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IMPROVING QUALITY THROUGH CLINICAL GOVERNANCE IN PRIMARY HEALTH CARE

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POLICY CONTEXT

Ensuring safe, high quality health care is as much a priority for the primary care sector as it is for hospitals. The National Health and Hospital Reform Commission has made a number of recommendations which foreground the need for accountable services that have overarching quality improvement systems. However, attempts to integrate quality assurance and improvement programs into the everyday work of the Australian primary care sector must contend with the diversity of service types, the lack of systematised communication within and between these service types and variation of managerial structures. This review explores clinical governance, a systematic and integrated approach to ensuring services are accountable for delivering quality services. Clinical governance as a policy framework was part of the National Health Service reforms of the early 1990s, but similar initiatives have also been developed in the US and Europe. The applicability of these initiatives to the diverse Australian primary care sector has not previously been studied.

KEY FINDINGS

Clinical Governance

The purposes of clinical governance are accountability and quality of care. There are seven 'strategic areas' that can be used to support clinical governance: ensuring clinical competence, clinical audit, patient involvement, education and training, risk management, use of information and staff management.

Accountability Orientations

Models of clinical governance can be classified according to the focus of accountability. Managerial accountability models view themselves as being accountable to the organisation, and highlight monitoring and reporting and staff management. 'Professional accountability models' view themselves as being accountable to their profession for delivery of good care, as defined by professional norms of best practice; these models highlight clinical leadership and ownership over quality initiatives. Community accountability models viewed themselves as being

accountable to the community that they served, and highlighted patient engagement and feedback. This model is exemplified by the Aboriginal community controlled service sector.

These models often overlap, with varying results. Professional accountability models often acquire with time a managerial accountability focus, as clinicians become more attuned to collecting and providing data on service performance. This model of professional and managerial accountability is exemplified by Kaiser Permanente. Managerial accountability models graft poorly onto community accountability models as they tend to pull the service in two directions, and risk overburdening the service with reporting requirements. This not infrequently happens with community-based NGOs and may be moderated by introducing a professional accountability focus to act as a buffer.

Clinical Governance & Dimensions of Quality

All models foreground capability, though very few described doing this by evaluating clinical competence – a strategy which appears to be located outside the practice rather than seen to be a responsibility of clinicians. Managerial models focus particularly on effectiveness, efficiency and safety, while foregrounded responsiveness and appropriateness, rather than safety. The community models highlighted responsiveness, and did not address sustainability or continuity of care. Responsiveness tended to reflect the self-assessment of the service rather than engagement with the public in quality assurance or improvement. Patient involvement was the strategy least used across all models in the literature.

Clinical Governance Needs

To be effective, clinical governance needs:

- supported peer networks, within services, between services of similar types, and between different ambulatory care services, such as community health services, general practices, pharmacies, and state-funded mental health services
- clinical leadership within services and at the regional level
- external support for clinical governance by the regional organisational level (Divisions or state-funded regional organisations)
- acceptance of the use of locally produced data that are of local relevance to underpin reflectiveness and flexible solutions
- the capacity to rapidly generate local data through software attuned to clinical governance; and to have ready access to tools to facilitate referencing clinical performance against agreed criteria and standards
- incentives to support the mechanics of clinical governance through financing mechanisms appropriate for different sectors.

POLICY OPTIONS

When clinical governance has been introduced in a top-down manner in other countries, there has frequently been a backlash among clinicians concerned about, and fearful for, their clinical autonomy. It is important to clarify that many elements of clinical governance are already undertaken by services and are recognised as part of their professional practice. The new element is its systemised nature, and the notion that both the organisation and patient care benefit from being accountable for the quality of service. In most ambulatory care, making clinical governance everyday practice is most efficiently done in a number of phases, in which the professional accountability model is elaborated first, and elements of managerial and community accountability are then grafted onto it.

Marketing Clinical Governance to Primary Care

Clinical governance is a poorly understood term, which different sectors of the primary care workforce equate with control by bureaucracy or medical dominance over a service. The conversation about clinical governance should be driven by recognised clinical leaders who are

able to generate a sense of excitement around the concept. Exemplary narratives offer the best way for participants to understand how the process works and various mechanisms including using the trade professional press should be used to disseminate discussion and narrative around clinical governance.

Creating & Reinforcing Peer Networks

There is good evidence that peer networks, if properly resourced and encouraged to be reflective, support practitioners to develop innovative ways of implementing evidence or developing novel solutions to service problems. The Australian Primary Care Collaboratives offer one example of a collaborative change model. General practice networks and regional state health authorities are well placed to develop and resource broader networks, ideally in collaboration.

Developing Clinical Leadership Capacity

Many practitioners are placed in clinical governance leadership roles with little support or training. There is a need to develop ongoing education for clinical leaders, possibly by partnering with universities.

Developing Robust & Relevant Indicators

Indicators need to be relevant, appropriate and streamlined, so that services do not become overburdened by reporting requirements. Funders and insurers have a legitimate interest in performance and quality improvement and should engage with service representatives to develop performance indicators that are targeted to health priorities and do not overwhelm services with monitoring requirements.

Developing Standards for Clinical Software

No software package currently has the capacity to fully support clinical governance in primary care. Effective software is the most efficient way to rapidly introduce governance mechanisms. These applications should have two elements: (1) local search applications; (2) methods for combining anonymous audit data from practices. Developing and promulgating standards is a priority for government and the industry.

Developing Appropriate Financial Incentives

Engaging in clinical governance should be a net income producer for services, not a financial drain. Funding mechanisms could include: Medicare service incentive payments provided to accredited and non-accredited general practices which engage in clinical governance; higher private insurance rebates for attendance to allied health service which engage in clinical governance; funding packages for organisations which achieve process indicators for clinical governance or reach certain quality targets. The business case for clinical governance should then be disseminated to services.

METHODS

We identified papers, written in English and published from 1999 onwards, addressing clinical governance concepts. We used both an overt and a covert (to identify papers using less obvious terminology) strategy to search the peer reviewed literature. We also identified a further series of papers through snowball sampling from relevant papers, and hand searched a selection of grey literature and relevant websites. Out of 3766 publications, 639 were read and evaluated, and 317 were included in the final review (54 of these were assessed as both high quality and of high applicability to the Australian primary care sector). We interviewed national and international informants, including indigenous health services, primary health care leaders, managers and general practitioners. We also assessed leading software packages for their capacity to support and drive clinical governance in practice.

For more details, please go to the [full report](#)

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