and delivering the main tasks before going live on 1 April 1999.

Bradford is one of the 10 largest cities in England. Bradford Health Authority serves the population of the city and surrounding areas. It is an area of great diversity, which incorporates some moderately affluent suburban communities as well as areas of substantial deprivation, poor housing, and high unemployment (box). The area is lively and culturally rich and includes some of the most beautiful countryside in England.

The diversity of the area is also reflected in its primary care provision. This includes two total purchasing pilots (groups of general practitioners who purchase hospital and community health services outside fundholding).[1] A range of fundholding practices have collaborated to develop joint contracts for commissioning a range of services. The district also has a substantial number of singlehanded practices, particularly in the inner city, and many of these have collaborated to form a support organisation for small practices. Despite the diverse needs of the communities served by primary care services in Bradford, sharing

Summary points

The introduction of primary care groups from April 1999 heralds some of the most sweeping changes ever in the NHS

The boards of these groups comprise general practitioners and nurses, and social services, health authority, and lay representatives

They have a collective responsibility for commissioning secondary care, delivering primary care, ensuring quality, measuring performance, reducing health inequalities, and improving the health of the population served

The timescale from configuration to "going live" is only eight months

New relationships have to be established, new ways of working developed, new objectives clarified, and action plans set

This is the first of four articles showing how primary care groups have been set up in various areas in Britain

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