

## Special interview

# Dr Clare Gerada

Mayur Lakhani, editor of *Quality in Primary Care*, interviews Dr Clare Gerada, newly appointed Directory of Primary Care at the National Clinical Governance Support Team (NCGST), which is part of the NHS Modernisation Agency in the UK.

### What is your exact role and what does it involve?

---

My role is around ensuring that issues relating to primary care are included in any thinking at the NCGST. At present much of the work has had an acute trust focus. My other role is pulling together the many loose strands that impact on clinical governance and primary care – for example appraisal, revalidation, general practitioners (GPs) with special interests (GPwSIs), defining the roles and responsibilities of clinical governance (CG) leads, defining a competency-based training agenda and supporting the development of a support network for CG leads and medical directors – and that is only for the first month!

### What is your motivation in doing this role?

---

I want to expand my current portfolio which has focused on drug misuse issues. I want to develop my own skills and knowledge by taking over a new brief.

### What are your views on progress in clinical governance in primary care so far?

---

Getting there!! I have held a stakeholder meeting to start the work around defining the core activities of CG leads, I am holding meetings to see what the gaps

are in relation to primary care and quality, particularly within *National Service Frameworks*. I am looking at tools for CG leads that they can use to embed CG at practice level, for example, the Royal College of General Practitioners quality team development (RCGP QTD) scheme, patient experience questionnaires and other tools aimed at looking at quality within general practice.

### What are the next big challenges?

---

Sorting out the boundaries of the post, ensuring that the work, and by implication the work that CG leads need to do, remains practical and do-able and simple.

### What should the patient notice if CG is working effectively in a practice?

---

That their voice is heard, that they have a direct influence on their primary care services, that their GPs and nurses are more up to date.

### Are you going to be working with practices or PCTs?

---

Predominantly strategic health authority clinical governance leads and primary care trust (PCT) CG leads.

### What will the NCGST actually be doing for practices?

---

At present much of our work is being done at PCT and professional executive committee level.

## How will the average practice notice what you are doing – you are almost invisible?

---

I hope that PCT leads will feel supported and hence be able to develop the culture of CG at practice level by liaising directly with them. I don't think I need to be so visible – in the end my success will be visible through CG leads.

## Do you think GPs have any enthusiasm left for clinical governance? Isn't their quality focus now just going to be on points for the new contract?

---

I think they are much the same – quality is CG!

## What do you consider to be the most pressing issues in relation to clinical governance?

---

Better patient involvement; better use of skill mix; ensuring that practices understand that CG is not a single entity but a culture of change and drive towards excellence.

## Much has been made of a positive culture or a culture in organisations where excellence can flourish? What is your sense of the progress made in this regard? How can we get this culture change?

---

I think we focus too much on errors and not enough on sharing excellence and rewarding good practice. Most practitioners do a great job and they need to be reminded of this. I am always amazed at the skills of GPs and nurses and how they manage in such difficult circumstances, and how they deal with the multiplicity of problems in their patients, and remain committed and smiling.

## What you think about the issue of clinician – particularly GP – disengagement from PCOs? What is this about? What are your concerns about this? How can we keep people on board?

---

I think that GPs work best when their skills in innovation can be used rather than sitting on boards or attending meetings. GPs are like bees – they fly around pollinating and then move on, they should work to that strength.

## Describe the publication/lecture/material that has most influenced your thinking about quality?

---

I went on a King's Fund leadership course that fundamentally changed the way I worked and gave me the confidence to lead.

## Some people think that CG has become too 'managerial' and less clinically focused – many PCOs do not have GP CG Lead

---

I agree – it needs to be through clinical leadership.

## In the recent Reith Lectures the downside of accountability was made apparent with overregulation of professions leading to a breakdown of trust and professionalism. What is your view of the balance between quality improvement and accountability?

---

This is the way the world is moving – we are public servants so we have to be accountable. Nevertheless, I agree we must not lose the good bits of profession-

alism, which means in the end doing a good job, staying until the job is finished, discussing mistakes and putting patients first. I can't remember where this came from but I was told that a GP has an 'itch' when things are not done and cannot rest until the itch is located and dealt with. This is the essence of professionalism. We risk undermining this through overmanagement.

**Underperformance – I want to explore your views of the link between appraisals and revalidation. Underperformance will become the prime responsibility of CG. Appraisal is developmental but appraisals sit in CG departments in PCTs. How do you see the relationships and the contradictions?**

If I were to redesign I would say that appraisal should have some summative aspects to it. I don't understand how you can be revalidated just by having undergone five appraisals yet still underperform. I think appraisal should involve some element of validation – especially where you are looking at GPs doing work beyond the generalist – e.g. GPwSIs. In the end however we have to start somewhere and appraisal is a good place to start. I have always felt that we know who the underperformers are and have never had the mechanisms to deal with them, now we can start – if only to highlight some areas that need more attention.

**Every practice (nearly) will have a clinical lead for clinical governance. How do you see this role? How effectively is this being discharged? Do you feel there is enough support at this level or not?**

I think the main barrier to good CG is time – time to provide a good service, time to reflect and time to learn. If this can be sorted then massive improvements will be made. I think that the new General Medical Services (GMS) contract will fail in providing this time – it needs to be factored into the

contract, not as an afterthought. CG leads may be able to help to remind practices of the need to reflect etc and can help to disseminate good practice.

**Patients notice fragmentation with multiple providers and particularly quality of care in the secondary sector seems to be a regular complaint of patients. Some might say that clinical governance has been less successful in dealing with interface issues and improving patient experience**

All this is true, though of course patients want different things for different problems – they don't really mind seeing a strange doctor or nurse if they have an acute problem and want it dealt with quickly – but if it's a long-standing chronic issue they want to see 'their doctor'. The skill is to be able to provide them with both. However, I do think that we are losing the essence of general practice – that is a long-term relationship with a patient and their family – but this decline started years ago with us opting out of Out-Of-Hours Services (OOHS) and using deputising services. As for multiple providers – this is skill mix. In the end it's the clinician's ability to engage the patient that matters, not their discipline. Patients want a doctor (or nurse) who listens, who sorts out their problems and who refers appropriately.

**Tell us how you explain clinical governance to the uninitiated?**

Creating a culture where all within it are able to continuously learn and develop and deliver high-quality care. CG is about delivering quality, learning and reflecting.

**Describe your dream IT system for clinical governance. What is your vision?**

Difficult question. I think that IT and CG is about easily accessible information to help us adapt our

services to meet patients' needs and implement good practice. So this would be about a system that, for example, would give feedback about prescribing, diagnosis, blood tests, etc. IT is vital to CG; getting it right will do a lot for patient care.

## **What do you think we can learn from abroad regarding quality?**

---

I think we can teach each other a lot. We have for years had such an underfunded service yet delivered high-quality care. If we are to learn anything it's about maintaining clean hospitals, efficiency and better use of skill mix.

## **Please state three key messages for our readership**

---

- Keep CG simple.
- Think what you would want if you were a patient or if one of your relatives were a patient.
- Maintain a level of clinical practice yourself – it keeps you grounded.

## **Are you still doing general practice? What do you do to relax when you are not working?**

---

Yes, I do . . . five sessions per week on average and I run a drug service. I have joined a gym and start yoga tonight!