Clinical governance — a new label for old ingredients: quality or quantity?

THE title 'clinical governance' is now part of our vocabulary, although it is not clear to many what it entails.[1] It is stated to be a famework to enable clinicians to continuously improve quality and safeguard standards of care.[2,3] In fact, it is a new label for old ingredients. These ingredients include clinical audit, guidelines, complaint procedures, clinical supervision, risk management, evidence-based practice, continuing professional education, and reflective practice.[4-6] Despite being comprised of old ingredients,[1] it is believed to be a helpful label to concentrate the minds of professionals and managers on the inter-relationships between the ingredients, disciplines, and care sectors. Clinical governance (CG) will make clinicians, together with managers, accountable for the quality of patient care.[7] This may result in decisions on health care provision being more, or less, based on clinical effectiveness and not just on cost effectiveness.

Clinical governance should be patient focused, universally applicable, and encompass a partnership between clinicians, managers, and the public.[5,8,9] There is a danger, however, that the management agenda of CG will overtake the professional agenda. The management agenda is concerned with making sure that uniform, minimum standards are met, procedures and checks are in place, and that budgets are adhered to. The professional agenda is concerned with the development of individuals and their teams, the educational requirements that they may have, and the quality of care that patients receive.[4,5] Monitoring frameworks will be appropriate for both agendas to improve existing care and to anticipate, prevent, and recognize poor performance,[10] although details may be problematic.[3] There must be a key relationship between CG and education, both uni-disciplinary and inter-disciplinary.[11,12]

Clinical governance activity may highlight three types of problem areas: clinical competence, organization of care, or lack of resources. These will each require a different solution. Educational innovation is needed, with doctors and nurses learning from each other's strengths. Clinical supervision,[13] mentorship,[14] tutors, and focused education will be required where clinical competence is poor. GP tutors should have a key role. New comparable nurse tutors could work in tandem with an expanded number of GP tutors. All should be appointed through the university system, have similar standing to existing GP tutors, and be primary care based. The ideal would be generic trained tutors who would assess the educational needs of all disciplines within their primary care group (PCG).

Organizational problems may require better primary or secondary care management or wider National Health Service (NHS) structural or policy changes. A commitment from all NHS organizational levels is required to enable nurses and doctors to truly inform and influence the development of health policies, organization, and quality care in the widest sense.[7,9] Clearly, individual primary care teams can work together and so can GPs from neighbouring practices, as demonstrated by the success of GP cooperatives for out-of-hours care. More substantial problems will need to be overcome if PCGs are to introduce shared prescribing and clinical care policies to improve care. The key may be to enhance practice management; the initial and ongoing education of managers lacks any national framework and has been studied far less than medical and nursing education. Perhaps the time is right to re-dress this imbalance.

Funding problems leading to poor CG must be addressed openly, although may well be more difficult to overcome.[8] It is inevitable that rationing care, because of PCGs' imposed fixed budgets, will lead to poor CG in some areas; government and the NHS Executive must acknowledge openly what front-line clinicians know only too well. Clinical guidance from the National Institute of Clinical Excellence (NICE) must be properly costed so that PCGs, clinicians, and the public know the costs of interventions as well as their clinical benefits.[6,10] Unless fully funded centrally, such new NICE recommended care might only be possible to implement by restricting other clinically effective care. The political rhetoric of 'adequate funding through efficiency savings' is no longer believable, even if it was at one time.

How will CG be executed? Because it is a new label for old ingredients, existing tools and structures can be used. Tools include audit templates, evidence-based guidelines, complaints procedures, health and safety regulations; structures include GP tutors, medical audit advisory groups, and college faculties. Both elements need coordinated and cohesive integration to strengthen and develop them, rather than the setting-up of new systems. Nominally there will be one person responsible for CG in any PCG. This lead needs to be a practising clinician in order to have credence with colleagues. In practice, it is likely that the PCG CG lead will chair a CG agenda across the whole breadth of primary care and across all disciplines. Perhaps the best model is for each PCG to identify individual clinicians to advise on CG issues for certain parts of primary care (e.g. primary care gynaecology); these individuals may also be their practice's CG leads as well.

Primary care groups will need to ensure adequate support for clinical supervision,[13,14] continuing professional development,[3,15,16] clinical audit, and access to evidence-based care to underpin practice. Primary care teams will require 'new' time in the working week, both to perform CG activities and for related education. Just maintaining the practice's previous service provision will need the employment of 'new' clinicians to provide clinical and management cover. Such clinicians will need funding. Even if practices introduce 'in service' training days, like teachers, closing their practice for say one day each month, this strategy still has hidden costs: patients will need to be seen sometime else in the month, so adding to the pressure on access and clinician stress, and a skeleton staff will need to provide some form of emergency service for the practice's patients.

But as PCGs are to have fixed budgets, one can envisage a situation where, to provide high quality care through CG, PCGs may well need to reduce money spent on direct patient care. For example, fewer heart operations could be purchased each year so that funding is available to enable clinicians to rigorously perform CG in the area of primary care coronary heart disease. So, without new government funding, we will then have the paradox of higher quality care for fewer patients, or usual care for the many — which option would the government like to promote?

LINDSAY F P SMITH
General practitioner, East Somerset Research Consortium
DENISE HARRIS
Nurse practitioner, Ilchester

References

1. Goodman NW. Clinical governance. *BMJ* 1998; **317:** 1725-1727.
2. Department of Health. *The new NHS: modern, dependable.* London: DoH, 1997.
3. Roland M, Olden J, Campbell S. *Quality assessment for general practice: supporting clinical governance in primary care groups.* Manchester: National Primary Care Research and Development Centre, 1999.
4. Department of Health. *A first class service: quality in the new NHS.* London: DoH, 1998.
5. Royal College of Nursing. *Guidance for nurses on clinical governance.* London: RCN, 1998.
6. Royal College of General Practitioners. *Practical advice on clinical governance for primary care groups.* London: RCGP, 1999.
7. Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998; **317:** 61-65.
8. Baker N. Clinical governance within primary care. *Practice Nursing* 1999; **10:** 18-19.
9. Wilson J. Clinical governance. *Br J Nurs* 1998; **7:** 987-989.
10. Black N. Clinical governance: fine words or action? *BMJ* 1998; **316:** 287-288.
11. Dorrett J. Partners in education. *Practice Nurse* 1995; **9:** 686-690.
12. Barr H. From multiprofessional to interprofessional education – putting principles into practice. In: *Learning together: professional education for maternity care.* London: NHSE, 1997.
13. Cook R. Clinical supervision and practice nursing. *Practice Nursing* 1996; **7:** 12-14.
14. Butterworth T. Preparing to take on clinical supervision. *Nursing Standard* 1994; **8:** 32-34.
15. Chief Medical Officer. *A review of continuing professional development in general practice.* London: DoH, 1998.
16. Royal College of General Practitioners. *Education and training for general practice.* [Policy statement 3.] London: RCGP, 1994.

Address for correspondence

Dr L F P Smith, East Somerset Research Consortium, Westlake Surgery, West Coker, Yeovil BA21 9AH. E-mail: ESReC@globalnet.co.uk

Partnerships or power struggles? The 'Crown' review of prescribing

THE relationships between the different disciplines of the primary health care team can, at times, be somewhat tribal. At the level of individuals there is rarely a problem, but trouble can arise when their national bodies start to posture and seek power for their particular faction. At one level, the *Final Report of the Review of the Prescribing and Supply of Medicines*[1] could provide an opportunity for those who wish to create power struggles of this sort, although that is not its intention.

There are three broad types of change — 'within role', 'extended role', and 'new role' — that form a likely hierarchy of ease of implementation. 'Within role' changes are those that sensibly consolidate the ability of a health professional to carry out the range of tasks he or she normally undertakes (such as the recent nurse prescribing legislation). Other professionals are unlikely to object and these changes should be easy to implement. 'New roles' imply new responsibilities, an associated change in training requirements, and usually — but not necessarily — a transfer of existing responsibility from some other professional (usually a general practitioner [GP] in the present context) that might generate opposition and make implementation difficult. 'Extended roles' are intermediate ground, where change might be easier to implement and new training might not necessarily be required.

What generates the pressures for role changes? One legitimate pressure must certainly be for increased efficiency, where it can be shown that an equivalent (or better) service might be provided at lower cost by transferring roles from, for example, doctors to nurses: a phenomenon euphemistically known as 'improved skill-mix'. Moreover, the available 'skill-mix' does not remain static but is driven, in particular, by educational changes. The progressive development of a graduate nursing profession is a good example of this. Pharmacy is already an all-graduate profession with high standards of scientific education and professional training, including well-developed programmes of post-qualification continuing education and imaginative proposals[2] that illustrate particularly well how a profession might make major alterations in its role while using existing education and training. Other professions, such as podiatry and optometry, are equally forward-looking in their education and training and some (e.g. chiropracty, homeopathy, herbalism) see themselves as offering a comprehensive alternative to the medical model.

Thus, no profession remains static, but that medicine (and especially general practice) is also dynamic has perhaps been underplayed. Most of the talk is of removing work from doctors to others, although each discipline has its distinct ethos and, generally, nurses and pharmacists do not want to be mini-doctors any more than most GPs want to be mini-specialists. Within Europe, the United Kingdom (UK) may have a relatively low ratio of doctors to population.[3] Nevertheless, doctors are expensive and, rather than train more doctors, some health care planners would prefer other solutions.[4,5]

The main recommendations of the Review[1] provide a framework under which new groups of 'independent' or 'dependent' prescribers could safely emerge. Possible examples given by the Review include that family planning nurses, tissue viability nurses, chiropodists, and physiotherapists might become independent prescribers strictly in relation to their specific areas of expertise. Specialist diabetes, palliative care, and asthma nurses might become dependent prescribers, usually within the framework of care plans for individual patients. Pharmacists might also become dependent prescribers in specific areas such as chemotherapy, asthma, and diabetes.

How is this likely to affect general practice? Independently of the Review, several developments already threaten the established UK concept of medical generalism. The monopoly on prescribing by doctors has already been broken[6,7] and a number of pilot schemes are already exploring new models of delivery of primary care and extensions of existing professional roles.[8] These include nurse prescribing,[9] the extension of the role of pharmacists,[10] and 'nurse-led primary care', in which doctors are employed by nurse practitioners.[11]

The special input of doctors can be seen as being about 'diagnostic skills' rather than therapeutic expertise. This lays the way open for others to assume therapeutic expertise where 'diagnostic skills' are less important, such as with most minor illness, while ignoring the fact that both minor and major illness may present in the same ways. It is also always possible to argue that someone who concentrates on one area of care, however limited, will become more expert in it and provide higher quality care in that area than someone who attempts to maintain a broad portfo-

lio of skills. However, the substitution of a cheaper professional (e.g. nurse practitioner) is only more cost-effective if they deal with the same problems in the same time as GPs, who operate very quickly because they are highly skilled. A more important argument is the need for comprehensive care. Increasingly, patients do not have just one problem; they may have one or more acute problems, some of which may be unrecognized, and they usually have ongoing problems and needs for opportunistic health promotion and education on how best to use the primary care system.[12] It is relatively easy to find other professionals who could do specific individual tasks that the GP carries out, but only the generalist can do them all in 'one stop'. The fact that other professionals could do specific components of general practice does not necessarily mean that they should.

To the ill-informed and ill-advised, therefore, many aspects of the work of general practice appear simple and amenable to changes in 'skill-mix'. In addition, other professions see themselves as perfectly capable of doing much of the work that GPs do.[13] Discussions about 'skill-mix' can be a thin disguise for attacking the perceived monopoly that GPs have over primary medical care. Also, the advantages of the system of general practice can be undermined by anecdotal dissatisfaction with the quality of an individual general practitioner's service. In a system that is so pervasive and frequently used, it would be surprising if most people had not at least one unsatisfactory experience. Rather, it is a striking thing that public satisfaction with the system is so high,[14] given its ubiquity.

There would be grave disadvantages in moving away from our integrated system of delivery of comprehensive primary care, much admired in most other countries, towards pluralistic access to 'specialist' primary care practitioners of various sorts, a system already substantially discredited and highly unpopular in the United States[13] and elsewhere, mostly because it benefits the practitioners more than the patients. It is therefore crucial that subdivision of the generalist function takes place within the context of the primary health care team, a proviso that might be possible to ensure within the National Health Service (NHS), but not necessarily in the private sector.

The extent of GP control over prescribing is nonetheless now set to change, for good reasons, and should precipitate a watershed in our consideration of the discipline, principally its worth to the public. This is not a threat, but an opportunity. UK general practice has a commendable record of innovation and response to the challenge of change. Within the context of well-developed primary health care teams (PHCTs) and NHS re-organization (primary care groups, LHCCs and PCTs) there is probably little to fear and much to anticipate with approbation. It is the effect on non-NHS practice and the possibilities for erosion of NHS values that may create cause for concern. In this context the Review advises that the Department of Health should look closely at the issues raised for accountability in the private sector. Conversely, the recommendations of the Review strongly support the development of new models of NHS primary care based upon the strengths of our existing system, with very strong provision that innovation should take place only within a framework which ensures public safety, increased efficiency, expansion of a holistic model of care supported by assured education and training of all professionals involved, effective quality assurance, and using the likely prospect of secure and reliable information technology.

There is, however, a final caveat. These changes are intended to result in safer, more efficient, and more effective care for our patients. But everyone knows that this is the way to 'sell' a proposed change in practice to the NHS. All or any of the proposals for new prescribing rights are likely to be carefully couched in these terms. As strongly as we should be open to beneficial change we should equally look out for the 'weasel' changes that might damage the system of which, for all its faults, we should still be proud to be a part of. One of the key tests will be: 'partnership or power struggle?'.

ROSS J TAYLOR

Senior Lecturer, Department of General Practice and Primary Care, University of Aberdeen

Dr Taylor was a member of the main Review Team and concurred with the recommendations of the Review. These views are, however, entirely personal and do not necessarily reflect those of the Review Team, the National Health Service Executive, or the UK Departments of Health.

References

1. Department of Health. *Final Report of the Review of Prescribing, Supply & Administration of Medicines*. London: DoH, 1999.
2. Council of the Royal Pharmaceutical Society of Great Britain. *Pharmacy in a new age*. London: Royal Pharmaceutical Society, 1996.
3. Fry J, Horder J. *Primary care in an international context*. London: Nuffield Provincial Hospitals Trust, 1994.
4. Richardson G, Maynard A. *Fewer doctors? More nurses ? A review of the knowledge base of doctor–nurse substitution*. [Discussion Paper No. 135.] York: University of York, 1995.
5. Anonymous. Getting a quart out of the NHS pint pot. *Pulse* 1997; **8 February:** 38.
6. Department of Health. *Report of the Advisory Group on Nurse Prescribing*. London: DoH, 1989.
7. *Medicinal Products: Prescription by Nurses Act, 1992.*
8. Bradley CP, Taylor RJ, Blenkinsopp A. Primary care - opportunities and threats: developing prescribing in primary care. *BMJ* 1997; **314:** 744-747.
9. Luker KA, Wright K, Austin L, *et al*. *Evaluation of Nurse Prescribing. Final Report, Executive Summary*. Liverpool: University of Liverpool, 1997.
10. National Prescribing Centre and NHS Executive. *GP Prescribing Support: a resource document and guide for the New NHS*. Liverpool: National Prescribing Centre, 1998.
11. Lewis R, Jenkins C, Gillam S. *Personal medical services pilots in London: rewriting the Red Book*. London: King's Fund Publishing, 1999.
12. Stott NCH, Davis RH. The exceptional potential in each primary care consultation. *J R Coll Gen Pract* 1979; **29:** 201-205.
13. Starfield B. *Primary Care: Concept, Evaluation and Policy*. Oxford: Oxford University Press, 1992.
14. Judge K, Mulligan J, New B. The NHS: new prescriptions needed ? In: Jowell R, Curtice J, Park A, *et al* (eds). *British Social Attitudes, the 14th report*. Aldershot: Ashgate Publishing Ltd, 1997.

Address for correspondence

Dr Ross J Taylor, Foresterhill Health Centre, Department of General Practice and Primary Care, University of Aberdeen, Westburn Road, Aberdeen B25 2AY.