

Primary care

Primary care groups

Improving the quality of care through clinical governance

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The UK government has set a challenging agenda for monitoring and improving the quality of health care. It is based on a series of national standards and guidelines, a strategy for quality improvement termed “clinical governance,” and a framework for monitoring the quality of care in and performance of NHS organisations (box). Clinical governance is “a 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 To be successful this strategy requires effective leadership by clinicians who have responsibility for improving quality; it must engage the doctors and nurses who provide care on a daily basis; and it must have commitment and support from managers within the NHS.

Clinical governance

Primary care groups and trusts are responsible for implementing clinical governance in primary care. These new organisations bring together general practitioners, nurses, other primary care professionals, and managers to develop services, raise quality standards, commission hospital services, and improve the health of populations of about 100 000 people. Operating initially as subcommittees of existing health authorities, all are expected to become free standing primary care trusts controlling their own budget for the health care of their populations by 2004.² In the past, primary and community services in the NHS have been fragmented, and general practices have not usually worked together as part of a larger organisation. One of the challenges facing primary care groups and trusts in implementing clinical governance is to develop a more corporate culture in which quality improvement becomes a shared enterprise. This will entail greater use of shared learning—that is, joint education and training during which different professions working in primary

Goals of quality improvement strategies in the NHS

National service frameworks, National Institute for Clinical Excellence—set standards, develop guidelines

Clinical governance—deliver care, improve quality

National performance framework, annual appraisal of doctors, Commission for Health Improvement, national surveys of patients—monitor quality and performance

Summary points

Primary care groups and trusts are responsible for implementing clinical governance, including monitoring and improving the quality of care

In their first two years they have concentrated on educating and supporting health professionals and encouraging shared learning

Information about the quality of care provided in general practice is being shared between practices and with the public, often in a form that permits practices to be identified

Many groups and trusts are offering incentives to practices to promote improvements in the quality of care

Sanctions and disciplinary action are rarely used when dealing with poor performance

Limited resources and the pace of change are potential obstacles to future success in improving the quality of care

care learn together and from each other—and a greater openness and willingness to exchange information about quality. It will require the development both of incentives and methods for tackling poor performance.

Primary care groups were established in England in April 1999. Progress in clinical governance during their first year was largely confined to putting in place an appropriate infrastructure, conducting baseline assessments, and establishing priorities.³ At the end of their second year we can begin to assess how they are implementing clinical governance. In this article we concentrate on the broad approaches to quality improvement that are being adopted; we use evidence from a recent survey.⁴

National tracker survey

The national tracker survey is a longitudinal survey of 72 of the 481 primary care groups established in England; it aims to evaluate their achievements and identify features associated with success in performing

their core functions, including quality improvement. The first survey was completed in December 1999³ and the second in December 2000.⁴ By October 2000, two of the groups in our original sample had merged with each other, and five had become trusts. Details of the survey were summarised in the first article in this series.⁵ The evidence cited in this article is derived from postal questionnaires returned by 49 (68%) of those who were in charge of clinical governance for their group or trust in 1999 and by 58 (81%) of those who were in charge in 2000. Forty eight (83%) of those responsible for clinical governance were general practitioners, but 20 (34%) groups and trusts had a general practitioner and a nurse who shared lead responsibility for implementing clinical governance. In these cases, only one of them completed the questionnaire.

Shared learning and partnerships

Primary care groups and trusts are using education to improve quality. By December 2000, 54 of 58 (93%) were actively encouraging development plans for their practices and implementing personal learning plans for general practitioners, compared with only two (4%) of those surveyed in 1999. Many of the initiatives created opportunities for learning to be shared and partnerships to be developed with other organisations (table 1).

Half day educational events organised for the whole primary care group were a notable initiative, promoting shared learning and reducing the isolation of practices. The commonest model used was for all practices in a primary care group to close for one afternoon a month, with emergency cases being covered by doctors from a neighbouring group. Sometimes these meetings were attended only by doctors and sometimes by the entire primary care team. In some cases regular attendance rates were higher than 95%.

These activities will represent a new point of departure for general practice in the United Kingdom. Before primary care groups were established, general practitioners worked largely independently of each other and may never have needed even to speak to doctors practising nearby. General practitioners and other practice staff are reported to be keen to take up opportunities to meet and learn together even though participation is voluntary. Similarly, encouraging cross practice audits of clinical care and working to develop local guidelines provide opportunities for health professionals to work together on quality improvement.

As well as facilitating shared learning between members of the group, many of those responsible for clinical governance also reported engaging in initiatives with other groups, including hospital trusts and providers of community health services.

Sharing information

To be successful, shared learning and other joint activities require a willingness to exchange information about quality of care. Successfully implementing clinical governance requires developing this willingness. In the past, information about the quality of care provided by doctors and nurses in general practice may not even have been shared with colleagues in the same practice depending, for example, on whether the practice undertook a clinical audit. However, infor-



mation from a clinical audit was hardly ever shared outside a practice. This is changing rapidly. Primary care groups and trusts already have access to routine data on practice activities, such as rates of cervical cytology and immunisation, and will increasingly have access to the results of cross practice audits.

There is an increasing move towards making information about quality of care more widely available. Virtually all groups and trusts surveyed were making anonymised information on quality available, but many were also providing information—to board members and other practices—that permitted individual practices to be identified (table 2). This represents an important change in both the practice and culture of primary care, where even sharing information with professional colleagues has been rare. Making such information available to the public is an even more radical step, and while plans to do this are much less advanced, some primary care groups and trusts are beginning to take tentative steps in this direction.

Providing incentives

Promoting shared learning and disseminating information help improve quality by increasing the acceptability of the need for improvement and through peer pressure. Although the surveys showed that some practices are still hostile to these changes, the majority reported that they had at least acquiesced to the new agenda if not enthusiastically embraced it.

Additionally, primary care groups and trusts are using financial incentives to promote quality improvement. Excluding prescribing incentive schemes, 50% (29/58) reported using specific quality incentive schemes in 2000, compared with 29% (14/49) in 1999. In general, these were associated with participating in audit activities or rewarding those who met targets.

During the past three years the government has been experimenting with new types of contracts for general practice (for example, the personal medical services pilot scheme) in which the nature and quality of services

Table 1 Most common clinical governance schemes for sharing learning and developing partnerships among primary care groups and trusts, October 2000*

Scheme	No (%) of groups and trusts participating (n=58)
Develop local guidelines for coronary heart disease	41 (71)
Organise activities with hospital trusts	35 (60)
Organise half day training events for all practices	33 (57)
Organise activities with other primary care groups	33 (57)
Use cross practice audits	25 (43)
Organise activities with community health services	22 (38)

Table 2 Primary care groups and trusts sharing information on quality of care, October 2000^a

Information available to	No (%) groups and trusts sharing or planning to share information (n=58)	
	Anonymised	Identifiable
Board or executive of primary care group or trust	16 (28)	36 (62)
General practices	21 (36)	29 (50)
Public	24 (41)	5 (9)

to be provided can be more closely specified. Altogether, 29% (17/58) of those responsible for clinical governance reported using contractual arrangements to improve quality. It seems likely that this trend will continue, and modifications to the main contract for general practitioners are likely to include specific payments linked to the quality of the care provided.

Dealing with poor performance

The approaches taken by groups and trusts to deal with poor performance in practices have been supportive and educational. Those responsible for clinical governance described their strategies as including having informal discussions, providing training for practices, and allocating resources to give extra to poorly performing practices. Conducting clinical audit and sharing information were also used as means of addressing poor performance; these approaches were taken to try to engage poorly performing practices with the quality improvement strategies being used by their peers.

Only 3% (2/58) of those responsible for clinical governance said that they intended to withdraw resources from poorly performing practices, and only 9% (5/58) had established any formal disciplinary procedures.

During 1999 and 2000, the NHS established formal procedures to identify poorly performing general practitioners. In most cases, these operate at the level of the health authority (that is, among several primary care groups in a geographical area). Because of this, groups and trusts have been able to adopt a supportive role, leaving disciplinary procedures to a higher tier of the NHS. Many of those responsible for clinical governance told us that in order to engage health practitioners in quality improvement, it is essential for them to be seen as helpful to and supportive of practices. However, this may become more difficult as groups become primary care trusts, a move that will ensure that they take on more responsibility for the quality of care provided by clinicians in their area.

Can groups and trusts improve quality?

The strategy developed by the UK government to improve the quality of health care is ambitious and wide ranging. Reports on progress in implementing this strategy come from those with responsibility for it, so their views may not fully reflect the activity under way or the views of grass roots primary care doctors and nurses. However, our research in primary care suggests that the strategy is resulting in substantial activity that is beginning to bring about a significant cultural change among both managers and clinicians in primary care. In many cases clinical governance is building on previous initiatives, such as the work of medical audit advisory groups. Nevertheless, the

changes that have taken place have been impressive given that clinical governance and primary care groups were only 18 months old at the time of the survey reported in this paper.

What has not yet been shown is that any of this activity has improved the quality of care because it is still too early to tell. However, the educational approaches being taken, which emphasise engaging practitioners in regular quality improvement activities, are soundly based. Furthermore, the managerial agenda is relatively well aligned with what primary care practitioners themselves wish to achieve—that is, better care for important health problems such as coronary heart disease. Again, this is likely to encourage clinicians to participate in quality improvement.

Implementing clinical governance is not without its problems. Limited time and resources remain important constraints restricting the speed at which change can take place. Altogether, 41% (24/58) of those responsible for clinical governance did not have a budget to support the implementation of clinical governance and 35% (20/58) said that they had little or no support. In some respects general practitioners seem to have engaged enthusiastically with shared learning activities, but our research suggests that the pace of reform in the NHS risks making them feel disengaged.

There is also a significant tension between the desire to engage practices in quality improvement and the need to ensure that poor performance is addressed. Primary care groups and trusts are focusing their energies on facilitating shared learning and offering support to practices. Where such supportive approaches fail to improve performance, it may be necessary to adopt other tactics. If responsibility for poor performance moves from health authorities to primary care trusts, the conflict between these two roles is likely to become more evident to those who are responsible for clinical governance.

Much has been achieved by primary care groups and trusts in their first 18 months. The elements of clinical governance, while varying according to local needs, are now mostly in place and changes are beginning to take effect. However, the task is formidable and the barriers should not be underestimated. Quality improvement cannot be imposed by decree but needs to be maintained and developed by adequately funded infrastructures. There remains a risk that the organisational structures that have been developed are not sufficiently established or funded to ensure that the expected improvements in the quality of health care can be delivered.

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