How are primary care groups approaching clinical governance? A review of clinical governance plans from primary care groups in London

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Abstract

Background The aim of this study was to investigate how primary care groups (PCGs) were implementing clinical governance in their first year.

Methods A structured review was carried out of clinical governance plans of 57 PCGs in London.

Results There was considerable variation in content of the plans. Priority areas were generally based on national service frameworks and local health improvement plans. The most commonly included clinical topic was coronary heart disease. Plans tended to focus on quality improvement rather than on dealing with poor performance. There was generally little information on how quality would be monitored, the data required and methods to change clinical practice.

Conclusion Clinical governance plans provide the main public record of PCGs' attempts to improve quality but there is considerable variation in the content of these reports. Plans should provide reliable and comparable data on progress in implementing quality improvement strategies and dealing with poor performance.

Keywords: clinical governance plans, primary care groups, London, quality

Introduction

Amongst the most challenging tasks given to primary care groups (PCGs) is that of clinical governance, the core component of the National Health Service (NHS) quality improvement programme.[1] PCGs now have a statutory responsibility for improving the quality of care provided by primary health care teams and community health staff. The objectives of clinical governance are to ensure that the clinicians practice evidence-based medicine, to reduce variations in access to health services, to improve the outcomes of health care, and to improve the standard of care provided by the NHS.[2]

In its preliminary guidance on clinical governance, the Department of Health required PCGs to establish leadership arrangements, carry out a baseline assessment, and develop an action plan and reporting arrangements (Table 1). However, there was a lack of prescriptive guidance and it was left to PCGs

Table 1 Areas to be covered in clinical governance plans and reports

The four key steps to be undertaken by April 2000

(1) *Establish leadership, accountability and working arrangements*
By April 1999 primary care groups, as well as Health Authorities and NHS Trusts, were to have identified lead clinicians for clinical governance and set up appropriate structures

(2) *Carry out a baseline assessment of capacity and capability*
Baseline assessments carried out in accordance with the guidance were to be completed by the end of September 1999, having agreed a process and time scale with the Health Authority

(3) *Formulate and agree a development plan in the light of this assessment*
In line with guidance, to produce and start to implement an agreed development plan for clinical governance locally; the plan should address closing gaps identified in performance, developing infrastructure, staff and Board developments, planning and determination of priorities, and, where appropriate, set milestones in assessing achievement; primary care groups to agree a process for progress reporting with the Health Authority

(4) *Clarify reporting arrangements for clinical governance within Board and annual reports*
Organizations to be able to deliver routine Board reports on their progress that reflect the guidance and look to both the short and medium term; annual reports should be prepared on what is being done to improve and maintain clinical quality, addressing issues identified in the guidance, and the three key steps described above

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to decide how they would carry out these tasks and what other steps they would take to implement clinical governance.[3] We wished to investigate how PCGs were interpreting the guidance on clinical governance and to see if they were planning to use evidence-based strategies for changing clinical practice.[4] We did this by reviewing the initial clinical governance plans produced by PCGs in London.[5]

Methods

All PCGs in England were required to prepare a clinical governance plan by 1 April 2000. In June 2000, we wrote to all 65 PCGs in London to obtain copies of these plans. Non-responders received a second letter and if they did not respond to this, they were contacted by telephone. We received clinical governance plans from 57 (88 per cent) of the 65 PCGs in London.

We prepared a template to extract key information from each clinical governance plan. The template recorded information on whether and how each PCG achieved each of the four key tasks set by the Department of Health.[6] The template also contained sections on other areas that would also be important in implementing effective quality improvement programmes. These included the resources allocated to clinical governance, the clinical and managerial areas identified as priorities, and the methods used to measure performance and change clinical practice. We also examined what information PCGs were planning to collect to measure the quality of care.

Results

Most PCGs used the Department of Health's four key steps as the basis of their plans and tried to relate their strategy to local health improvement plans and the requirements of national service frameworks. A few plans went beyond this and were much more extensive in the material they covered (Table 2).

Leadership and working arrangements

Twenty-nine (51 per cent) PCGs reported that they had identified a clinical governance lead, most commonly a general practitioner (GP; 16 reports) or a GP and a nurse together (eight reports). Only 19 plans stated the number of members of clinical governance subgroups; these subgroups ranged in size from five to 19 people. The membership of the clinical governance subgroups comprised GPs (14 groups), managers (13 groups), nurses (14 groups), prescribing advisers (11 groups), and lay people (nine groups).

Development of plans

Priority areas for inclusion in clinical governance plans were mainly derived from local documents, such as local Health Improvement Plans, and from national documents such as national service frameworks. Table 3 shows the number of

Table 2 An example of a good clinical governance plan

Greenwich PCG: annual report on clinical governance
• Comprehensive background material
• Includes details of the individuals leading clinical governance and the resources allocated to it
• Relates results directly to the four key tasks set by the Department of Health
• Identifies eight 'building blocks': clinical leadership, clinical supervision, continuing professional development, poor performance, risk management, team building, clinical audit, and input from patients
• Develops clinical indicators around these eight key areas
• Includes a stand-alone development and action plan that follows on from priorities identified in the baseline assessment
• Supporting information included in appendices
• Clearly written and presented

PCGs that identified a particular priority in their baseline assessment, and the number that included that priority in their clinical governance plan.

Topics included in plans

Clinical topics were included in all plans, most commonly coronary heart disease, followed by cervical screening, diabetes, mental health and asthma. In 38 (67 per cent) plans, PCGs discussed the development of disease registers, templates for recording clinical information, and improving clinical records. Prescribing issues (such as cost-effectiveness of prescribing and antibiotic prescribing) were discussed in 30 plans. Many plans also included a commitment to public involvement. Thirteen PCGs identified this as a priority in their baseline assessment and 29 PCGs included targets for patient involvement in their plans.

Risk management strategies and other quality assurance functions were not well addressed in many reports. Performance measurement and quality assurance issues were identified as priorities in the baseline assessment by 19 PCGs and included for action in clinical governance plans by 45 (79 per cent) groups. Issues covered included clinical governance indicators, local protocols and standards, complaints procedures, methods of tackling poor performance, and performance monitoring. Some PCGs included risk management as one method of quality assurance; for example, through monitoring and reporting of adverse events or through significant event audits. Fifty-three (93 per cent) plans included continuing professional development, training and education of primary care staff as core areas. The introduction of personal development plans was included in 36 and practice development plans in 19 clinical governance plans, respectively.

Infrastructure issues were included in most plans. This included information technology (48 plans), such as extending computerization in primary care, and making internet and e-mail facilities more widely available. Despite the frequency of

Table 3 Areas commonly identified as priorities in development plan

	No. of plans (*n* = 57)	Percentage
Collaborative working and partnerships	51	89
Training of clinical and practice staff	53	93
Information and communication technology	48	84
Coronary heart disease	44	77
Risk management and evidence-based practice	40	70
Staffing issues	42	74
Management of performance	45	79
Personal development plans and personal learning plans	36	63
Chronic disease register and disease templates	32	56
Clinical audit	30	53
Prescribing	30	53
Public, patient and user involvement	29	51
Cervical screening	27	47
Diabetes	26	46
Training and workshops in clinical governance	26	46
Clinical guidelines, local protocols and standards	24	42
Mental health	22	39
Communication (newsletters and public meetings)	21	37
Complaints procedure	20	35
Critical incident, adverse event and significant event monitoring	20	35

inclusion of information technology, no plan stated that an information technology professional was a member of the clinical governance subgroup.

Most PCGs (51) included collaborative working with other organizations in their plans (Table 4). This was most commonly with health authorities, and other PCGs. Methods of communicating with the public and professionals about progress in implementing clinical governance included holding public meetings and publishing newsletters (21 plans).

Resources and incentives

Several plans commented that for clinical governance to be successful, it would need to be supported by adequate resources. Twenty (35 per cent) plans stated that financial incentives were in place or were planned, most commonly for achieving prescribing targets (17 plans). The other incentives most frequently mentioned were for taking part in the clinical governance process (eight plans), and in education and training (five plans). Many plans included comments on the problems of trying to implement clinical governance with limited resources and with general practices that had their own problems to address (Table 5).

Addressing inequalities

One of the main objectives of clinical governance is to reduce variations in health care access, process and outcomes. Some clinical governance plans included profiles of their population and some targeted patient groups, such as the elderly, disabled, ethnic minorities and refugees. However, plans rarely included specific details of how inequalities were to be monitored and addressed.

Discussion

Most PCGs adhered to the four key steps issued in national guidance. However, in other areas their approaches to reporting their progress in implementing clinical governance have been highly variable. Our review also showed that certain themes emerge, such as the adherence to national service frameworks and health improvement plans, indicating that such documents are powerful tools for determining clinical governance priorities.

Many PCGs concentrated on establishing leadership and working arrangements. The focus in most plans was getting policies and procedures into place, rather than on changing clinical practice. There was also considerable emphasis on developing teamwork and building collaborative working arrangements with external organizations. Clinical governance plans also tended to emphasize quality improvement, and only 19 plans discussed methods of identifying and tackling poor performance. In the longer term, PCGs will need to implement quality improvement strategies while at the same time developing methods of dealing with poor performance.[7]

Most PCGs tried to link their clinical governance strategies to national service frameworks, most commonly to the cardiovascular diseases framework.[8] Some PCGs also tried to link professional development and educational activities for GPs to quality improvement initiatives in the same areas.[9]

Previous guidance on quality improvement strategies in primary care emphasized the importance of information for measuring quality, measuring progress towards targets to warn of potentially serious failures in clinical services, and ensuring public accountability.[10–12] Forty-eight (84 per cent) of the plans

Table 4 Partners identified in clinical governance plans

	No. of plans	Percentage
Collaborative working and partnerships	51	89
Health authority	27	47
Community trusts	26	46
Acute trusts	15	26
Other primary care groups	12	21
Public health departments	12	21
Local authorities	10	18
Community health councils	7	12
Medical Audit Advisory Groups	7	12
Voluntary sector	7	12
Medical schools and academic institutions	7	12
Local Medical Committees	5	9
Pharmacy teams	5	9
National Institute of Clinical Excellence	3	5
Royal College of General Practitioners	3	5
General Medical Council	2	4
King's Fund	2	4
Professions allied to medicine	1	2
United Kingdom Central Council	1	2

did include information and communication technology as a priority area, including the development of disease registers. However, progress in this area has been slow because of limited financial investment in information technology, and differences in the level of computerization among general practices.[13]

Our results were limited to what PCGs said they planned to do about clinical governance. We were not able to determine whether they implemented the activities they described in their plans or to evaluate the impact of activities that were not

Table 5 Financial issues and problems within general practices – some quotes from the plans

- The financial implications of establishing a comprehensive and effective clinical governance programme that addresses all the needs of a primary care trust have yet to be appraised. However, it is clear that significant additional resources will be required to develop, implement and monitor such a programme including quality care initiatives
- Funding has been an issue from day one. Clinical governance has been made a foundation of the new NHS, although very few new resources have been provided
- The clinical governance group clearly cannot provide the level of involvement required, or indeed cover all the areas necessary, without adequate support staff both in practice and at primary care group level
- Keeping the prescribing budget in check without sacrificing the quality of patient care is one of our greatest challenges
- The use of the word 'clinical' allowed non-medical staff to disassociate themselves from what was designed to be a multi-disciplinary programme ... It was reported how demanding the roles were and how much additional support was needed if the programme was to be successful
- The clinical governance co-ordinators group was unable to attract colleagues in numbers sufficient to promote the active 'community' that had been envisaged

included. None the less, we believe that clinical governance plans do give a reasonable picture of how PCGs are starting to approach clinical governance and the degree to which they are following central priorities, and the limitations of this approach.[14] The plans are also the main method through which other organizations and the public can evaluate the achievements of PCGs in clinical governance. Using clinical governance plans in this way would be helped greatly if there was central guidance on the contents of these reports. This would also allow greater opportunities to learn from the varying strategies being adopted by different PCGs.[15]

Conclusions

PCGs are making progress towards introducing system-wide approaches to quality improvement in primary care. However, there are large differences in how PCGs are approaching clinical governance. Moreover, systems do not yet exist to enable PCGs to undertake group-wide quality monitoring. Ultimately, the test of the success of clinical governance will be whether it results in improvements in the quality of clinical care. To help measure PCGs' achievements, clinical governance plans need to provide comparable data on what progress PCGs are making in meeting this objective.

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Contributors

A.B. and A.M. had the idea for the study and prepared the protocol for the Commonwealth Fund. All four authors were involved in planning the implementation of the study. S.G. obtained and extracted information from the clinical governance plans and carried out the analysis. All four authors contributed to writing the paper. All four authors will act as guarantors for the paper.

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