Clinical governance in Scotland: an educational model

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SUMMARY
The concepts underpinning clinical governance are similar throughout the United Kingdom but models for its implementation will differ widely. This model aims to enable practices to identify areas for further learning and development against specific outcomes. Criteria sets and standards are suggested and a governance plan is used to allow practices to prioritise their objectives. Resourcing will always be a major issue and such a model should be fully evaluated.
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Introduction

THE concepts underpinning clinical governance are similar in the four White Papers covering Scotland,[1] England,[2] Wales,[3] and Northern Ireland;[4] however, the structures for the implementation and monitoring processes vary in their detail.

This paper relates to a model for Scotland. The size of its population is roughly the equivalent of one large English region. Scotland's White Paper, *Designed to Care — Renewing the National Health Service in Scotland* was published in June 1998 with one paragraph (68) referring to clinical governance. A working group, led by the chief nursing officer, produced a consultation paper which was distributed widely with resulting comments helping to produce the definitive guidance on the implementation of clinical governance in the NHS in Scotland.[5] However, despite this there has been an increasing demand from local healthcare co-operatives (LHCCs) for a more structured and definitive programme.

There are five directors of postgraduate general practice education in Scotland. They provide leadership and direction on all matters relating to education for general practitioners and accredit educational material for the Postgraduate Educational Allowance. They have an infrastructure of associate advisers (course organisers in England and Wales, tutors in Northern Ireland) to deliver educational programmes. They therefore possess the necessary experience to help the chief executives of the new primary care trusts to deliver clinical governance.

The five directors collaborated to produce a generic model, which would provide a structured and cohesive framework of a wide range of activities already in existence and supported by current funding. The model aims to give a sense of direction to those who may want something more specific to build upon rather than some other models in existence.[6,7] The objective is to specify governance tasks and then to enable practices to identify areas where learning and development are required, in order to deliver specific governance outcomes.

An educational model for clinical governance

The model for clinical governance consists of four domains and three levels of attainment.

The four domains are clinical effectiveness, risk management, delivery of patient services, and continuing professional development.

Clinical effectiveness and risk management (Boxes 1 and 3) cover:

— disease management;
— prescribing;
— significant event analysis; and

	Level 1	Level 2	Level 3
Clinical effectiveness			
A. Disease management	Disease register and practice protocol for diabetes, asthma, ischaemic heart disease and one further option as decided locally, such as a fourth chronic disease, leg ulcer management, postnatal depression management.	Continued updating of prevalences of chronic diseases.	
	Quality process and outcome measures for each disease (Box 4).	Target set at 50% between baseline and standard of quality process and outcome measures achieved.	Achieving or within 80% of standards for process and outcome measures.
B. Prescribing[45]	Ratio of inhaled steroids to sympathomimetic bronchodilators for asthma.	Improvement in ratio towards 0.75.	Steroid-bronchodilator ratio 0.75.
	Defined daily dose (DDD) per 1000 adjusted prescribing units (PUs) for hypnotics and anxiolytics.	Minimum of 10% reduction in the defined daily dose per 1000 PUs for hypnotics and anxiolytics.	Maximum of 20% variation between highest and lowest prescribed DDD per 1000 PUs for hypnotics and anxiolytics.
		Top five non-steroidal anti-inflammatory drugs (NSAIDs) account for 85% of NSAIDs prescribed.	Variation in drug expenditure no greater than 20% within a local health co-operative (LHCC).
		Reduce by 50% prescribing of two drugs of limited clinical value as decided locally.	Variation in generic prescribing no greater than 5% within an LHCC.
			Evidence-based substitutions of two comparable drugs as decided locally.
Risk management			
A. Significant event analysis[46]	Three to be analysed to a set format.	Further five to be analysed with previous three re-visited.	SEAs analysed should involve hospital or community sector.
B. Identification of at-risk groups	List of all asthmatics on a beta-blocker.	Justification for any asthmatic on a beta-blocker.	5% reduction from baseline in smoking population aged 16 to 65.
	Register of smokers aged 16 to 65 years to be constructed.	Written protocol for smoking cessation with evidence-based interventions identifiable.[47]	

Box 1. Clinical effectiveness and risk management.

— identification of at-risk groups.

Delivery of patient services and continuing professional development (Box 2) cover:

— patient access;
— staff development and teamwork; and
— individual and multiprofessional continuing professional development.

The three levels of attainment offer flexibility for all practices at any stage of their development, to address the highly complex issues of collecting, analysing, and feeding back data.

Level 1 provides a benchmarking exercise to allow LHCCs to see the spread of activity in their constituent practices. Much of these data will already be collected.[8]

Levels 2 and 3 will provide a framework to allow practices to measure their progress towards the pre-agreed desired standards.

The practice will be the denominator for the model, as it is the functional unit of care and therefore for clinical governance. However, the model also recognises the importance of the individual within the practice team through consultation satisfaction, skills in information technology, and individual continuing professional development.

There will be exemplar practices demonstrating areas of high quality care, the 'norm' representing the majority of practices, and a small number of practices with problems of underperformance, who would require support and encouragement. It would be possible for a practice to be an exemplar in one category, the 'norm' in another, and potentially under-performing in another.

Criteria and standards

A measure of the success of clinical governance will be the achievement of explicitly set standards which should be in the public domain. Full advantage was taken of the availability of the Scottish Intercollegiate Guidelines Network (SIGN)[9] for providing many of the review criteria which are

	Level 1	Level 2	Level 3
Practice structure A. Patient Access	Surgery satisfaction questionnaire administered (SSQ).[48] Consultation satisfaction questionnaire (CSQ) administered for each partner.[49] Appointment availability audit. Waiting time audit. Consultation time audit.	SSQ and CSQ or 'enablement'[50] or general practice assessment survey (GPAS)[51] questionnaires administered. Target set at 50% difference between baseline and standard.	Standard reached in each area.
B. Staff development and teamwork	A written health and safety policy[52] should be available. A written staff appraisal system for the whole practice should be available. Protected time for team development should be documented.	Audit of health and safety policy demonstrated. Actual appraisal of each member of staff including medical and nursing staff. Training manual and diagnostic tool for assessing teamwork at basic level.	Diagnostic tool to measure teamwork at higher level.[53]
Continuing professional development A. Multiprofessional	Needs assessment for governance plan (level 1).	Needs assessment for governance plan (level 2).	Needs assessment for governance plan (level 3).
B. Individual	30% of postgraduate educational allowance (PGEA) as practice-based. Information management and technology (IM&T) skills diagnostic checklist completed.[54,55]	70% practice-based for PGEA Complete IM&T course or exemption	Own self-directed learning plan

Box 2. Practice structure and continuing professional development (CPD).

broadly similar to those for the same diseases published elsewhere.[10]

The standards set in the model are optimal, based on consensus and achievable under ideal working conditions. The need for minimal standards, based on actual evidence, will be of increasing relevance as systems for collecting valid and reliable data improve.

However, at present we acknowledge that there is still much to debate about the process of setting and implementing standards. Some examples of standards from the model are:

- patients should be seen within three working days (suggested standard 90%);[11]
- patients should be seen within 20 minutes of their appointment time[12] (suggested standard 80%);
- the average time spent with a patient should be eight minutes[13] (suggested standard 30%);
- the prevalence of identified diabetes should be between 1% and 2% of the practice population;[14]
- HbA_{1c} should be recorded for patients with diabetes in the past year[15] with a target level of less than 7%[16] (suggested standards 95% and 30%);
- patients with coronary heart disease should be on aspirin[17] (suggested standard 90%); and
- there should be a reduction in the practice smoking population aged 16 to 65 years over three years[18,19] (suggested standard 5% reduction).

The practice governance plan

The directors' responsibility is to facilitate the meeting of educational needs. At present, the postgraduate educational allowance (PGEA) is at best a fairly crude system for providing continuing education for doctors with much emphasis on didactic, lecture-based formats, and often supported by the pharmaceutical industry in highly selected areas, such as prescribing.[20] The precise role of the latter as a provider of education merits wide debate.

The educational element of the model will be achieved through the governance plan. By stating specifically what is to be achieved, the needs of a practice team can be more easily identified and prioritised. The plan therefore enables practices to establish and meet their governance objectives through a continuing series of small focused tasks. The practice governance plan could be set out as shown in Box 4.

An example of how the plan might work in practice is shown in Figure 1. The data from all four areas are collated by the practice governance coordinator and sent to the LHCC regional centre where they are analysed and prepared for peer comparison and sent back to consider any differ-

ences and perceived difficulties the practice may have in moving towards levels 2 and 3. The practices are all asked to bring their results to the next meeting of the LHCC to explore the best way of helping those practices who are struggling and to begin to address issues of data collection and quality, and staff training, e.g. with information technology.

This process is continued at intervals for the other areas of level 1 until the LHCC are ready to move on to levels 2 and 3. Those practices who require help with specific areas are offered the support of the local governance team who can call on the wider educational network as needed.

Discussion

Clinical governance must become a continuous but evolving process. This model follows the advice given by the Scottish Executive although the model content reflects aspects of daily general practice as performed throughout the United Kingdom. The model is intended to offer direction and encourage discussion about the 'best mix' which will represent the many interpretations of clinical governance at a local level. It should not be taken as being prescriptive.

The clinical governance process

The setting up of a local clinical governance infrastructure requires a strong focus on the identification of educational needs. The strength of clinical governance will be determined by the ability to deliver on explicitly set national standards involving the many political and patient groups in existence. There is conflicting evidence from the scanty published literature on the subject of whether a 'top down'[21] or 'bottom up'[22] approach affects performance in meeting a standard, although we felt that suggestions for the former would produce a more rigorous debate about the latter.

The concept of a 'managed clinical network'[23] with close co-ordination at practice, locality, and trust levels, can only effectively inform plans for health improvement if there is a system of strong educational support resulting in a sound peer review system based on valid and reliable data. The accuracy, precision, and completeness of clinical coding will need to be given a high priority.[24] The introduction of clinical audit in the 1990s[25] led to the unfocused collection of huge amounts of data[26] at significant cost[27] with little meaningful change.[28] Accountability, which is such a vital part of clinical governance, should ensure that such mistakes are not repeated.

The skills needed to review existing standards, develop new ones, and provide for the wide range of educational needs that will arise, will be beyond the scope of many LHCCs. Existing resources, such as postgraduate education departments, the Royal College of General Practitioners, and various audit groups are well-placed to meet many of these needs, while the Clinical Standards Board for Scotland will ensure that adequate processes are being implemented. The ability to feed back reliable comparative data on outcomes of the quality of care being provided at a local level may require a centralised database system which, in Scotland, is currently lacking.

Asthma: process and outcome measures[56]

Review in past year
Peak flow recorded once in past year
Peak flow within 80% of best achievable rate
Inhaler technique recorded as checked in past year
Spacer device used for preventer MDI
Smoking status (active or passive) recorded

Ischaemic heart disease: process and outcome measures[57]

Review in past year
Systolic and diastolic blood pressure recorded in past year
Last blood pressure recording less than 140/85
Smoking status recorded in past year
Total cholesterol recorded in past five years
Total cholesterol less than 5.0 in past three years
Aspirin prescription status recorded

Diabetes: process and outcome measures[58]

Review in past year
$HbA1_c$ recorded in past year
$HbA1_c$ less than 7%
Systolic and diastolic blood pressure recorded in past year
Blood pressure less than 140/80 in past year
Proteinuria recorded in past year
Fundi checked in last year
Feet checked in last year
Smoking status recorded in past year

Leg ulcer management[59]

Register of current leg ulcer patients
Ankle brachial pulse ratio recorded for each by Doppler
Use of graduated compression bandaging defined
Five year follow-up plan

Postnatal depression management[60]

Procedure for screening with Edinburgh Postnatal Depression Scale (EPDS)[61]
Register of patients scoring greater than 10
Written educational material available
Referral and follow-up policy

Box 3.

Stage 1:	Initial meeting with all staff to discuss and explain governance and its implications.
Stage 2:	Prioritise areas requiring action.
Stage 3:	Construct specific questions around the priorities.
Stage 4:	Create an action plan to include allocation of learning activities.
Stage 5:	Agree on a date for feedback.

Box 4. Stages for constructing a practice governance plan.

The model, education and change

Many of the techniques used in this model draw on evidence from the few reviews available on successful educational interventions in continuing medical education.[29-31] Strategies for implementing change, such as audit with targeted feedback, are reinforced over the three levels.[32,33]

Educational need should be based on evidence from a range of sources.[34] The model builds a more cohesive educational approach for practices around audit, clinical effectiveness, outcomes of research, and continuing education.[35] In many ways the ultimate attraction of the model is its emphasis on relating education to the work that doctors actually do.[36,37]

Learning, not teaching, is more likely to result in changes

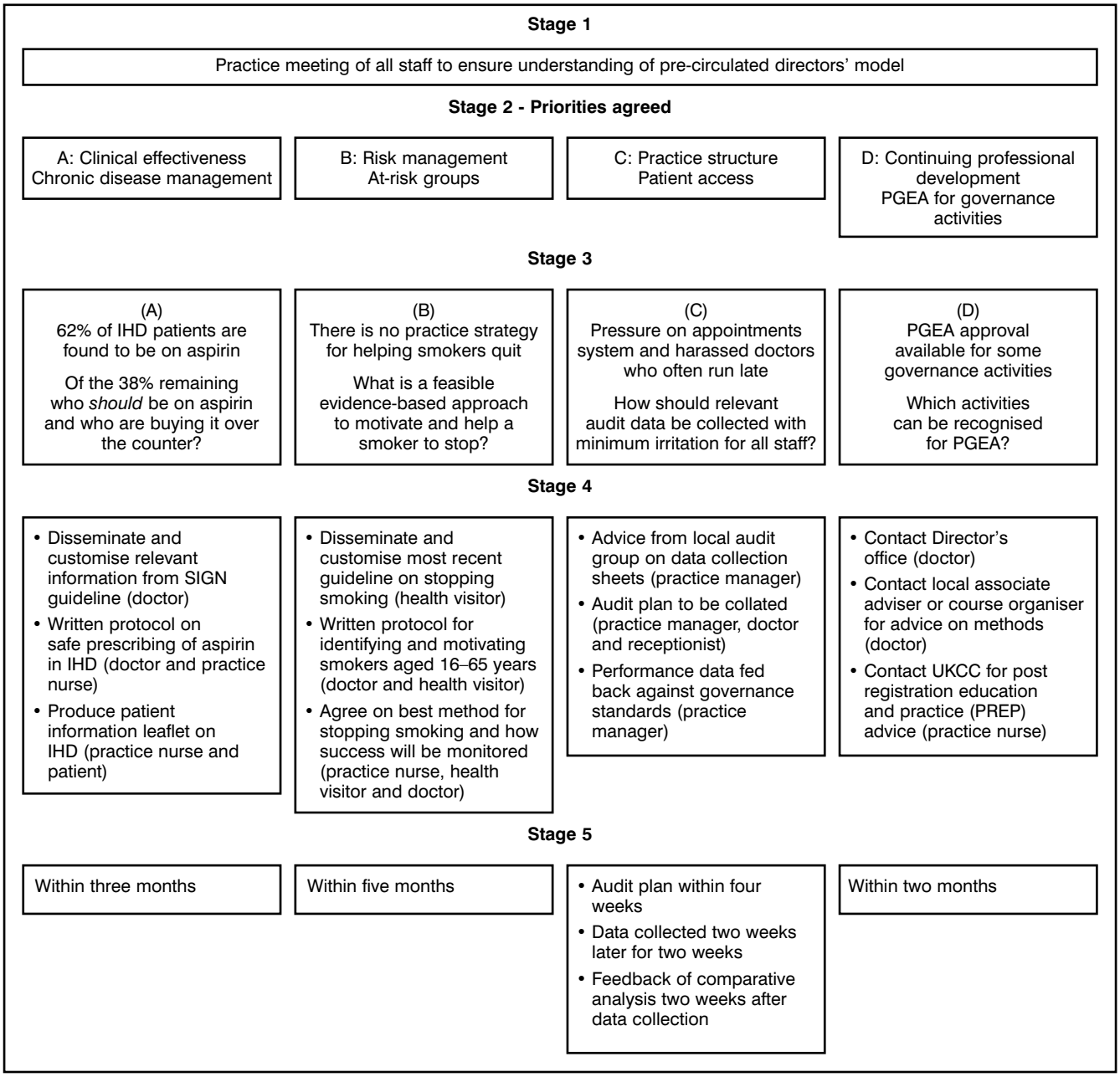

Figure 1: Example of clinical governance plan in action.

in practice.[38] Geboers recommends a task-orientated approach to continuing quality improvement and successful implementation of change[39] The governance plan is based on this premise and marks a shift away from traditional styles of expert-led teaching to a more focused experiential learning style.[40]

The widespread passive dissemination of SIGN guidelines is in itself insufficient to induce change.[41] Integrating effective strategies for implementing change, such as educational interactive meetings and practice visits[42] within the governance plan, might increase the opportunity for a relevant guideline to be adapted to local circumstances, thus promoting its uptake by an LHCC more effectively. The key is to ensure that all stakeholders involved in the guideline are included in the discussion.[43]

Limitations of the model

While recognising that the model offers a wide range of staged activities, we accept that high-achieving practices may not be adequately challenged by those offered. It is more likely, however, that many practices will struggle to put in place even the basics for the first of the three levels. One reason for this could be the exposure of dysfunctional teams with individuals who may try to block any move to implementing change. Governance has a vital role in supporting those within such practices who may be, or may become, despondent at their thwarted efforts to achieve task-orientated goals. Crucial to this will be the development of team

building, small group working, and leadership skills, all of which are essential for effective quality improvement.[44] By providing direction and addressing areas of practice need through the governance plan, the model can drive development of these skills.

It is also acknowledged that protected time will be required for practice teams to give adequate attention to the monitoring of their governance objectives. A formal evaluation of a governance plan over a period of three years would be helpful in informing discussion on the time and resources needed to support clinical governance in a wider context.

This paper aims to inform discussion on practical ways to measure certain aspects of the quality of care (quality assurance). It also reinforces the imperative for LHCCs and Trusts to respond to the many problems — human and technological — which will undoubtedly accrue (clinical governance). The latter offers a bewildering choice of options and potential obstacles which will require a sophisticated level of management, and possibly funding, which much of general practice currently lacks. If education is the driver then good practice by all will be encouraged and poor practice, where identified, will be addressed and, where possible, rectified. The need to avoid creating a culture of blame is paramount. Governance should be seen as an opportunity, not a threat.

References

1. The Secretary of State for Scotland. *Designed to Care: Renewing the National Health Service in Scotland.* Edinburgh: Stationery Office, 1997.
2. Secretary of State for Health. *The new NHS*. [Cm3807.] London: Stationery Office, 1997.
3. Secretary of State for Wales. *NHS Wales: Putting Patients First.* London: Stationery Office, 1998.
4. Minister for Health and Social Services. *Northern Ireland. Fit for the Future*. Belfast: Department of Health and Social Services, 1998.
5. Department of Health, (Scottish Office). *Clinical Governance*. [MEL (1998) 75.] Edinburgh: DoH, 1998.
6. Royal College of General Practitioners, Scottish Council. *Practical Guidance on the Implementation of Clinical Governance in Primary Care in Scotland.* Edinburgh: RCGP, 1999.
7. Baker R, Lakhani M, Fraser RC, Cheater FM. A model for clinical Governance for Primary Care Groups. *BMJ* 1999; **318:** 779-783.
8. Department of Health (Scottish Office). *Statement of fees and allowances*. [Para 30. Regulation 31.] NHS (General Medicine and Pharmaceutical Services) (Scotland) Regulations, DoH, 1974.
9. Scottish Intercollegiate Guidelines Network (SIGN). *Clinical Guidelines: criteria for appraisal for national use.* Edinburgh: SIGN, 1995.
10. Campbell SM, Roland MO, Shekelle PG, *et al*. Development of review criteria for assessing the quality of management of stable angina, adult asthma and non-insulin dependent diabetes mellitus in general practice. *Qual Health Care* 1999; **8:** 6-15.
11. Allen D, Leavey R, Marks B. Survey of patients' satisfaction with access to general practitioners. *J R Coll Gen Pract* 1988; **38:** 163-165.
12. Heaney DJ, Howie JGR, Porter AMD. Factors influencing waiting times and consultation times in general practice. *Br J Gen Pract* 1991; **41:** 315-319.
13. Wilson A. Consultation length in general practice: a review. *Br J Gen Pract* 1991; **41:** 119-122.
14. Howitt AJ, Cheales NA. Diabetes registers: a grass roots approach. *BMJ* 1993; **307:** 1046-1048.
15. British Diabetic Association. *Recommendations for the management of diabetes in primary care.* London: BDA, 1993.
16. Krans HM, Porta M, Keen H (eds). *Diabetes care and research in Europe: the St. Vincent Declaration action program.* Copenhagen: World Health Organisation Regional Office for Europe, 1992.
17. Antiplatelet Trialists' Collaboration. Collaborative overview of randomised trials of antiplatelet therapy. 1: Prevention of death, myocardial infarction and stroke by prolonged therapy in various categories of patients. *BMJ* 1994; **308:** 81-106.
18. Silagy C, Mant D, Fowler G, Lancaster T. Nicotine replacement therapy for smoking cessation. Database of Abstracts of Reviews of Effectiveness. In: *The Cochrane Library*, Issue 2. Oxford: Update Software, 1998.
19. Fiore MC, Bailey WC, Cohen SJ, *et al*. *Smoking cessation.* Rockville, MD. Agency for Health Care Policy and Research, US Department of Health and Human Services, 1996. [Clinical practice guideline No. 18. Publication No.96-0692.]
20. Kelly MH, Murray TS. Motivation of general practitioners attending postgraduate education. *Br J Gen Pract* 1996; **46:** 353-356.
21. Butler C, Peters J, Stott N. Glycated haemoglobin and metabolic control of diabetes mellitus: external versus locally established clinical targets for primary care. *BMJ* 1995; **310:** 784-788.
22. Mashru M, Lant A. Interpractice audit of diagnosis and management of hypertension in primary care: educational intervention and review of medical records. *BMJ* 1997; **314:** 942-948.
23. Management Executive, Scottish Office. *Introduction of Managed Clinical Networks within the NHS in Scotland.* [MEL (1999) 10.] Edinburgh: DoH, 1999.
24. McKee M. Routine data: a resource for clinical audit? *Qual Health Care* 1993; **2:** 104-111.
25. Department of Health and Welsh Office. *General Practice in the NHS: a new contract.* London: HMSO, 1989.
26. Smith A. Data collection in general practice. *BMJ* 1998; **316:** 1600.
27. Walshe K. Opportunities for improving the practice of clinical audit. *Qual Health Care* 1995; **4:** 231-232.
28. Hearnshaw H, Baker R, Cooper A. A survey of audit activity in general practice. *Br J Gen Pract* 1998; **48:** 979-981.
29. Davis DA, Thomson MA, Oxman AD, Haynes RB. Evidence for the effectiveness of continuing medical education. A review of 50 randomised controlled trials. *JAMA* 1992; **268:** 1111-1117.
30. Oxman AD, Thomson MA, Davis DA, Haynes RB. No magic bullets: a systematic review of 102 trials of interventions. *CMAJ* 1995; **153:** 1423-1427.
31. Davis DA, Thomson MA, Oxman AD, Haynes RD. Changing physician performance: a systematic review of CME strategies. *JAMA* 1995; **274:** 700-705.
32. Wensing M, Grol R. Single and combined strategies for implementing change in primary care: a literature review. *Int J Qual Health Care* 1994; **6:** 115-132.
33. Bero LA, Grilli R, Grimshaw JM, *et al,* on behalf of the Cochrane Effective Practice and Organisation of Care Review Group. *BMJ* 1998; **317:** 465-468.
34. Violato C, Marini A, Toews J, *et al*. Feasibility and psychometric properties of using peers, consulting physicians, co-workers and patients to assess physicians. *Acad Med* 1997; **72:** 82-84.
35. Calman K. *A review of continuing professional development in general practice: a report by the Chief Medical Officer.* London: Department of Health, 1998.
36. Horder J, Bosanquet N, Stocking B. Ways of influencing the behaviour of general practitioners. *Br J Gen Pract* 1986; **36:** 517-521.
37. Knowles M. *The adult learner: a neglected species.* Houston, TX: Gulf Publishing. 1990.
38. Fox RD, Bennett NL. Learning and change: implications for continuing medical education. *BMJ* 1998; **316:** 466-468.
39. Geboers H. Implementing continuous quality improvement in general practice: the whole package or a series of projects? *Qual Health Care* 1997; **8:** 77.
40. Stanley I, Al-Shehri A, Thomas P. Continuing education for general practice. 1: Experience, competence and the media of self-directed learning for established general practitioners. *Br J Gen Pract* 1993; **43:** 210-214.
41. Implementing clinical guidelines: can guidelines be used to improve clinical practice? *Effective Health Care* 1994; No. 8.
42. Bero LA, Grilli R, Grimshaw J, *et al*. Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings. *BMJ* 1998; **317:** 465-468.
43. Effective Health Care. *Getting evidence into practice.* York: University of York, 1999.
44. Wicock PM, Campion-Smith C. Never mind the quality: feel the improvement. *Qual Health Care* 1998; **7:** 181.
45. Audit Commission. *A prescription for improvement: towards more rational prescribing in general practice.* London: HMSO, 1994.
46. Royal College of General Practitioners. *Significant event auditing.* [Occasional Paper 70.] London: RCGP, 1995.
47. Raw M, McNeill A, West R. Smoking cessation guidelines for health professionals. A guide to effective smoking cessation interventions for the health care system. *Thorax* 1998; **53 suppl 5 [2]:** S1-S19.
48. Baker R. Development of a questionnaire to assess patients' satisfaction with consultations in general practice. *Br J Gen Pract*

1990; **10:** 487-490.
49. Baker R, Whitfield M. Measuring patient satisfaction: a test of construct validity. *Qual Health Care* 1992; **1:** 104-109.
50. Howie JGR, Heaney DJ, Maxwell JJ, *et al*. Quality at general practice consultations: cross sectional survey. *BMJ* 1999; **319:** 738-743.
51. General Practice Assessment Survey. In: Roland M, Holden J, Campbell S. *Quality assessment for general practice: a guide for primary care groups.* Manchester: National Primary Care Research and Development Centre, 1998.
52. Health and Safety at Work Regulations 1992. In: *Croner's General Practice Management*. Croner Publication, 1998.
53. Anderson NR, West MA. Measuring climate for work group innovation: development and validation of the team climate inventory. *J Organis Behav* 1998; **19(3):** 235-258.
54. Information for Health. *An information strategy for the modern NHS 1998–2005. A national strategy for local implementation*. NHS Executive,1998.
55. Department of Health (Scottish Office) *A strategic framework for information management and technology in the national health service in Scotland taking action 1998-2002.* Scottish Office DoH, Management Executive, Computing and IT Strategy Division, 1998.
56. Scottish Intercollegiate Guidelines Network. *Primary care management of asthma*. Edinburgh: SIGN, 1998.
57. Scottish Intercollegiate Guidelines Network. *Secondary prevention after myocardial infarction.* Edinburgh: SIGN, 1999.
58. Scottish Intercollegiate Guidelines Network. *Report on a recommended minimum data set collection for people with diabetes.* Edinburgh: SIGN, 1998.
59. Scottish Intercollegiate Guidelines Network. *The care of patients with chronic leg ulcer.* Edinburgh: SIGN, 1998.
60. Clinical Resource and Audit Group (CRAG), Working Group on Maternity Services. *Report on detection and early intervention in postnatal depression.* Edinburgh: CRAG, 1996.
61. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. *Br J Psychiatr* 1987; **150:** 782-786.