

# CG Clinical Governance: a practical guide for primary care teams

Martin Roland  
Richard Baker

ISBN: 1 901805 11 5

© University of Manchester 1999

Typeset by One-Five Design 0161-624 5055

**For extra copies of this report please write to:**

**P.O. Box 777, London, SE1 6XH**

**or fax: 01623-724 524**

**or tel: The NHS Response Line 0541-555 455**

Full copies of this document can be downloaded directly from the official clinical governance development website, which also contains a range of other information and resources relating to the development and implementation of clinical governance. The website address, which is on the NHS net, is:  
[www.doh.nhsweb.nhs.uk/nhs/clingov.htm](http://www.doh.nhsweb.nhs.uk/nhs/clingov.htm)



Clinical Governance Research  
& Development Unit  
Dept. of General Practice & Primary Health Care  
University of Leicester  
Leicester General Hospital  
Gwendolen Road  
Leicester LE5 4PW  
Tel: 0116-258 4873 Fax: 0116-258 4982  
[www.le.ac.uk/cgrdu](http://www.le.ac.uk/cgrdu)

National Primary Care  
Research &  
Development Centre  
University of Manchester  
5th Floor  
Williamson Building  
Oxford Road  
Manchester M13 9PL  
Tel: 0161-275 7601 Fax: 0161-275 7600  
[www.npcrdc.man.ac.uk](http://www.npcrdc.man.ac.uk)



**Martin Roland** is a GP in Manchester and Director of the National Primary Care Research and Development Centre at the University of Manchester.

**Richard Baker** is a GP in Leicester and Director of the Clinical Governance Research and Development Unit in the Department of General Practice and Primary Health Care, University of Leicester.

We are very grateful to Ian Purves, Director of the Sowerby Unit, University of Newcastle, for information on PRODIGY. We thank the doctors, nurses, practice managers and health authority staff who commented on drafts of the handbook. We are grateful to the NHS Development Unit who funded the printing and distribution, and to Dr Philip Leech at the NHS Executive who gave particularly helpful advice. We also thank Mick Wright of Leicester who drew the cartoons.

The National Primary Care Research and Development Centre is a Department of Health funded initiative based at the University of Manchester. NPCRDC is a multi-disciplinary centre which aims to promote high quality and cost-effective primary care by delivering high quality research, disseminating research findings and promoting service development based upon sound evidence. The Centre has staff based at three collaborating sites: The National Centre at the University of Manchester, the Public Health Research and Resource Centre at the University of Salford and the Centre for Health Economics at the University of York.

The Clinical Governance Research and Development Unit (CGRDU) is an integral part of the Department of General Practice and Primary Health Care, University of Leicester. It is core funded by Leicestershire Health Authority with 'pump-priming' support from Eli Lilly and Company Ltd, and its principal remit is research and development of effective methods of clinical governance.

# Contents

<b>Introduction</b>	<b>1-2</b>
Who is this handbook for?	1
Why is clinical governance needed?	2
<b>Getting started</b>	<b>3-14</b>
What is clinical governance?	3
Where to start?	5
Choosing someone to be responsible for clinical governance in your practice	10
Choosing topics for quality improvement	11
• Working with national priorities	
• Working with locally agreed priorities	
• Working out your own priorities	
<b>What does clinical governance actually consist of?</b>	<b>15-29</b>
Practising safely (or risk management)	15
Clinical audit	17
Significant event audit	18
Evidence-based practice	18
Consulting skills	20
Learning from complaints	20
Involving patients and carers	22
Working with other practices	23
Clinical governance across the interfaces	23
Professional development for your practice team	24
Getting the culture right	26
Practice assessment: external awards	28
Professionals whose performance gives cause for concern	28
<b>Practical issues in implementing clinical governance</b>	<b>30-33</b>
How can you find time for all this?	30
Meeting your postgraduate education needs	31
Information technology	32
Whose information is it anyway?	33

<b>Where can you find more information?</b>	<b>34-39</b>
Internet resources to support clinical governance	34
Books	36
Other resources	38
<b>Primary care groups (PCGs) and primary care trusts (PCTs)</b>	<b>40-43</b>
What is your PCG clinical governance lead expected to do and how can you help?	40
What will happen if your PCG moves towards trust status: what difference will it make?	42
<b>Appendices</b>	<b>44-47</b>
1 PRODIGY	44
2 Practice professional development plans and personal development plans	47

## Introduction

### Who is this handbook for?

This handbook is for primary care teams. It is to help you decide where to make a start with clinical governance. We have written it mainly for doctors, practice nurses, managers and receptionists. Detailed advice for community staff has not been included, but we are planning another handbook for them.

In the first section, we outline the steps to take when you are starting to think about clinical governance. Since different teams will be starting from different points, this includes making an initial assessment of your practice. Then you will be able to make plans for the next few years. We discuss asking someone to take the lead on clinical governance for your practice and working out your own priorities for improving quality.

In the next section we describe some of the things that make up clinical governance. You can decide which elements to introduce and when, and you can make plans that meet your own circumstances.

Next, we consider some of the practical issues for getting clinical governance off the ground in your practice. These include finding time for clinical governance and using information technology.

We have not included detailed advice about every aspect of clinical governance. We have included a section on other places you can find help – including internet resources, books and other sources of help.

Finally, we discuss the role of primary care groups (PCGs). We outline what the person leading clinical governance for your PCG is expected to do. This will help you understand how clinical governance in your practice relates to the wider expectations of your PCG. We also describe how moving from PCGs to primary care trusts (PCTs) might affect what you do. Although this will not be an important consideration in 1999, a number of PCGs are keen to move to trust status during 2000 and 2001.

For teams that already have quality awards (e.g. those offered by the Royal College of General Practitioners or the King's Fund), much of what we say may be old hat. However, we hope that there will be something for everyone in the handbook.

We may produce further guides like this in future, so we would welcome any feedback you have. You can send this to Martin Roland in Manchester or Richard Baker in Leicester (our addresses are on page *i*). You can also get help and give feedback by joining our e-mail clinical governance discussion group (see page 34).

## **Why is clinical governance needed?**

Quality of care varies wherever you look: in primary care, in secondary care, in all specialities and in all countries of the world where it has been studied. We all know there are times when things go well and times when they don't. Even when we are trying our best. So, we need a way of reducing inappropriate variation in care and minimising the risk that care will not go well. The introduction of clinical governance does not imply that people aren't working hard. The point is that, despite this, our care can sometimes be better. The idea of clinical governance is to encourage a culture where health professionals routinely think: 'How could my care be better?'

Clinical governance also recognises that health professionals are part of a public service. So, we have to be accountable for what we do. Even so, clinical governance gives health professionals the lead in planning how to provide the best care they can. It is an opportunity for doctors and nurses to take charge of the quality agenda while at the same time providing the accountability that is now expected of us.

We hope that this practical guide will help you to get clinical governance going in your practice, to the benefit of your patients and the team who care for them.

## Getting Started

### What is clinical governance?

The idea of clinical governance has been around for just over a year now, but it still confuses people. So what is it?

Clinical governance has been defined by the Government as *“a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.”*

What does this mean for primary care? In simple terms, clinical governance is a way of maintaining and improving the quality of your care. Any efficient organisation has a system for improving quality: clinical governance is the system in the NHS.

Here are some key points about clinical governance:

- Clinical governance is about every member of staff recognising their role in providing high quality care. It is also about the care that the whole team provides.
- Clinical governance is about improving care using whatever method is most suitable. It involves finding aspects of care that need improvement, making plans to improve them and monitoring your success.
- Clinical governance is about being externally accountable for your care. The idea of being able to demonstrate to others that you are providing good care is of increasing importance in the public sector. So we need to demonstrate high quality care in order to earn and retain the trust of our patients and colleagues.
- Clinical governance is about managing your practice well to provide high quality care. A good nurse is unlikely to provide excellent care if she works in a practice that is poorly managed where, for example, clinics are poorly planned or the training needs of staff are ignored.

OK, these ideas sound fine, but what will clinical governance look like in practice?  
The boxes include examples of different aspects of clinical governance.

**R**usset Health Authority had selected coronary heart disease as a priority. Practices were asked to implement CHD guidelines in line with the National Service Framework. The Old Kent Road practice had not undertaken much audit in the past and were anxious about what would be expected of them.

They appointed their practice manager as clinical governance lead and she was delegated by the team to lead plans for implementing the guidelines. So she talked to the GPs and practice nurse to find out what problems they would face. Several found that a lot of information in the guidelines was new and unfamiliar, especially that about new treatments for hypertension.

So she invited one of the local cardiologists to come to their regular lunchtime meeting. The GPs got PGEA approval for the hour, and the nurse recorded the time for her PREP profile. Using information about repeat prescribing as the starting point, the practice manager set up a register on the practice computer so that patients with angina who had not been seen for a year could be identified. She went on to use the computer to monitor their care, and showed that, as a result of their efforts, the proportion of patients with hypertension whose blood pressure was controlled rose and the proportion of angina patients who were known to be taking aspirin also increased.

**D**octors in the Vine Street practice had always felt confused about which inhaler device to give patients. One of their nurses had an interest in asthma and told the doctors she would take responsibility for giving advice about inhalers provided she had additional training.

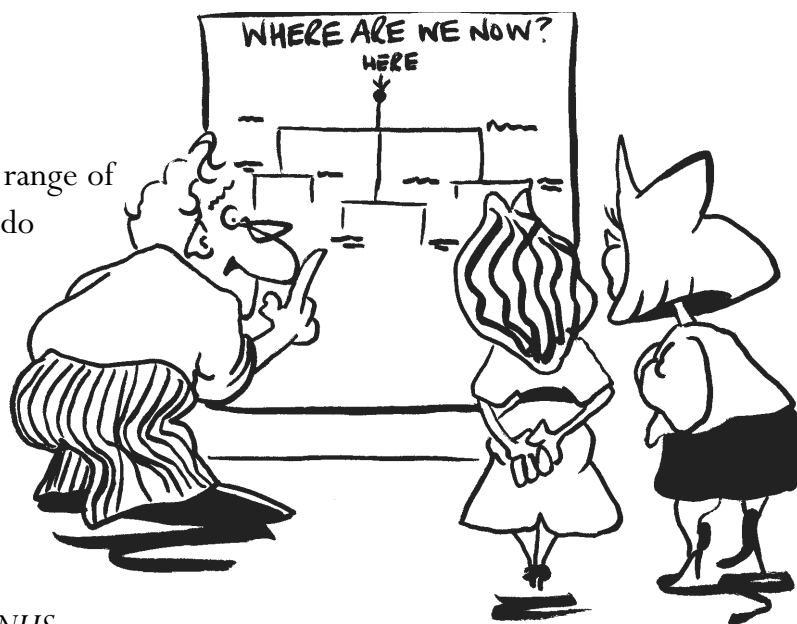
After she had been on an asthma training course, she was up to date with all the available inhalers. Then the doctors sent patients to the nurse to decide which device would suit a patient best: she also checked that they could use it properly. The doctors no longer worried that they might not be giving the best treatment, the nurse used her new training and the patients got better care. The nurse undertook a simple audit to show how care had improved.

**T**he Park Lane practice had been interested in quality improvement for several years. They had done a large number of audits, and were recognised by local GP registrars as excellent audit teachers on the vocational training scheme. However, they were dissatisfied. They hardly ever completed the audit cycle to check that performance improved and, on the few occasions when they did, they found that little had changed. Yet everyone in the team had their own ideas for new projects. The team seemed to move from one project to the next, without ever seeing one through to the end.

They set time aside to discuss what was happening. After acknowledging and accepting the problems, they made plans to overcome them. They formed a small group to approve and oversee projects. They also gave a member of the administrative staff the role of quality co-ordinator. After she had been trained, she took responsibility for the design of quality improvement projects, managing data collection and looking after the training needs of staff. They managed to harness their energy and see projects through to completion.

## Where to start?

Clinical governance includes a wide range of activities. It would be impossible to do everything at once. The best way to start is by thinking about where you are at the moment. In fact, that is one of the things your PCG clinical governance lead will probably ask you to do (see page 40).



The Government's health circular  
*Clinical governance: quality in the new NHS*

(HSC99/065, <http://tap.ccta.gov.uk/doh/coin4.nsf>) recommends that clinical governance should start with a baseline assessment. The circular suggests that the baseline assessment should include: identifying the strengths and weaknesses of the care which your practice provides; identifying areas for development; how these relate to health improvement programmes and national service frameworks (see pages 11 and 12), and working out how to get the information you need to monitor and improve the quality of your care.

We think that this is pretty ambitious and we know that a lot of practices will find the prospect daunting. Equally, everybody recognises that if clinical governance is to be successful, it is about producing long-term and sustained changes to primary care, not a sudden flash in the pan. So this handbook is about finding the best places to start.

There are various ways you can do this. All involve members of the practice team meeting together. You will probably want to make some sort of list of what you have done in the past and start to think about what looks most relevant to you for the future.

Some teams use brainstorming, others favour more structured discussion. Some practice teams have done more formal SWOT analyses (analysing your own Strengths and Weaknesses, and the Opportunities and Threats that you can see). You could get someone, e.g. your practice manager, to talk individually to staff or to groups of staff. The best methods will give everyone the opportunity to have their say. Teams are more successful where they share objectives.

### **First steps**

- Think about where you are now.
- Decide as a team who is going to be responsible for clinical governance in your practice.
- Make plans for what the team is going to do.
- Choose the topics which you agree are important.

The plans need to take into account the circumstances of your team and the particular problems you face. The examples in the boxes on pages 7 and 8 illustrate how three different teams started off. Some teams have only limited previous experience of quality improvement; others have much more. Some have difficulty in implementing the decisions they take: others are more successful. Some face the challenges of caring for disadvantaged patients: others have a high proportion of elderly patients. All teams will have limited time and resources to help develop clinical governance. You will have to take account of these when you make your plans.

### **Clinical governance might include:**

- risk management (or practising safely) (see page 15);
- developing information systems (see page 32);
- audit (see page 17);
- significant event audit (see page 18);
- professional development (see page 24);
- working out your own priorities, taking account of local and national priorities and the needs of your practice (see pages 11-14).

The plans you make in 1999 do not mean you have to carry out enormous audits across all the major areas of care you provide straight away. No-one has got the time to do that. What the Government hope teams will do is to make plans about what to do over the next 2-3 years. This is the start of a process, not a sudden 'big bang'. The aim is to make looking at quality of care part of the normal life of your practice. And the best way is "learning by doing".

So be realistic about the plans you make. If you decide to concentrate on risk management, you could decide to cover the things listed on page 16, plus some more that you think are important. You can't do this overnight, so your team will need to set a timetable to achieve its goals.

**T**he Kings Cross practice has never done an audit before. Quality improvement methods are unfamiliar and threatening. The team is already stretched because of a high workload and a demanding population. They are anxious about what clinical governance might mean and doubt they have the time or energy to devote to it. They would like to catch up with other local practices if that were possible. However, making a plan for three years seems too ambitious, because this is all fairly new.

They decide to start with significant event audit (page 18) because they realise that they have no way of sharing problems when things go wrong. It is also one of the easiest and least intrusive ways of getting started.

The doctors and nurses decide to hold a monthly meeting to discuss clinical problems. This will be the first time they have met together to discuss cases. They agree with their primary care audit group (PCAG) that a member of the PCAG staff will come along to the meetings to start with to help them get going. This support is important since they need to learn how to discuss events openly. They talk to their PCG clinical governance lead, making clear that they want to develop clinical governance further but need more support to do so. She agrees to visit them in six months time to see how the significant event auditing is going and to help them to make longer term plans.

**T**he Pall Mall practice has done some audit in the past, though not very much. They have three partners, have good relationships with patients and started a patient participation group three years ago. One partner would like to develop their practice organisation, increase practice income and apply to become a training practice in the next two or three years.

They decide that they can address most of the major items relating to risk management: they need to be able to check these off anyway for the training practice inspection. They also decide to find out about putting PRODIGY on their computer system and to carry out a series of audits over the next three years. One nurse takes the lead in collecting evidence from the literature to prepare for the audits they are planning. The GPs should be able to get PGEA approval for the audit meetings and they will count towards the nurses' PREP requirements.

**T**he Mayfair practice is a training practice which has been doing audit for some years. There is an established programme of education meetings in the practice, but some members of the team rarely come. They realise that clinical governance gives them an opportunity to develop their educational and quality improvement activities into a more comprehensive system.

They decide to bring together their current activities under the management of a practice clinical governance group with the job of making their activities more systematic. They plan these to meet the needs of individual doctors and nurses as well as the team as a whole. Since some members of the team have not taken part in any quality improvement activities in the past, they begin by questioning whether their assumptions about the culture of the team are correct. Why do some members seem to think that efforts to improve quality are optional? They introduce an internal appraisal and mentoring system to identify the needs of each member of staff and to ensure that the nurses have access to clinical supervision with peer support. At the same time, audit topics are chosen to meet the needs which they identify.

The examples in the boxes show that each team faces different problems. So you will have to tailor clinical governance to your own circumstances. The diagram opposite illustrates this, but you will need to add the details to make your own map. The map also makes another point. Clinical governance involves gradually using a wider range of methods to improve and account for quality. It is not an end-point or a single destination. Each practice should be making progress at whatever speed it can manage in its own circumstances.

## Three sample plans for the first year

- Initial assessment - where are you now?
- Team meeting discussions - brainstorming - SWOT analysis - practice manager talking to individual staff or groups of staff
- Work out what you have done in the past
- Make realistic plans for the future

1

### Old Kent Road practice

Little past experience, e.g. audit  
No team meetings  
No organised staff development  
High workload and no time

- Choose someone to lead on clinical governance
- Identify local sources of support
- Discuss support with your PCG clinical governance lead
- Introduce team meetings to improve communication
- Think about risk management and significant event audits as places to start
- Get PGEA approval for practice meetings

2

### Vine Street practice

Some audits in the past  
Staff training systems in place  
No experience of monitoring patients' views

- Choose someone to lead on clinical governance
- Select topics for audit
- Think about risk management
- Find a way of getting patients' views
- Work on a practice development plan
- Organise staff training to focus on quality improvement

3

### Park Lane practice

Lots of audits in the past  
Full continuing professional development programme in place  
Risk management system in place

- Choose someone to lead on clinical governance
- Update IT system (?PRODIGY)
- Identify further areas for audit
- Review consultation skills

## Choosing someone to be responsible for clinical governance in your practice

One of the things practice teams are expected to do is to find someone to take responsibility for leading clinical governance. This is something the government has asked all practices to do and your PCG clinical governance lead will want to identify someone in each practice to communicate with.

Finding someone to take nominal responsibility for clinical governance does not mean that everyone else can ignore the issue. Unless clinical governance is a team effort, it is unlikely to work at all.

Thinking of your own practice's clinical governance lead, he or she:

- could rotate between members of the team;
- could be a doctor, nurse or practice manager;
- will be the key person to link with the PCG clinical governance lead;
- needs support from the rest of the team.

In many practices, it will be natural for a doctor or nurse to take this role initially. However, sometimes the practice manager is already closely involved in quality improvement activities such as audit, and he or she may be the natural choice. Remember that whoever takes on the role must have the confidence of the team and be able to provide some leadership.

You could also choose to rotate the clinical governance leadership in your practice - this will help partly because the job will feel more like a finite commitment, and partly because you will then involve a range of practice staff in taking the lead on quality improvement. It may also be helpful to identify a small group to support the lead, for example, the practice manager and person responsible for your computer system might be useful members of the group.



### A 'job description' for a practice clinical governance lead.

1. Working out a plan for clinical governance in collaboration with the team.
2. Helping to get clinical governance activities going.
3. Reporting progress to team meetings.
4. Getting trained in quality improvement and clinical governance methods.
5. Identifying the training needs of team members.
6. Identifying local sources of support such as audit groups and post-graduate tutors.
7. Acting as the practice link with the PCG clinical governance lead.

## Choosing topics for quality improvement

There isn't time to do everything at once, so you have to decide on your priorities. All teams will need to be aware of national priorities such as the national service frameworks and the local priorities included in the health improvement programme (HIMP). But many teams will also have priorities of their own. For example, one practice may have a relatively high number of patients with chronic mental illness, while another has a large number of students.

### Working with national priorities

For some things, there may not be much choice about the areas of quality you decide to focus on. For example, national service frameworks are being produced in a number of areas and will provide guidance on standards of care that all patients should expect. These cover important clinical areas: coronary heart disease and mental health in 1999 and the elderly and diabetes in 2000. They are designed to highlight aspects of clinical practice that really make a difference.

*The new NHS. Modern and Dependable – Establishing Primary Care Groups* (HSC 98/065, <http://tap.ccta.gov.uk/doh/coin4.nsf>) recognised that it would be impossible to do everything at once. A choice from four areas of national importance was suggested:

- antibiotic prescribing;
- cancer services;
- mental health services;
- coronary heart disease.

The circular also suggested working with a health topic of local interest. This should be a topic of interest across the whole of your PCG.

The National Institute of Clinical Excellence (NICE) will also be producing guidelines in due course. NICE is also supporting the development of guidance in PRODIGY (see page 44). You may also want to take into account a set of primary care quality indicators which the Government are planning to publish in autumn 1999 when you select priorities.

#### **Examples of topics relevant to the National Service Framework for patients with coronary heart disease**

- Ensuring that patients with angina are taking aspirin unless contra-indicated.
- Ensuring that patients who have had a recent myocardial infarction are on beta-blockers unless contra-indicated.

One of the requirements which the Government has placed on PCGs is 'ensuring the clinical standards of national service frameworks and NICE recommendations are implemented'. Practices will need to decide with their PCG clinical governance lead how much effort to put into meeting particular national service framework standards. We all know from cervical cytology and immunisation targets that there is a law of diminishing returns if you try to achieve 100% coverage, but equally if you are some distance away there is more to gain. PCGs may in due course set their own targets, which will depend on local circumstances.

One factor that you will need to take into account in selecting topics is how to monitor how you are doing. This will often be dependent on your record system. Computer systems can be helpful if care is taken to record appropriate information on the computer.

Concentrating excessively on one set of targets may distort attempts to introduce clinical governance in other important areas. In our previous quality handbook (see page 34), we outlined the wide range of areas where quality assessment was potentially important. PCGs will have a balancing act to perform to make sure that nationally agreed priorities do not use up all the time and energy that may be needed for important local problems. PCGs are also expected to involve patients in developing plans for clinical governance. As we described in the previous handbook, they may bring a rather different set of priorities e.g. ones to do with access and good inter-personal care.

### **Working with locally agreed priorities.**

This is in large part about the HImP - the health improvement programme. Every health authority has to develop one. The HImP is about identifying where the main remediable health problems lie so that resources can be targeted at them.

Practices will already have had an opportunity to feed into the HImP. If you missed it (or it missed you), then look out for the next one. These are the real problems which you see in your patients and which you believe deserve greater attention and/or resources.

The HImPs are going to be powerful influences on how PCGs spend their money and on the local focus of clinical governance. To some extent they will reflect national priorities. But the whole point of them is that they should also reflect local need.

Clinical governance may feed into the HImP by identifying weaknesses in the provision of services or the quality of care. If, for example, you believe that greater resources are needed for physiotherapy, you may be able to demonstrate this by auditing how long patients have to wait for treatment.

## Working out your own priorities

This is about identifying where your own care needs to be improved: and doing something about it. It is about being realistic and honest where there are problems in the care your team provides. For example, the team may already be aware that they do not provide the quality of care they would like to a group of patients e.g. those who have recovered from an acute myocardial infarction.

Selecting priorities is also about the specific needs of your practice population. For example, if you have a high proportion of patients from minority ethnic groups, you may have different priorities to nearby practices with a different patient mix.

Individuals in your team may also have priorities for improvement of personal performance. Although most doctors and nurses perform well most of the time, all of us could do some things better. Personal development plans can identify and address such topics (see page 47). Research shows that doctors tend to choose education events in areas where they are already strong. So, in your practice you need to develop reliable ways of identifying problem areas.

### **Ways that have been used to identify problems areas:**

- discussing randomly selected cases with colleagues;
- making a point of talking about problems you find during the normal course of your work;
- auditing care of individual conditions (see page 17);
- identifying problems through clinical supervision – so far mainly done by nurses;
- significant event audit (see page 18);
- investigating complaints - especially several about the same problem or the same member of staff (see page 20);
- surveying patients (see page 22);
- needs assessment (see resources section on pages 35 and 37).

There is a basic minimum for most of these to happen: you have to meet regularly with your colleagues to discuss your clinical work. If you do not do that, then there is no real chance of any shared learning happening.

Having ways of identifying your own problems and sorting them out is likely to be a key part of the replacement for GPs' PGEA allowance (see page 31). And it is also likely to form part of the requirements for re-validation of GPs. So, if you do not already have a forum to discuss clinical problems with colleagues, you might as well start now! Similarly, evidence of improvement in personal performance can form part of a nurse's professional portfolio, again a requirement for continued registration.

A few professionals have more general problems in performance. However, one of the characteristics of professionals who get into serious problems is that they are either unaware of the problems, or defensive when problems are pointed out (e.g. when a patient makes a complaint). We discuss this issue more on page 28.

Clinical governance is supposed to promote a spirit of openness about problems in the care we provide - a tall order, as no-one likes being criticised. However, this is crucial to the success of the whole endeavour. Remember that clinical governance is not about doctors or nurses who don't work hard enough. It's not about not trying hard enough. It's about the improvements in care that can be achieved despite working flat out. In fact, working flat out sometimes gets in the way of seeing that things need to be improved.

## What does clinical governance actually consist of?

So far we have outlined the first steps to be taken in implementing clinical governance: the initial assessment; making plans; identifying a practice clinical governance lead; and selecting topics for quality improvement. But clinical governance includes a wide range of other activities. You can introduce and monitor these activities gradually in line with your own plans. In this section, we describe some of the individual elements that make up clinical governance.

### Practising safely (or risk management)

Most mistakes do not harm patients, but occasionally a patient does suffer seriously. The principal aim of risk management is to reduce the chance of patients being harmed. However, bear in mind that risk management will also reduce the risk of complaints or litigation against you or your practice.

Risk management tries to make sure that the way you run your practice does not build in the likelihood of mistakes being made.

#### A serious mistake at the Whitehall practice

In the Whitehall practice, receptionists routinely took requests for visits during morning surgery. One included a request for a visit for a patient with abdominal pain, which the receptionist put in the visit book. Later in the morning, the patient's wife phoned to say that her husband was worse. The receptionist said the doctor would be out later. The patient died of a coronary shortly afterwards.

Many practices train receptionists to screen visit requests. When the patient's wife called back, the receptionist's training should have alerted her to the need to get a doctor to decide on the urgency of the visit. A disaster might have been avoided by this simple change in procedure.

There are some common causes of complaints and litigation in primary care. An analysis by the Medical Defence Union (MDU) shows that the most common reasons for complaints were in order: failure/delay in diagnosis; inadequate treatment/management; rude attitude; failure/delay to visit; prescription problems; administration problems; and inadequate examination. These are often exacerbated by complaints about the attitude of staff, the MDU says: "*failure to communicate effectively is the root cause of most complaints*".

A risk management programme for the team should begin with an assessment of the systems you have to prevent these errors. For example, the prescription system may need changing to reduce the risk of prescribing errors, or staff may need training to communicate better with patients, or the team may want to look at how urgent referral letters are processed through the practice.

Most of the effort in risk management is in setting up the right systems – some examples are shown in the box. Once you have got things running smoothly (and safely), maintenance of these systems should involve little additional resource. In other cases, risk management can be built into routine practice.

**Some examples of risk management - a list of areas where you could check that you are practising safely:**

- Can your patients get through on the phone in an emergency?
- Do receptionists make decisions about the priority of patients' request for consultations?
- Do you have a full range of drugs you might need in an emergency?
- Is there a system for keeping them up to date?
- Do you have a system for following up results that might be important?
- Are your records legally defensible - to avoid ending up in court because of something you were unaware of - having notes and letters in order, an entry for each consultation, and easy access to information on current drugs are a minimum. A summary greatly reduces the risk of error in complicated patients.
- Do you have a system for reviewing repeat prescriptions, so that patients on long-term drugs get reviewed when you decide they need it?
- Do you have a good system for dealing with complaints? Dealing with complaints effectively in-house prevents them going further and helps you to think of ways in which the practice needs to be improved.
- Are you asking staff (or yourself) to do things they are not properly trained for?
- Do you have a system for checking the credentials of doctors and nurses providing locum cover?

Your PCG clinical governance lead may have developed a policy about risk management for local teams, and may be able to provide advice about the methods we have suggested.

## Clinical audit

Audit is a key element of clinical governance. It provides the mechanism to monitor the success of efforts to improve performance. Most teams have undertaken some audits in the past 10 years. Since there are many publications on the methods of audit, we have not included a detailed description of audit.

However, here are a few points about the inappropriate methods that are sometimes used in audits. All too often, the audit cycle is not completed; unless you check that performance has improved by collecting data for a second time, you can not be sure that change has occurred. Sometimes inappropriate samples of patients are selected for audit, even though there are simple sampling methods suitable for use in general practice (eg see Fraser et al 1998, details on page 37). Finally, systematic plans to implement change are frequently overlooked, or made but never carried through.

Advice about undertaking audit is available in most areas. Medical audit advisory groups (MAAG) were set up several years ago to provide support. Some have changed their titles, for example to primary care audit groups. Some are evolving into clinical governance support groups. But whatever local arrangements to provide support have been established, you should not be slow in asking for help. We list some resources on page 34 to 38 to help you with audit.

Having established your priority topics (see page 11 Choosing topics for quality improvement), audit will be a common way to proceed.

### An audit at the Pall Mall practice

**T**he Pall Mall practice selects coronary heart disease as a priority topic. They decide to concentrate on key elements of care of people with known coronary heart disease, as suggested in the national service framework.

One doctor and a nurse decide to lead the audit. Their first task is to identify all their patients with coronary heart disease. They use their prescribing system and disease register, then review the records of their patients. The criteria used in the audit include the need to record whether patients are taking aspirin and whether they smoke. They set an initial standard of 90%, although in the long-term they hope to reach 100%. They find that only 60% of patients have a record in their notes that they are taking aspirin and only 72% have a recent record of smoking habits.

They discuss the results at a practice meeting and suggest putting a reminder in the notes to prompt them to check these points with patients when they next consult. During the meeting, one GP says that it is very difficult to get patients to stop smoking. The nurse responds that at a recent meeting she went to, motivational interviewing was described as effective in getting people to stop smoking. They decide to invite a local health psychologist to one of their (PGEA approved) meetings to explain what motivational interviewing is and how it might help their patients stop smoking.

One year later, they repeat the audit and find they have reached their target of 90% for the two criteria. They are also pleased to find they have been more successful in helping motivated patients to stop smoking.

## Significant event audit

Significant event audit is a simple idea, and if used correctly can form an important part of clinical governance in any practice. The heart of the method is organising meetings for team members in such a way that they can talk fully and openly about events they have experienced in their work. The discussion that follows enables the team to learn how to improve care, or to plan other activities such as formal audit to investigate matters further.

Either adverse or positive events may be reported in a significant event audit meeting and all members of the team should be able to attend a meeting appropriate for them. The role of the chair is of critical importance – the aim is to learn and improve, not blame or shame. Good descriptions of how to carry out significant event audit are available (see page 37).

### Significant event audit at the King's Cross practice

Since the team has not done this before, they decide to learn more about it first. One GP contacts her PCG clinical governance lead and is advised to talk to a local practice that has used the method for several years. After some discussion with a GP in this practice, she takes on the role of chair of the first few significant event audit meetings at King's Cross practice.

At their first meeting, a receptionist described what happened when a patient's request for a repeat prescription had been lost. Three of them decided to investigate the repeat prescription system and found things which could be improved. A GP then discussed the care of a patient with diabetes who presented with a vitreous haemorrhage in one eye. The patient had not had a routine eye examination for three years. They agreed to organise an audit to see how many people with diabetes in their practice did not have regular eye examinations. They kept minutes of the meeting to help them check that the recommendations had been implemented.

## Evidence-based practice

Much has been said and written about evidence-based practice (or evidence-based medicine) in recent years. Opinions about its role differ. Some believe that widespread adoption of evidence-based practice would transform the clinical effectiveness of the NHS. Others argue that the imposition of guidelines limits the essential freedom to tailor care to the needs and circumstances of each patient. This is particularly the case in primary care, where patients' problems often do not fit neatly into the sorts of questions addressed in research trials.



Even so, doctors and nurses accept that they need to be aware of the best evidence relevant to their patient's condition. Indeed, patients generally assume that their clinician is up-to-date. But keeping up-to-date is difficult since research publications can be difficult to interpret and there are so many publications that only a very small proportion can be studied.

So if you want to use the best current evidence you will need access to reliable summaries of evidence and the skills to use them. Good quality summaries of evidence are increasingly available. For example, all practices receive *Effective Health Care Bulletins* and *Effectiveness Matters* from the NHS Centre for Reviews and Dissemination. We describe these and other good ways of finding out about evidence on pages 34 to 38. The Internet in particular is becoming a useful source of information, although the quality of some internet sites is variable. The BMJ book "Clinical Evidence'99" is a useful desktop guide to evidence relating to common clinical problems (page 37).

PRODIGY (page 44) is another way in which you can get hold of guidance. With PRODIGY, the information is integrated into your practice computer system so that you can access it during consultations.

#### **Evidence-based practice at Old Kent Road**

**A**t the Old Kent Road practice, the registrar asked her trainer, Dr Boot, why he continued to prescribe norethisterone for women with heavy regular periods, when tranexamic acid had been shown to be more effective. She showed him an *Effective Health Care Bulletin* from the practice library that reviewed the relevant evidence.

Dr Boot could not come up with a convincing reply. He agreed that sometimes the practice overlooked current evidence. The registrar and trainer talked about ways of keeping up-to-date. Although they could identify several approaches, the practice did not have a systematic plan.

Dr Boot discussed the issue with the practice clinical governance lead. The lead developed a plan that was presented to a team meeting. Each GP and practice nurse took on responsibility for reviewing selected publications and reporting important new evidence to the team. The team could then agree on policies for implementing the evidence if necessary. This sounded quite ambitious, but they decided to try it out for a year, and then review how successful they had been - and try to work out how often evidence had actually informed their practice.

## Consulting skills

The consultation with a patient is at the core of primary care. Things we do during consultations e.g. listening carefully, explaining things, involving patients in decisions, are of central importance to patients. So, one way of improving the quality of clinical care is to improve consulting skills. Some quality awards for general practice e.g. MRCGP and fellowship by assessment, involve the GP's consulting skills being assessed from a videotaped surgery. Summative assessment for general practice now includes an assessment of consultation skills.

One way you can look at your consulting skills is by using the Leicester Assessment Package which was developed to help GPs assess and improve their consulting skills. It allows you to assess seven aspects of consultations: interviewing/history taking; physical examination; patient management; problem solving behaviour and relationship with patients; anticipatory care; and record keeping.

The package includes structured forms for the person who is acting as assessor to provide written feedback on the doctor's strengths and weaknesses along with strategies for overcoming problems and enhancing strengths. A version is currently being produced for nurses.



One system used in summative assessment of GPs was developed in the West of Scotland. This involves the videotaping of consultations, followed by independent assessment by two assessors. An alternative method uses simulated patients: the doctor's performance in response to the standard simulated patient is assessed and the "patient" also evaluates the doctor's performance. We give more details of these packages on page 38.

## Learning from complaints

A practice-based complaints procedure was introduced in 1996. Since then, most complaints have been dealt with at practice-level. When a complaint is unresolved it can be referred to the health authority's independent review procedure. The very small number of complaints that still remain unresolved are investigated by the health services commissioner.

The number of complaints is gradually rising. Experiencing a failure in care is obviously distressing for the patient or relative, but it can also be very difficult for the health professional and team. It is very easy to be defensive about complaints. As a result, you may fail to respond to the complaint in a way that recognises the complainant's distress (so that they pursue the complaint and eventually sue you). But being over-defensive also means that you may fail to take steps to avoid the problem happening again.

Complaints can be an important indicator of problems with the care you are giving, so the complaints system is an important element of clinical governance. The issue is not so much to do with isolated complaints. You should look to see if there is a consistent pattern to the complaints you receive about your practice.

An effective complaints system should help you to respond positively and constructively. The new system helpfully separates out any possible questions of disciplinary action (e.g. service committee hearings) so it is easier to use in a positive way. However, it is important to use the system in your practice effectively, as the examples illustrate.

**D**r Hat issued a prescription for digoxin to an elderly patient, but the dose was wrong. The patient was admitted to hospital, but after a stormy few days recovered fully and was discharged. The patient and her relatives complained to the practice. The practice replied to the patient after a delay of three weeks to tell her that such mistakes occasionally happen, but they always did their best to avoid them.

The patient was unhappy with the tone of the reply and asked for an independent review from the health authority. However, the health authority was able to organise a resolution following a conciliation meeting between the various parties. The other partners in the practice were unsure how to handle the situation, and were quite critical of their colleague. Communication between them deteriorated. Dr Hat felt isolated and depressed. In consequence, he eventually decided to leave the partnership.

**D**r Iron received a complaint after declining to visit a patient with what sounded like a minor respiratory infection. Unfortunately, the patient was admitted to hospital later the same evening with pneumonia. On receiving the complaint, the practice identified one partner to provide support for Dr Iron. Another partner investigated the complaint. This led to an apology being given to the patient. In addition the patient and his relatives were invited to the practice to discuss how the practice as a whole proposed to respond. They explained how it can sometimes be difficult to be certain about the seriousness of clinical symptoms, but that as a result of the complaint, the practice had instituted a series of meetings for the team to review their handling of requests for home visits. Dr Iron was kept fully informed throughout and participated in all the discussions.



## Involving patients and carers

A key feature of clinical governance is involving patients and their carers, but many teams will be unsure about what method can ever be really effective. There are a variety of approaches but it is unrealistic to expect practices to implement them all. Some methods require special skills which will not be readily available. However, it is possible to undertake some simple steps at a fairly early stage.



Members of all teams should be aware of the importance of being responsive to the patient's and carers' needs. For example:

- Have your receptionists received appropriate training in dealing with the public, and do they receive support in dealing with difficult situations?
- Does your practice provide up-to-date information about its services, and offer information in minority languages if you care for substantial numbers of patients from minority ethnic groups?
- Do you have a system for reporting comments that patients and carers make about the services or care they receive? They can often point to aspects of care that need improvement. Comments and suggestions should be noted and discussed at a team or significant event audit meeting.
- Have you thought about carrying out a survey of patients' views of your practice? A number of standard measures of user opinion are available. We included advice about these in NPCRDC's previous handbook (see 'Where to find more information' page 34). You will need some help if you have not carried out a survey before - your PCG clinical governance lead should be able to show you where to find help.
- Direct communication with patients or their representatives can be helpful. Informal meetings between team members and users can throw light on what it is like to be a patient in the practice. Some teams have found patient participation groups helpful and, in other areas, practices have made contact with voluntary and support groups for users with particular problems. Liaison with such groups can help your team understand the problems that face people who use your practice and help you find out about other services available to help.

There are other powerful methods for investigating the users' views, including focus groups and interview techniques. However, these are complex and need special expertise. If you wish to use such methods, make sure you get advice or you may obtain misleading information.

## **Working with other practices**

Perhaps the most radical feature of PCGs is the notion that GPs and other primary care staff have a shared responsibility for providing high quality care. Quality is a shared endeavour. That is why some PCG clinical governance leads are developing standards that they hope to use across all practices in a PCG.

So the topics identified as priorities for quality improvement are likely to include some that are selected by the PCG. The efforts of your practice will therefore contribute to the PCG as a whole. As a result, you may find yourself under pressure from your peers to change your practice. This will be a new experience for teams and the approaches that will be adopted by PCGs are not yet clear. We suggest that in all but the most exceptional circumstances, PCGs should respond by supporting practices who are having difficulty meeting locally agreed quality standards.

This is also an opportunity to arrange meetings between practices. They may be organised by your PCG clinical governance lead. Clinical governance is also an opportunity to build meetings between local practices into your own educational programme. If you are working to achieve common standards with your neighbours, then why not meet to share ways of overcoming the difficulties? Practice twinning is an interesting idea being developed in some PCGs.

## **Clinical governance across the interfaces**

Referring patients to secondary care, social care and other services requires clear and effective communication from the practice and clear communication back again. We all know that failures in communication occur and that as a result, patient care suffers. Acute and community trusts have clinical governance systems and social services also have quality improvement systems. Your PCG clinical governance lead should identify the clinical governance leads in local trusts and social services and establish effective communication with them. National service frameworks or HImPs may be a good place to start looking across these interfaces.

Looking actively at clinical governance across the interface will become more important as your PCG takes on commissioning roles. At least you should be able to inform your PCG clinical governance lead of any problems you have in the quality of care provided by other organisations. You may find that your PCG takes part in quality improvement activities to improve the co-ordination of care of patients who are referred to hospital, community care or social services. A measure of patients' views of care across the interface with secondary care is now available (the patient career diary - see page 35).

## Professional development for your practice team

Continuing education and training for teams are key parts of clinical governance. Clinical governance builds on arrangements for education and training which have been established for many years. It incorporates the principle of education tailored to the needs of the individual or to the needs of the team. This approach facilitates the development of individuals (the personal development plan: PDP) and the development of the team (the practice professional development plan: PPDP) – see page 47 for more details of these. These are also key parts of the Chief Medical Officer's proposals for changes to medical education (see page 36).

PDPs and PPDPs for practice teams are core features of the concept of lifelong learning. Some PCGs have appointed a member of their Board to lead the development of PPDPs in practices. Your local department of postgraduate general practice education will have experience of professional development plans and will be able to advise PCGs and practices about the methods that can be used.

How does a practice decide what training is needed and how does a team decide what help or support it needs? Again, your approach should be to begin with simple methods, making gradual progress towards more complicated systems such as team surveys. The topics you have chosen as priorities for quality improvement should be taken into account. In larger practices, an education co-ordinator could take the lead in supporting the development of PDPs in association with the clinical governance lead.

The development needs of attached community staff should also be thought about. Your PCG should try to co-ordinate arrangements for attached staff with the local community trust: or at least make sure that the PCG knows what the trust is doing and vice versa. The local education and training consortium may be able to offer advice and support with this task. Many community and practice nurses will already be involved in clinical supervision schemes that will identify individual training needs.

One of the PCG's jobs is to 'assess and provide services to meet the needs of the local population'. In doing this, they may identify a particular training need for staff, and practices should be ready to respond to a lead from their PCG. Primary care trusts (PCTs) will have a defined responsibility to match up the needs of their population with the available skills of their health professionals (see page 42). So PCTs may play an even more prominent role in education and training.

In research studies, questionnaires and interviews have been used to identify the training needs of individuals. However, complex approaches can't be used in routine practice. Nevertheless, the principle of discussion with the people concerned is important: individuals in every team will have ideas about their own needs for education. This information should be supplemented with information about actual performance.

Appraisal can be an effective way of identifying the education and training needs of individuals. Some practices already have appraisal systems, including appraisal for all the partners.

### **Appraisal in the Mayfair practice**

In the Mayfair practice, the GPs had introduced a system to identify their individual education needs three years ago. Other members of the team asked why they could not have something similar. The practice manager was delegated to find out about practical methods they could use.

She suggested that they introduce annual appraisal for all members of staff, including the GPs. She went on a training course and then took responsibility for undertaking the appraisals. The purpose of each appraisal was to identify the development goals of each individual and agree a plan for helping the individual to achieve those goals.

At a subsequent meeting, the team members agreed that the appraisal system was excellent. They also noted that the focus was on themselves as individuals, not as a team. They also wanted information about their teamwork. So the practice manager attended another course (this time on team facilitation) and, as a result, an annual team appraisal was introduced that included a confidential assessment of communication and agreement of objectives within the team.

Advice about assessments may be available from your local department of postgraduate education, local trust or health authority. They may also have advice about methods for establishing the development needs of the team. Portfolio learning (eg see [www.wisdom.org.uk](http://www.wisdom.org.uk)) offers an approach for linking education and training with PDPs and PPDPs. Local continuing medical education and nurse tutors will also be able to offer relevant advice.

Individual professionals have an important influence on performance, but so can the team as a whole. Failure in communication, or poor collaboration often leads to problems for patients. So clinical governance should include thinking about the team. If your team is not working satisfactorily, it will be difficult to introduce clinical governance successfully.

It can be relatively simple to identify problems in a team. The approaches that can be used include convening a meeting with team members and asking them to brainstorm the strengths and weaknesses of the team. Why not ask team members for their views about the level of communication in the team and the extent to which they participate in decision making? Another approach would be to meet separately with individuals and ask for their opinions confidentially. Finally, you could ask members of the team to complete a confidential questionnaire. A number of standard questionnaires which give useful information are available (e.g. in Pritchard P, Pritchard J. *Teamwork for Primary and Shared Care*. Oxford University Press, 1994. We give more details of this on page 37).

In primary health teams it is quite common to find that objectives are unclear, communication is variable and individual team members have little opportunity to participate in decisions about the work that they do. You could use clinical governance as an opportunity to change this in your practice.

Multidisciplinary practice-based learning can help the team improve communication as well as learn. Again, advice may be available from the local CME and nurse tutors.

## **Getting the culture right**

The idea of culture is increasingly mentioned when explaining the performance of health care teams. One feature of clinical governance is claimed to be a culture change. What does this mean?

The culture of your team is the way it thinks and acts, and is about its values. Your team will be different from others. For example, you may have particular attitudes to new ideas:

- you may welcome PCGs or be uncertain about them;
- you may value clinical governance or be suspicious about it;
- you may be pleased to share information about performance with patients or reluctant to do this;
- you may have a hierarchical system for decision making in your practice or one which involves all staff.

The culture in your team will influence the plans you make for introducing clinical governance and will influence the success you have in improving quality. So it's worth considering how your team culture might affect what you achieve. The first step is to identify your culture. You could do this by asking the team where it stands on the four issues listed above.

Successful clinical governance requires a culture in which team members:

- are willing and able to acknowledge their problems;
- work together to improve performance;
- value personal development and education;
- feel valued in their work;
- recognise the importance of the patient's experience of care;
- seek ways of improving care as a matter of routine.

You cannot create a culture to order. It will take time to develop this type of culture in your team. However, you can include the development of team culture as part of your long-term plans for clinical governance.

#### **The culture in a poorly performing practice (Kings Cross 1997)**

Individual:	Little interest in personal performance (clinical and/or interpersonal care) or in the performance of colleagues. Little motivation to improve.
Organisation:	Poor communication within the team, ineffective procedures for anticipating and addressing administrative and management problems, sparse infrastructure. Responsibilities and accountability of staff not clear.
Values:	Little sense of responsibility for patient care or staff welfare, little value given to education, research or professional development.
External relations:	Little professional contact outside the practice, unwilling to discuss potential quality issues.

#### **The culture in a practice performing well (Kings Cross 2002)**

Individual:	Positive interest in personal performance (clinical and/or interpersonal care) and performance of colleagues. Commitment to audit.
Organisation:	Good communication within the team, with shared objectives and full participation in decision making. Effective procedures for anticipating and addressing administrative and management problems. Good IT system.
Values:	Acceptance of responsibility for patient care, staff welfare and education. Research and professional development are valued.
External relations:	Extensive contact outside the practice (with the PCG, education providers, patient groups), willing to discuss potential quality issues.

## **Practice assessment: external awards**

Several methods are now available for the external assessment of a practice, leading to some sort of quality award. Much of this has been developed by the Royal College of General Practitioners (RGCP) - including Fellowship by Assessment, the Quality Practice Award, Membership by Assessment of Performance, and Research Practice Accreditation. Training practice accreditation is another example. Systems for the accreditation of certain clinical services are also being developed, for example some areas are developing a system for the accreditation of cancer services. We have given details of award schemes in our previous handbook (see page 34).

Each system uses a set of criteria for assessing the practice, and the team usually has to undertake considerable preparation beforehand. The process of preparation itself can be rewarding, since teamwork is often improved. The team identifies its strengths and weaknesses and new ideas often arise not directly related to the accreditation process. In this way, accreditation can support practice professional development. However, a lot of work may be involved and teams should not embark on accreditation without careful thought.

## **Professionals whose performance gives cause for concern**

Most health professionals do a good job. However, the performance of a small number falls below acceptable standards. There are various reasons for consistently poor performance, including lack of knowledge or skills, stress or poor health.

The aim of clinical governance is to prevent poor performance in the first place by ensuring the development of professionals and offering support to those who need it. However, if a professional does not appear to be performing well, action is required.

Community nurses have well-established appraisal systems through trusts. Recently, particular attention has been given to doctors whose performance gives cause for concern. The General Medical Council (GMC) introduced new performance procedures in 1997, and health authorities, PCGs, professionals or patients may contact the GMC when they have concerns about a doctor. The GMC has the power to undertake an investigation, require re-training and if necessary suspend a doctor's registration.

Most health authorities have instituted schemes to help GPs who appear to be consistently under-performing. These schemes are not concerned with occasional lapses of judgement. The poorly performing doctors schemes are about GPs who repeatedly have the same or similar problems.

A number of features are important for the success of schemes designed to help professionals whose performance is causing concern:

- collaboration between relevant local agencies e.g. local medical committee, health authority, PCG, Department of Postgraduate General Practice Education;
- supportive and fair approach;
- widely promoted and well understood by local professionals.

More details of these schemes were given in our previous handbook on 'Quality Assessment in General Practice' (see page 34).

PCGs should also give some thought to systems to support professionals who are stressed or unwell (see also resources on page 39). The way in which PCGs and teams regard and support colleagues who experience these problems is a key aspect of developing the right culture for clinical governance.

## Practical issues in implementing clinical governance

### How can you find time for all this?

Clinical governance can include a wide range of activities. At first sight it looks like a major undertaking. However, the challenge is not as great as it might seem. The plans on page 9 show how clinical governance can be introduced gradually. The NHS Executive has made clear that the introduction of clinical governance is expected to take place over several years. Clinical governance is about a cultural change in the way we think about quality, not a quick fix.



The things your PCG is supposed to do in the first year are described on pages 40-42.

In the previous sections of this guide we have discussed the role of the person who takes the lead for clinical governance in your team, the things to think about when you assess where you are now, and some of the things you can include in your future plans.

Once you have made a plan, you need to set about putting it into practice. The pace will be determined by the circumstances of your own team, and the resources and other sources of support available to help.

Some practical tools are already becoming available, for example checklists to help with the baseline assessment are being distributed by some NHS Executive regional offices and other organisations. Local organisations such as audit groups, postgraduate general practice education departments and health authorities are all making plans to help primary care teams get started on clinical governance. Your practice clinical governance lead should identify the available local sources of support and you should make liberal use of them.

The local primary care audit group may also be able to offer help. Some audit groups have developed schemes for supporting practice-based audits or offer help with data collection. They can also provide well tested audit protocols so the team does not have to spend time developing its own.

The PCG should be an important source of support and potentially of resources. Each PCG will have its own plans for developing its practices, including plans for clinical governance. You should make sure you understand your own PCG's objectives for clinical governance and how these relate to your own objectives.

The key contact at the PCG will be the clinical governance lead and this person will be able to advise about resources and other support. Any resources the PCG has are more likely to be available to you if your practice plan bears some resemblance to the PCG's.

## **Meeting your postgraduate education needs**

Identifying and addressing your needs in relation to clinical governance could overlap almost completely with your postgraduate education needs.

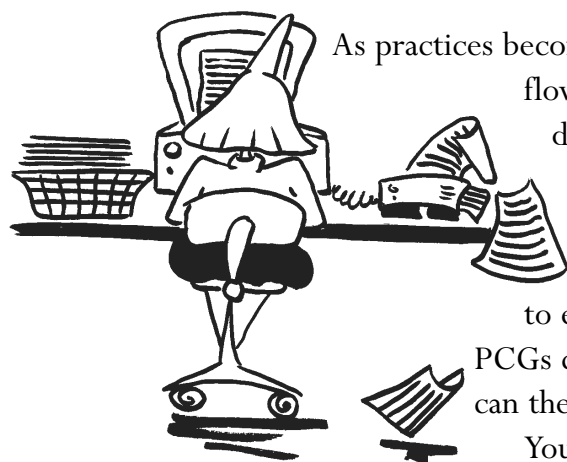
GPs can apply for PGEA approval for education activities in the practice, or for developing individual learning plans, or for prolonged study leave to set up systems for clinical governance. Education activities may include meetings about clinical governance and meetings leading to the development of a practice professional development plan (PPDP). Over the next few years, it is likely that PGEA approval for GPs' education activities will disappear, being replaced by a new system of continuing professional development (see page 36). This is being designed to encourage doctors to identify their own education needs and find appropriate ways of meeting those needs.

All doctors are also going to have to undergo compulsory re-validation quite shortly - probably within the next two to three years. The GMC, BMA and RCGP are working on how it is going to be done. The likelihood is that having a reasonable go at clinical governance, including a report of activities and the differences they have made, will be a lot of what you need for revalidation. So if you are a GP, starting to think now about the things your practice needs to improve should turn out to be just what you will need to do in a couple of years time to get credits for postgraduate education. This will satisfy much of what you have to do for revalidation as well.

Nurses also have to meet specific requirements for continued registration. The UKCC's standards for postgraduate education and practice (PREP) underpin the system for maintaining registration. These include a minimum of five days or equivalent of study activity and maintenance of a personal professional profile containing details of professional development. Nurses will be able to include participation in clinical governance activities as part of their requirements for continued registration.

## Information technology

Clinical governance becomes a whole lot easier if you have data available on the quality of your care. Although there are many ways of collecting clinical data, using computers is by far the most efficient. Computers are good at reminding people about clinical quality (e.g. drug interactions), helping them to collect data in a standardised way and producing summary reports. Programmes such as MIQUEST ([www.clinical-info.co.uk/miquest.htm](http://www.clinical-info.co.uk/miquest.htm) or [www.nottingham.ac.uk/chdgp](http://www.nottingham.ac.uk/chdgp)) are being developed to help extract anonymised datasets from practice computer systems so that information from different practices can be compared. Of course data recorded for clinical practice are not the same as the data that might be wanted for other purposes e.g. audit or health needs assessment. But computer systems such as PRODIGY and MIQUEST are being designed to help clinicians do both.



As practices become linked to NHSnet and the Internet, clinical data will flow via electronic data interchange, e.g. results from labs and discharge summaries from hospital wards. This will save time for practice staff and improve communication with hospitals. Other tools are being developed to support clinicians in practice: from simple e-mail, to electronic discussion groups and shared electronic resources. PCGs can develop databases of locally available resources which can then be made available on local electronic networks. You can join our electronic discussion group on clinical governance (see page 34).

Decision support systems will also become an important part of practice. PRODIGY is one decision support tool that offers guidelines within the consultation on more than 150 primary care conditions. It does not take over from the clinician but offers advice on what to do once the problem is known (e.g. what to prescribe, advice leaflets to give to patients, advice on referral and investigation). PRODIGY also contains 'off-line' education material and is regularly updated. In due course it will also offer a service to enable clinicians to compare themselves against standards. Of course the patient and clinician still have flexibility to choose what treatment they think is best for an individual patient. We give more information about PRODIGY on page 44.

Your patients will soon have access to wider information resources from the Internet and from the National Electronic Library for Health (see page 34). A quarter of the population of the UK are already on the Internet and the rate of uptake has increased with free internet services and interactive digital television, which will be widely available by the end of 1999. This will raise many challenges for clinicians. Patients will become increasingly well informed and expect up-to-date, understandable and relevant information about their problems.

## Whose information is it anyway?

At present, information on quality of care is normally confidential, except very basic things like surgery times which are in practice leaflets. Audits such as those conducted by primary care audit groups or MAAGs only give identifiable information to the practice concerned.

This will gradually start to change. For example, members of PCG boards will have access to information that you provide in the context of clinical governance. At present, this will remain confidential. However, you do not have to look very far to see that the Government is keen on publishing information on the performance of public services, from league tables on school results to ones on hospital mortality. It seems likely that general practice will not be too far behind. In fact, the Government lists 'providing information to the public about the quality of services provided' as one of the jobs of a PCG, though we do not yet know how detailed that is expected to be.

You will need to decide where to position yourself on this: what is the culture in your team in relation to use of information? Do you, for example, want to let your patients know about things you are doing to improve care in your practice? Responsibility for developing our own systems of clinical governance carries with it an increasing expectation of accountability. The ways in which teams will be expected to be accountable to their patients remain unclear. However, some teams have already decided to publish the results of their audits on their own websites, e.g. see page 35.

It is important to remember the requirements of the Data Protection Act and the responsibilities of the new Caldicott Guardians (Health Service Circular HSC 1999/012), who are there to protect patients' interests as information is increasingly widely shared in the NHS (e.g. by establishing electronic links). Every PCG should have a Caldicott Guardian, and the actions taken by PCGs to protect the use of patient information will be monitored. If you are worried about information about your patients not being treated confidentially, you should talk to your PCG chairman or clinical governance lead.

## Where can I find more information?

### Internet resources to support clinical governance

We have established an e-mail discussion group for issues relating to clinical governance in primary care. Once you have joined the group, any messages you send will go to all members of the group. Anyone in the group may reply but no-one is under any obligation. You can use it to spread good ideas, share problems or ask for help with particular issues. If you wish to join the group, please e-mail us at [governance-primary-care-request@mailbase.ac.uk](mailto:governance-primary-care-request@mailbase.ac.uk) including some details of your own interest in clinical governance (e.g. PCG board member, practice clinical governance lead etc).

NPCRDC's previous handbook (Quality Assessment for General Practice: supporting clinical governance in primary care groups) can be downloaded from NPCRDC's website ([www.npcrdc.man.ac.uk](http://www.npcrdc.man.ac.uk)) or ordered from 0161 275 7126.

Wisdom ([www.wisdom.org.uk](http://www.wisdom.org.uk)) offers an electronic approach to postgraduate education ('networked professional development') which is PGEA approved for GPs in Trent. It includes other resources such as an electronic library, and virtual conferences on topics that include portfolio learning and clinical governance in primary care.

WAX ([www.medinfo.cam.ac.uk/wax/default.asp](http://www.medinfo.cam.ac.uk/wax/default.asp)) is a new type of electronic library designed for both practices and PCGs. As well as containing its own 'WAX books', it allows you to create your own, incorporating local information. It also provides links to guidelines and other sources of information.

A comprehensive search facility for guidelines and sources of evidence on effectiveness is available at [www.gwent.nhs.gov.uk/trip/](http://www.gwent.nhs.gov.uk/trip/). The excellent site is designed for people working in primary care.

The Centre for Innovation in Primary Care ([www.innovate.org.uk](http://www.innovate.org.uk)) will include programmes to help implement evidence based practice in primary care, as well as resources to help practices share information with each other.

Alphabetical listing of over 300 evidence-based practice sites is available at [www.shef.ac.uk/~scharr/ir/netting.html](http://www.shef.ac.uk/~scharr/ir/netting.html). An American site ([www.ahcpr.gov/clinic/](http://www.ahcpr.gov/clinic/)) also acts as a clearing house for clinical guidelines. In due course, we would expect this type of information to be available on the NICE website ([www.nice.org.uk](http://www.nice.org.uk)). The National Electronic Library for Health ([www.nelh.nhs.uk](http://www.nelh.nhs.uk)) is another site that will become a useful resource, though it is very basic at present. It is being designed to have sections for both patients and professionals.

Information on audit protocols and instruments to assess patients' views on their care is available from the Clinical Governance Research and Development Unit in the Department of General Practice and Primary Health Care, Leicester University on [www.le.ac.uk/cgrdu](http://www.le.ac.uk/cgrdu). The patient career diary may also be downloaded from the site for looking at issues at the interface between primary and secondary care. It also has audit protocols available for a variety of topics, including hypertension, angina, heart failure, osteoporosis, incontinence, schizophrenia and depression.

The York *Effectiveness Bulletins* are available on [www.york.ac.uk/inst/crd/](http://www.york.ac.uk/inst/crd/).

The Centre for Evidence-Based Nursing is also at York on: [www.york.ac.uk/depts/hstd/centres/evidence/ev-intro.htm](http://www.york.ac.uk/depts/hstd/centres/evidence/ev-intro.htm), and includes links to evidence-based nursing sites.

Abstracts of reviews in the Cochrane Library are available on [www.update-software.com/ccweb/cochrane/cdsr.htm](http://www.update-software.com/ccweb/cochrane/cdsr.htm). It is necessary to subscribe to the Cochrane Library to get the full text of reviews.

The *British Medical Journal* home page ([www.bmj.com/](http://www.bmj.com/)) is a useful resource. It also includes access to Medline.

*Bandolier* is a newsletter to support evidence based practice. It is available on [www.jr2.ox.ac.uk/Bandolier/](http://www.jr2.ox.ac.uk/Bandolier/).

Some MAAGs have published their own audit packages or the results of audits. For example, Suffolk MAAG ([www.suffolk-maag.ac.uk/disease/index.html](http://www.suffolk-maag.ac.uk/disease/index.html)) gives details of audit packages for appointment requests, appointment satisfaction, asthma, benzodiazepine prescribing, cervical smear defaulters, child health surveillance, contraceptive services, diabetes, epilepsy, hypertension, lithium treatment, minor surgery, obstetric care, thyroid disease, well woman clinics. North Essex MAAG ([www.equip.ac.uk/](http://www.equip.ac.uk/)) has published the results of 67 audits.

Holland House surgery at Lytham St Anne's has links to PCG sites and sites relating to informatics, telematics and evidence-based care – [http://ourworld.compuserve.com/homepages/Nick\\_Lowe/](http://ourworld.compuserve.com/homepages/Nick_Lowe/).

CHAIN (Contacts, Help, Advice and Information Network) is a designed to facilitate links between health care professionals and others interested in evidence based health care and clinical effectiveness. It provides a network for exchanging information and views on clinical effectiveness. It is available on [www.nthames-health.tpmde.ac.uk/chain/introduction.htm](http://www.nthames-health.tpmde.ac.uk/chain/introduction.htm). Joining CHAIN also allows users to search for individuals with an interest in particular aspects of health care (e.g. you can search for someone with an interest in thyroid disease in your area).

Health Needs Assessment in Primary Health Care. A workbook for primary health care teams. J Hooper and P Longwith 1998. This is a very clear workbook that could form the basis of a course for PCGs to develop health needs assessment together. It has a very useful resource pack in it. Available on the web at [www.geocities.com/HotSprings/4202/index.html](http://www.geocities.com/HotSprings/4202/index.html).

The Royal College of General Practitioners ([www.rcgp.org.uk](http://www.rcgp.org.uk)) has information on the various quality awards of the RCGP. The Royal College of Nursing has a site on clinical governance for nurses ([www.rcn.org.uk/services/promote/quality/latest.htm](http://www.rcn.org.uk/services/promote/quality/latest.htm)). It includes examples of clinical governance and information about useful resources. The UKCC web site is [www.ukcc.org.uk/ukcc.htm](http://www.ukcc.org.uk/ukcc.htm) and the GMC's is [www.gmc-org.uk](http://www.gmc-org.uk).

The NHS Executive has its own website for primary care [www.doh.gov.uk/pricare/index.htm](http://www.doh.gov.uk/pricare/index.htm) where you will find government documents on primary care and links to other sites. The North Thames regional office of the NHSE [www.open.gov.uk/doh/ntro/cgov.htm](http://www.open.gov.uk/doh/ntro/cgov.htm), has a site designed to support clinical governance as does Northern & Yorkshire Region ([www.doh.gov.uk/nyro/clingov/cghome.htm](http://www.doh.gov.uk/nyro/clingov/cghome.htm)). This site also includes practical models of clinical governance developed by primary care groups.

The Association of Managers in General Practice ([www.nhsconfed.net/amgp/](http://www.nhsconfed.net/amgp/)) provides support for practice managers. The site offers information about continuing professional development and a set of management standards that may be used by managers who wish to compile a portfolio for NVQ assessment or as a tool for implementing standards in practice. See also information on MESOL on page 38.

## Books

Baker R, Hearnshaw H, Robertson N (eds). *Implementing Change with Clinical Audit*. John Wiley & Sons, 1999. This book provides an approach to addressing obstacles to change, and shows how audit, education and management relate to each other.

Chambers R. *Clinical effectiveness made easy: first thoughts on clinical governance*. Radcliffe Medical Press, 1999. A useful introduction to clinical effectiveness in primary health care.

Chambers R. *Patient and Public Involvement*. Radcliffe Medical Press. September 1999. This book will be an useful resource for PCGs and practices who want guidance on patient involvement

Chief Medical Officer. "A review of continuing professional development in general practice." Department of Health (London, 1998). This report is likely to form the basis of changes to practice-based education, identifying individual and practice needs, and developing of a plan for both practice and personal development. It is also available from [www.doh.gov.uk/cmo/cmodev.htm](http://www.doh.gov.uk/cmo/cmodev.htm).

Fowler J. *The handbook of clinical supervision – your questions answered*. Marck Allen. Salisbury. 1998

Fraser RC, Lakhani MK, Baker RH. Evidence-Based Audit in General Practice. From principles to practice. Butterworth-Heinemann, 1998. This book introduces the method of audit and includes five audit protocols (diabetes, otitis media, routine access, smoking cessation, depression).

Gillam S, Murray S. "Needs Assessment in General Practice". RGCP. Occasional Paper 73.1996.

Godlee F (ed). "Clinical Evidence'99". BMJ Publishing Group 1999.

Grol R, Lawrence M. "Quality Improvement by Peer Review." Oxford General Practice Series No 32 (Oxford University Press, 1995). This book outlines both the theory behind peer review, and practical steps that practices can take to look at their own performance.

Harris A. (ed). "Needs to know. A guide to needs assessment in primary care". Churchill Livingstone 1997. A series of articles looking at the needs assessment from many perspectives. Not a work book, but provides excellent overviews of the topic.

Lawrence M, Schofield T. "Medical Audit in Primary Health Care." Oxford General Practice Series No 25 (Oxford University Press, 1993.) This book describes the principles of audit, and gives examples in specific topic areas.

Pringle M, Bradley C, Carmichael C, Wallis H, Moore A. "Significant Event Auditing." Occasional Paper No 70 (Royal College of General Practitioners, 1995). This outlines how practices can use analysis of significant or critical events to audit their own care.

Pritchard P, Pritchard J. Teamwork for Primary and Shared Care. Second edition. Oxford University Press, 1994. This contains a questionnaire which will give you practical ideas for improving teamwork. There are questions about team goals, personal roles, participation, decision making, managing conflict, mutual support and feeling valued. When each member of the team completes a questionnaire, the combined results show how well the team works together.

Ridsdale L (ed). Evidence-Based Practice in Primary Care. Churchill Livingstone 1998. A practical guide for primary care teams.

Silagy C, Haines A (eds). Evidence Based Practice in Primary Care. BMJ Books, 1998. This book has guidance on how to translate 'evidence based care' into consultations with individual patients.

Van Zwanenberg T, Harrison J. Clinical governance in primary care. Radcliffe Medical Press (publication October 1999). This looks to be an accessible background book on clinical governance.

## **Other resources**

### **Evidence-based care**

You can learn about evidence-based medicine and develop critical appraisal skills using CD-ROM based material from the Critical Appraisal Skills Programme at Oxford (contact Nicky Clisby 01865 226730).

### **Professional development for practice managers**

MESOL (Management education scheme by open learning) runs programmes appropriate for practice managers through the Open University. Details are available from the MESOL National Office, The Manor House, 260 Ecclesall Road South, Sheffield S11 9PS. Phone 0114 226 3000 (Helpline) or 0114 226 3206 (Enquiries). Courses run by the Association of Managers in General Practice can be downloaded from [www.nhsconfed.net/amgp/courses.htm](http://www.nhsconfed.net/amgp/courses.htm) or from AMGP, Suite 308, The Foundry, 156 Blackfriars Road, London SE1 8EN (Phone: 0171 721 7080).

### **Risk Management**

The Medical Defence Union has produced a training programme and associated materials on risk management in general practice. If your practice does not have an MDU member, contact the Medical Defence Union 192 Altrincham Road, Manchester M22 4RZ

### **Consulting skills**

All components of the Leicester Assessment Package are contained in a folder accompanied by full instructions. All the forms can be photocopied. The Leicester Assessment Package is available from APEX, Exhibition House, London Road, Macclesfield, SK11 7QX and costs £32.25. Further details are also available from Professor Robin Fraser, Department of General Practice and Primary Health Care, University of Leicester, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW.

A consultation skills package designed for use on videotaped surgeries has been developed in the West of Scotland. It has been described in two articles in the *British Journal of General Practice* (vol 45, 1995, page 137 and vol 36, 1996, page 411). Another method for assessing consulting skills involves the use of simulated patients. The doctor completes an evaluation form about the consultation, and the simulated patient also completes an evaluation. The method is reported in the *British Journal of General Practice* (vol 48, 1998, page 1219).

### **Personal support/counselling**

The BMA has introduced a 24 hour counselling service for members and their families. It offers confidential support with workplace problems, stress and anxiety, alcohol and drug misuse and other personal difficulties (Phone: 0645 200169). A similar system is available for nurses through the Royal College of Nursing (Phone: 0345 697064, 9am-5pm). There are also some local schemes, for example the staff support scheme in Staffordshire. Details about how this local scheme works can be obtained from Professor Ruth Chambers, School of Health, Primary Care Department, Staffordshire University, Leek Road, Stoke-on-Trent ST4 2DF (Phone: 01782 294000).

## Primary care groups (PCGs) and primary care trusts (PCTs)

### What is your PCG clinical governance lead expected to do and how can you help?

Your PCG clinical governance lead has already been told what he or she needs to do, these are four 'key steps' which are supposed to be completed by April 2000.

#### Four tasks for PCG clinical governance leads:

- establish leadership, accountability, and working arrangements;
- carry out a baseline audit of capability and capacity;
- formulate and agree a development plan in the light of the assessment;
- clarify reporting arrangements for clinical governance within boards and produce an annual report.

### What do these tasks mean, and how can you help?

#### *Establish leadership, accountability, and working arrangements*

This means that PCG chief executives have to appoint a clinical governance lead (all have now done so), and that this person must have 'free access' to the chief executive and to the Board. The clinical governance lead will make contact with all practices. Teams can help by trying to come to meetings which the clinical governance lead arranges. At the end of the day, clinical governance in your area will be what you make it. Your clinical governance lead will almost certainly set up a local sub-committee and invite people to be on it.

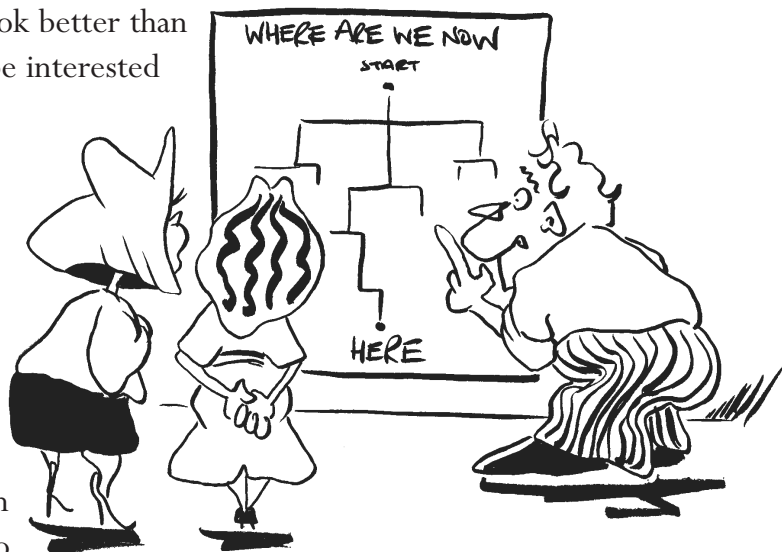
#### *Carry out a baseline audit of capability and capacity*

This is about finding out what is already out there and available to help start the process off. In most districts, there are already activities which will help get things going. For example, there may be skills within a local primary care audit group (PCAG) to help practices carry out audits. Some PCAGs also have staff to help summarise medical records. In some areas, teams have already banded together to develop local guidelines, and in some cases there are local awards for practices which meet quality standards.

Often there will be lots of quality related activities scattered around. Some may come from secondary care and others from community trusts. Your PCG clinical governance lead will be trying to make an inventory of what is available to help - this is supposed to be done by the end of September 1999. In addition, he or she will have access to the information on practices which health authorities currently keep e.g. smear and immunisation targets.

He or she will probably want to find out what you have done so far in your practice. Some practices already have a lot of experience, they have for example, taken part in one of the RCGP's quality initiatives such as the Quality Practice Award, or Fellowship by Assessment. However, when the clinical governance lead asks what you have already been doing, this is not the time to make things look better than they are! The sorts of things he or she will be interested in are on pages 5 to 8. Your clinical governance lead needs an absolutely honest appraisal of where you are at. Otherwise he or she will go back to the PCG board and report that much more can be achieved than is actually possible.

At this stage, the PCG clinical governance lead also needs to know what problems you can foresee in being able to play your part in clinical governance. Again, this is the time to get all the problems on the table, whether they are about your patients or other members of the team, so that you can make realistic plans about what is possible.



### ***Formulate and agree a development plan in the light of the assessment***

This is where the PCG clinical governance lead tries to pull all the information from the baseline assessments together to make a plan. This will include identifying where the main problems lie, where resources are needed, where there are education and training needs. This is a very important document as it will form the basis of any bid the PCG makes for additional resources to help with clinical governance.

### ***Clarify reporting arrangements for clinical governance within boards and produce an annual report***

This is back to that question of accountability. It is about demonstrating publicly (through the PCG board) that quality is being taken seriously. PCGs are expected to publish annual clinical governance reports, which describe their starting position, how much progress has been made, how it was monitored or evaluated and the plan for the next year.

The annual report will be expected to report action taken in relation to national service frameworks, NICE guidelines and the local health improvement plan. It will be expected to detail how educational resources have been used to support clinical governance and the ways in which patients and the public have been involved. It will also report on actions taken to protect confidential patient information.

In undertaking these tasks, your PCG clinical governance lead should be able to draw on the experiences of other leads in the area. Arrangements to enable clinical governance leads to exchange ideas are being established in most areas.

### **What will happen if your PCG moves towards trust status: what difference will it make?**

Some PCGs want to move to become primary care trusts (PCTs) and the pace of this change may turn out to be quite fast. However, the Government have made it clear that progress on the clinical governance agenda will be one of the things they expect to see before giving approval to PCTs.

The Government guidance contains the following sentence in its notes on moving to primary care trust status: “The more substantial and searching the issues the (PCG) board discusses, the more it will be concluded that the organisation has a clear sense of direction on clinical governance, and is taking it very seriously”. This gives a fairly clear hint of what the Government is looking for in PCGs hoping to move to trust status.

Among the things that potential PCTs are likely to be asked to show are:

- effective leadership in clinical governance: shown, for example, by having successfully engaged local practices in improving quality of care;
- widespread participation by practice staff in clinical governance activities;
- education programmes and other types of support to help practice staff meet their clinical governance needs;
- contributions to the delivery of the local health improvement plan (HImP) and progress towards meeting national targets (e.g. national service frameworks);
- agreed ‘risk management’ plans - these could include a set of basic standards which are achieved across the PCG/T with some way of monitoring them;
- ways of helping practices which are not able to meet local standards, or are performing poorly in some other way.

PCTs will need to show that they have made clear progress along the clinical governance road. Another government circular talks about ‘a systematic approach to monitoring and developing clinical standards in practices’ and ‘there will need to be regular board level discussions of the big quality issues and strong leadership’. At the same time, the circular talks about a cultural shift: moving away from a culture of blame to one of learning. Quite a challenge!

At level 4, clinical governance will involve community trusts also, and many PCG clinical governance leads are already talking to their opposite numbers from community trusts. Community trusts bring different types of experience to clinical governance. For example, mentorship is a common method of supporting community nurses, but is little used in general practice.

PCTs will also assume responsibility for clinical governance of services which are delivered by multiple agencies: a really challenging issue, as this is often where quality breaks down. This includes the quality of secondary care services commissioned by PCTs. The size of the agenda is daunting. But at the same time, GPs know that it is often at the boundaries between services that care breaks down. So it’s an agenda which many GPs and nurses will sympathize with. Clinical governance is clearly going to become more important not less, as PCGs progress to PCTs.

## Appendix 1. PRODIGY - a resource to use in consultations to improve quality of care

More and more is expected of doctors and nurses when they see patients. Not only do we have to deal with what our patients want, but we are also expected to practice evidence-based care, to keep up to date with the medical information explosion and to follow clinical guidelines. Some of these will be of interest to PCGs and clinical governance leads who want to reduce the variation in ways in which different doctors and nurses treat patients. PRODIGY is about helping with this.

### A story of PRODIGY in the consultation

Dr Jones sits at his desk looking at his computer. He sees that the next person to come in is Josh Taylor. The computer highlights that Josh is overdue his MMR. Josh comes in with his mother. He looks miserable and is holding his left ear. It's no surprise to hear that he has been up all night crying. Looking in Josh's ear, it is dull red. Dr. Jones explains that Josh has an ear infection and tells his mother he will give her something. They will choose the best treatment with the help of his computer. She thinks this is a bit novel but is pleased that her doctor is keeping up-to-date. She looks at the computer with her GP. They find some helpful guidance which enables her to discuss the options in simple English. The computer then prints an individualised leaflet that covers what the two have discussed and a prescription for some paracetamol. Dr Jones mentions the MMR and makes an appointment for this to be done in two weeks time.

Back at his computer Dr Jones finds that Frank Pearson is next: he's had his endoscopy. If only the endoscopy lab sent electronic messages of their findings! Fortunately Mr Pearson comes in with the result in a brown envelope. Sure enough it was a duodenal ulcer and he is *H. Pylori* positive. It is easy to bring up the guidelines for treating *Helicobacter*, and after a couple more keystrokes, Dr Jones prints off a prescription for triple therapy and a leaflet on *H. Pylori*. Dr Jones makes a few annotations on the leaflet for Frank, and off he goes.

## **What do I need to use PRODIGY?**

1. You need a clinical computer system. PRODIGY can already be supplied on 85% of GP computer systems, including AAH Meditel, Aremisssoft, EMIS, In Practice Systems and Torex. The other suppliers have to deliver PRODIGY by April 2000 to be eligible for reimbursement. Most systems do not need additional computer hardware to run PRODIGY but you should check with your system supplier. PRODIGY has driven a move to single sheet computer prescriptions to enable advice leaflets to be printed out for patients: financial support should be available to change your prescription printer to a laser printer or add a second one in your consulting room.
2. You need to use your computer during consultations to use PRODIGY.
3. You will need to be trained on PRODIGY by your system supplier. Two thirds of GPs also feel that they could do with some general training on the best ways of using a computer in the consultation.

## **How do I get what I need to use PRODIGY?**

1. Your system supplier will automatically give you PRODIGY free of charge. The PRODIGY module may need to be enabled or turned on. It can also be turned off.
2. Basic keyboard skills help a lot. A list of typing tutor programs is available from the PRODIGY National Dissemination Office or from your computer system's user group.
3. Training will be provided by your system supplier, probably included with training for other modules. In addition there will be opportunities to discuss PRODIGY issues with a 'Champion' at a local meeting or conference: contact the National Dissemination Office for a list of forthcoming events.
4. If you want to learn more about using the computer during the consultation, the PRODIGY National Dissemination Office can give advice.

## **Contacting the PRODIGY National Dissemination Office**

From the PRODIGY web site;

<http://www.schin.ncl.ac.uk/prodigy/>

or

### **PRODIGY National Dissemination Office (CG1)**

Sowerby Centre for Health Informatics at Newcastle

Newcastle University

Primary Care Development Centre

Newcastle General Hospital

Newcastle. NE4 6BE

Tel: 0191 256 3100

Fax: 0191 256 3099

e-mail: [prodigy-enquiries@schin.ncl.ac.uk](mailto:prodigy-enquiries@schin.ncl.ac.uk)

## Appendix 2. Practice professional development plans (PPDPs), and personal development plans (PDPs)

These terms are going to become as commonplace as PGEA for GPs over the next few years, and are part of PREP registration requirements for nurses. If you want to know more about these, you could visit WISDOM ([www.wisdom.org.uk](http://www.wisdom.org.uk)) which contains a model GP educational portfolio including an assessment of learning needs and a personal learning plan. However, here is a brief outline of what the terms mean.

### Practice professional development plans (PPDPs)

Developing a PPDP involves asking yourselves these questions:

- What are the things we need to improve in our practice?
- How have we identified them (discussions, surveys, audit, significant event analysis)?
- Do these reflect priorities in the wider NHS, within the health authority and the PCG? They don't necessarily have to, you are likely to have problems quite specific to your own practice, but you should be mindful of external priorities.
- How are we going to address these needs?
- How will we judge our success?

Note that PPDPs are all about 'we'. They are the team's approach to practice development, no-one needs to work on their own. In that respect it matches well to the ethos of clinical governance.

## Personal development plans (PDPs)

You may also hear personal development plans discussed (or sometimes personal learning plans). These are similar to PPDPs, but for individuals. Again, they involve working out the ways in which you need to improve your own care, and then finding out how to do it. The idea is that you choose your education on the basis of what you need to learn. Quite revolutionary really! The personal development plan is part of the practice professional development plan. In addition to meeting the needs of the individual, the team may also require an individual to learn new skills in order to develop services.

There are two other terms which you will probably hear used as well.

- Continuous professional development (CPD) is going, as a phrase at least, to replace 'postgraduate education'. The proposals are described in the CMO's report on the subject (see page 36). CPD has two key elements - 'reflection' - i.e. working out what you need, and 'education' - i.e. doing something about it.
- Accredited professional development is a voluntary RCGP system for accrediting GPs who are involved in an approved programme of professional development.

You can see that there is a lot in common between clinical governance and these new buzz-words. The idea is that education in future should help you to maintain and improve the quality of your care (ie clinical governance). So clinical governance should go a long way towards what you need for your own professional education and development.