SHORT REPORT

Clinical governance in UK commercial occupational health providers

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Introduction

Clinical governance has been introduced as a new model for continual quality improvement [1]. It has been defined as ‘a system through which organizations 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’ [2]. The essence of clinical governance is that it is ‘multifaceted and multidisciplinary’ [3].

It has not been established what arrangements are needed for quality improvement programmes to be successful in health care [4]. In a recent review of the literature, Thomas found ‘no sound evidence exists to support the claim that clinical governance will increase service quality’ [5]. There is, however, a growing body of evidence that increasing the quality of patient ‘service’ can improve clinical outcome [6].

Although most health care providers in the United Kingdom are subject to a legal duty to implement clinical governance, commercial occupational health providers are not. To date there have been no published studies of clinical governance in occupational health.

Method

Commercial providers of occupational medicine in the United Kingdom were identified from published sources, including market research reports. Organizations employing only one doctor were excluded. The senior clinical manager of all the 17 organizations identified was asked to complete a questionnaire designed for this purpose. Respondents provided information on their arrangements for clinical governance and their opinion on governance issues. A single reminder was sent after 1 month. Completed survey data were anonymized and subjected to descriptive statistical analysis. Where necessary, data were analysed using a Likert scale (very low = 1, very high = 5).

Results

Fourteen (82%) managers, all doctors, responded on behalf of their organizations. Only eight companies (57%) had a formal clinical governance system in place. In addition, another three companies supplied information on component activities they did have in place (Table 1).

Only one company had not identified a senior person who was responsible for ‘day-to-day’ clinical governance. Normally, this person was the senior clinical manager. In most cases, this responsibility was included in the job...
Almost all the providers had formally identified someone at executive level to lead clinical governance (12/14, 86%). Eleven (79%) organizations regularly reviewed clinical governance at executive meetings. Most commonly, this review was held at least every 3 months (8/11, 73%).

Almost all the companies had a system to address poor clinical performance (13/14). However, only about half had a system in place to encourage excellent clinical performance (8/14).

None of the respondents disagreed with any of the core values for the medical profession [7]:

(i) commitment,
(ii) caring,
(iii) competence,
(iv) integrity,
(v) confidentiality,
(vi) ability to work in a team,
(vii) concern for the individual and community,
(viii) education and training and
(ix) contributing to the knowledge base.

Six organizations had made formal statements of their values. Additional values fell into three domains: how people associated with the organization should relate with others generally, how the organization should treat its workers and the style of the organization in the sector.

Respondents were invited to give their opinion on the importance of each of the potential components of clinical governance as contributors to quality (Figure 1). They placed the lowest importance on public and patient involvement.

### Discussion

The respondents identified a range of components that contribute to clinical governance. Only one of these, learning and development, was common to all. The essence of clinical governance is better quality of care for patients. However, the respondents placed least importance on public and patient involvement.

Although most organizations had systems in place to address poor performance, fewer had systems to promote excellent performance. This suggests an approach guided by attempts to avoid system failures rather than maximize quality from the patient’s perspective. However, it may also properly reflect clinical practice in occupational health where treatment of the patient, in the traditional sense, is often not the primary purpose of the consultation. Models of clinical governance implemented in large organizations providing a range of health services may need adaptation to properly meet the needs of the occupational health function.

The literature indicated that a senior person should be identifiable who provides leadership to clinical governance [8,9]. Most organizations had given someone responsibility for the day-to-day management of clinical governance and included this responsibility in a job description. In addition to senior leadership, it has been suggested that clinical governance is enabled by a ‘non-hierarchical’ climate and a wider sense of personal ownership [10]. The limited information was consistent with previous work suggesting that someone should be accountable for the overall effectiveness of the system while a wider group shared responsibility for effective clinical governance [8,9].

Although most large and medium sized commercial providers will have been surveyed, it is possible that not all eligible providers were identified. There is no easily accessible source of information on the number of UK providers and the number of doctors they employ.
The questionnaire used allowed respondents to give their views on the importance of potential components of clinical governance. However, they were not asked to rank items in order of priority and this was inferred from the mean score of pooled results. It has not been possible with this method to consider items together as one system and so understand how managers are dealing with the complexity of competing priorities. It is possible that a higher priority would have been given to some components, most notably patient involvement, if a different method had been used.

The results are similar to the public health care sector. A recent survey found incomplete implementation of component ‘structures and systems’ of clinical governance in up to half of public health care providers [11]. The majority of respondents were still to be convinced whether clinical governance was very effective.

The surveyed organizations provide occupational health care for hundreds of thousands of workers although this was not measured by this study. The response rate was high (82%).

This was the first study of clinical governance in occupational health in the United Kingdom. Although there is no legal obligation to implement clinical governance, many commercial providers of occupational health have already put systems in place. These systems are consistent with established models. The focus on quality and accountability in health care is unlikely to decrease. Further work is needed to understand how governance should be developed so that all recipients of health care can expect it to be of a high standard whether there is a legal duty or not and whether at work or not. The introduction of models of clinical governance into occupational health and the effectiveness of those models warrant further study.

Conflicts of interest
None declared.

References