Strengthening clinical governance in primary health and community care

Large numbers of people die each year in hospitals as a result of preventable errors. High profile cases like the Royal Bristol Infirmary in the UK or the King Edward Memorial Hospital in Western Australia highlight the problem in the popular media, putting pressure on governments, providers and the professions to improve safety and quality in hospitals. In Australia, the Quality in Australian Health Care study reviewed the medical records of 14,179 admissions to 28 hospitals and found that an adverse event occurred in 16.6% of cases, with 51% considered to have been preventable (Wilson et al., 1995).

Hospitals have long been required to ensure good corporate governance. Clinical governance is now becoming popular to improve quality and safety. Good clinical governance should include structures and procedures for risk management, performance management, quality improvement, quality information, and accountability (McSherry & Pearce, 2002).

Increasingly, governments are specifying clinical governance principles and frameworks for the health service providers to follow. For example, the Victorian Safety and Quality Improvement Framework consists of a strategic approach to quality and safety through four key organisational elements: governance, leadership and culture; consumer and community involvement; competence and education; and information management and reporting (Victorian Quality Council, 2003).

More recently, the distinction between primary, acute and sub-acute settings is becoming blurred. Fiscal pressure, changes in information and treatment technologies, and the emergence of consumer rights and preferences have seen a dramatic shift from institutional and bed-based care to community provision for more complex needs. Same day procedures, hospital in the home, rehabilitation in the home, and home and community-based care have been added to episodic primary care and population health programs.

Comparatively, few studies have investigated errors in primary care. Those that have largely focus on diagnostic and medication errors. Even so, the studies that have been conducted suggest all is not well. Bettering the Evaluation and Care of Health (BEACH) data suggest that nearly 1% of general practice consultations involve dealing with an adverse event (although not all occurred in primary care settings [Hargreaves 2001]). But estimates are unstable because methodologies and definitions vary. In contrast to the BEACH findings, Fischer, Fetters, Munro, and Goldman (1997), for example, estimated 3.7 adverse events per 100,000 GP consultations.

While clearly more research is needed, the available studies nevertheless suggest that significant numbers of people die or are harmed by preventable adverse events in primary care each year. Should there be a greater focus on clinical governance in primary care as well in hospital settings?

As care complexity in primary and community settings grows, clinical governance procedures will become more important. Obviously, governance arrangements in primary care should ensure that clinical quality and safety are taken seriously to improve health outcomes for consumers.

More pragmatically, primary health and community care providers, such as general practice, community health services and community nursing agencies, will need to be able to demonstrate strong clinical governance for acute care providers to be willing to devolve clinical responsibility for the management of chronic illness and ambulatory care sensitive conditions to them. Either way, there are good reasons why research and development to improve clinical governance in primary health and community care should be moved up the agenda.

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