# Ten Questions About Clinical Governance

The government's new quality programme for the National Health Service (NHS) is currently being implemented with the setting up of a National Institute of Clinical Excellence (NICE), a Commission for Health Improvement (CHI) and a local system of clinical governance[1]. Whilst the details of NICE and CHI are fairly clear, the implementation of clinical governance in primary care less is well described. Amidst this uncertainty, local commissioning groups up and down the country – Primary Care Groups (PCGs) in England, Local Health Groups in Wales and Local Health Care Co-operatives (LHCC) in Scotland – are now in the throes of setting up their organisations and planning a programme of work for clinical governance. For many, clinical governance still remains a somewhat ill defined and vague concept and there are questions about its nature and implementation. In this editorial I consider some of these issues for discussion and debate rather than offering any definitive answers.

A key question for many primary health care professionals is still just what is clinical governance? Some very helpful insights into this question are available from two recent reports: *Quality assessment for General Practice: Supporting Clinical Governance in PCGs*[2] from the National Primary Care Research and Development Centre (NPCRD) and *Practical advice on the implementation of clinical governance in primary care in England and Wales*[3] from the Royal College of General Practitioners (RCGP).

*Quality assessment for General Practice: Supporting Clinical Governance in PCGs* is a review of the concepts of quality and a discussion of the aspects of care most highly valued by patients, including availability and accessibility, technical competence, communication skills and interpersonal care. Quality is defined as having three elements: accessible health care, high standards of clinical care, and well developed interpersonal skills. The report includes advice about the assessment of patient satisfaction including patient enablement. The RCGP document states that clinical governance is largely a new name for established concepts such as a commitment to high standards, reflective practice, risk management and personal and team development. The tasks of clinical governance are to protect patients, develop people, and develop teams and systems. It gives advice about a programme of work in the first year which starts with a 'diagnostic' phase.

The 'what' question is hopefully somewhat clearer by now but readers may still reasonably ask 'so what is different about clinical governance from what we have been doing so far?' This is an important and relevant question that goes to the heart of the nature of clinical governance. Some of our own current work at the Centre is concerned with this question. Our thinking suggests a number of key differences, one of which is that clinical governance encompasses both quality improvement and accountability[4]. Once quality has been defined, the PCG is accountable for ensuring that its constituent health care individuals and teams are providing it. After a series of high profile medical mishaps such as the Bristol case, the case for improved accountability is irrefutable[5]. Evidence confirming acceptable performance needs to be gathered and shared with the health authority, the Commission for Health Improvement, patients and health care professionals themselves.

How will clinical governance be organised and managed? – particularly as a range of different activities and organisations are currently involved in quality improvement: how will it all fit together? One approach to clinical governance would be to link these activities through a unified management structure with a committee with representatives from each activity. However, the impact of this would be limited because clinical governance requires all these components to be integrated. The challenge is to integrate these components effectively. A key test will be how organisations responsible for postgraduate general practitioner and nurse education will link with audit groups and clinical governors particularly in the development of practice professional development plans[6]. Our deliberations suggest that a more systematic, rigorous and integrated approach to quality improvement will be required which relies on effective methods of changing performance.[4]

How is clinical governance to be funded? The clinical governance agenda is large and ambitious. For example the adoption of evidence-based practice by a PCG is a major undertaking. Large numbers of staff, both clinical and non-clinical will require education and training. How is the time and support going to be

funded? Clinical governance leads cannot deliver clinical governance on their own. Discussions suggest that protected time will be necessary for practice teams. But how is this to be funded? - when even the funding for PCG clinical governors is uncertain at present. Funding for clinical governance is outwith the management allowance. To give protected time to practices will require some radical and innovative change in the organisation and funding of primary care. Opportunities may lie in the modernisation fund. In the mean time clinical governors should build alliances to use existing skills and resources to maximum benefit[5].

How will PCGs involve patients in clinical governance? The consultation document *A First Class Service*[1] stated that 'public involvement in the NHS can act as a lever for quality improvement'. Beliefs and values relating to patient participation are rapidly changing, and there are now calls for a more strategic role for patients in all aspects of the work of the NHS including quality improvement[7]. The General Medical Council has decreed that doctors must develop a positive attitude to patients and listen to their wishes and needs.[8] Smith[9] has recently said, 'patients should no longer be viewed as the enemy but as equal partners with every right to define the quality of care they receive'. At a national level, both NICE and CHI will include lay representatives.

There are examples of effective user involvement in clinical audit.[10] As there is evidence that patients' priorities can differ from those of health care professionals and managers[11], it is necessary to involve patients at the outset in discussing the PCG's objectives for quality improvement. Quality improvement which is guided by the views and experience of users is the true hallmark of quality[4]. That users should be involved is clear but how they can become involved in an effective fashion is yet to established.

How will clinical governance be performance managed? Health authorities and CHI will be required to monitor the quality of care provided by PCGs. Reporting mechanisms and performance management criteria are not yet fully developed. Some health authorities are discussing a set of performance indicators for PCGs. One approach is the use of disease specific indicators, such as the use of ACE inhibitors in heart failure[12]. Others have argued against this narrow approach and have called instead called for broader measures of quality that reflect the generalist nature of primary health care[13]. An interesting development will be whether we will see a greater emphasis on outcome measures and targets over and above measures of process of care.

The General Medical Council in a recent historic move has decreed that: 'Specialists and general practitioners must be able to demonstrate, on a regular basis, that they are keeping up to date and remain fit to practice in their chosen field'. Revalidation will be linked to registration. So, what is the relationship between clinical governance and revalidation? Clinical governance can be regarded as a local system of self regulation which will underpin a national framework of revalidation. After all, a key task of clinical governance is to protect patients from poor performance. What criteria will be used to determine this and how will they differ, if at all, from the criteria for revalidation? Who will be responsible for managing revalidation at a local level and how will this link in with clinical governance? A good clinical governance system should be able to identify under performance long before it becomes a serious threat to patients and take corrective and supportive action. A linked question is how will the system of clinicians governing clinicians work at a local level? Although peer review has been part of quality assessment in general practice e.g. in approving training practices and more recently as part of the GMC performance procedures, it remains to be seen whether it will be acceptable and effective at PCG level.

Will clinical governance work? If clinical governance fails to improve the quality of care, then it will be, and should be replaced by something else. A key issue will be the balance required between continuous quality improvement and accountability. To some extent this is in the hands of health care professionals themselves, but if there are further pressures for greater accountability from managers and the government, then it might lead to an oppressive approach to clinical governance with emphasis on measurement and monitoring. However with doctors and nurses having a significant role in managing the health service, the opportunity is there for health care professionals to develop a credible and effective quality improvement system which meets the needs of the public, the government and the professions.

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