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1 CG is WOMBAT without BGB

This is the first of a series of five articles looking with a completely fresh look at what matters in Primary Ocular Care. In this article I want to demystify Clinical Governance, and show easy it is to break it down into manageable portions with definite goals and different methods.

As is traditional I'll start with some definitions: Clinical Governance can be (a) platitudes about continuous development, (b) a bunch of dreadfully implemented regulations or (c) voodoo systems with ritual paperwork copied from management consultants with nothing better to do on a wet Friday. In short: A Waste Of Money, Brains And Time or WOMBAT. CG cannot continue to be filed in the 'too-difficult' file for ever because it is *one* important component of a proper quality system. (I will be filling-in the gaps concerning Quality in a future article.) Quite simply, CG is: "Ensuring the *competence* and *diligence* of the *people* involved with the system."

You can't lump all matters relating to let's say 'professional standards' together. Dealing with alcoholics and Masters degrees in the same way is plainly barmy. Hence the Bad-Good-Best model: Bad practice is that which we won't countenance and is basically a list of Don't!'s. Good practice is the standard we expect from most people all of the time or all people most of the time. Best practice is what we would like everyone to aspire to but realistically expect a few highly motivated people to acquire specialist competencies. The following table shows the different nature of Bad, Good and Best.

	Bad	**Good**	**Best**
Description	Falling below acceptable standards. Urgent need of attention.	The highest standards realistically attainable by all optometrists in everyday practice.	Ideal standards achievable by investment, training and new methods.
Activators	Complaints.	• Initial training. • 'Keeping up' with developments. • Audit.	• Personal motivation • LOC leadership
Moderators	Rule book	• Hand book • Informative articles	• Professional Standards Programme • Clinical literature

Notice how the things that get each started (Activators) are utterly different. Notice also that the tools we use to deal with each (Moderators) are also completely different.

Bad practice

This can be tackled with a two-pronged approach:

1 Use properly documented clinical and clerical protocols for specific issues.
2 Use a general rule book for general 'professional conduct' matters.

An example of the first is referring to formal protocols in contracts. Although policing protocols is very difficult in practice you can't expect people to do exactly what you want if you don't give them accurate instructions.

You might think that having a rule book is an impractical recipe for confusion, paperwork and general shenanigans. You are very right to be worried on this score but this need not be the case. I have developed such a rule book: The headline 'Don't!'s' are shown in the box. The real value of a rule book comes in the way it is operated which is also defined in the book: In brief there are two principles: (a) Any investigation should be by a peer group which has spent time discussing the grey areas and what might be the best answer in this particular case and other similar ones; and (b) Any investigation is transparent and comes to a definite conclusion. By constituting this 'rules committee' in the right way, encouraging self-reporting of near-misses in a non-adversarial situation, and publishing results we can use it to improve everyone's awareness of pitfalls. Prevention is better than cure.

1	Always reach the minimum standards of Clinical Care.
2	Not do anything in a clinical context that will bring the profession of optometry into disrepute.
3	Not mis-represent their level of qualification.
4	Accept that the primary responsibility for ensuring a high standard of patient care rests with each individual optometrist.

Good practice

Good practice is what we expect of every average optometrist. Please read the following very carefully: The average optometrist is expected to be committed to maintaining their professional competence. That is the full and complete definition of the CG requirement It recognises

- skills get rusty with lack of use,
- knowledge becomes out of date
- requirements change
- the responsibility lies with the individual optometrist.

If an optometrist can show they are maintaining their competence then they have fulfilled their obligation. Notice that it doesn't say they must get better. (Do we really expect know-nothing graduates to continually develop into specialists with international reputations!) The problem with the scatter-gun approach of '1001 things to tick to make sure you're competent' is that (a) not all people need to know all areas (b) valuable in-depth study scores vary badly in comparison to easily ticked items (c) you might pick up missed items but then this is a bad practice thing not a

good practice approach (d) diligence and responsibility are not covered, and perhaps most importantly (e) a slog through an exam you can do standing on your head is a big de-motivator. Particularly with the unusual structure of optometry we can't afford de-motivation if we are to get optometrists to invest their own time and money in improving the essential skills base. There are answers.

There is plenty of easily accessible printed information (mostly clinical) for those who want it but other training is a neglected and haphazard subject. An important tool for reference is a Good Practice handbook if only to enumerate the issues and be a framework for more detailed study and a focus for promoting important changes. Obviously this is something of national scope but existing materials need completely overhauling.

There isn't enough space here to discuss auditing, ensuring that optometrists have the necessary opportunities to brush-up their skills and avoiding making mountains out of molehills.

Best practice

Best practice is the extra level of competence achievable by many but not all, most but not all of the time in some but not all areas of skill and knowledge. Best practice covers:

- knowledge
- skills
- participating in optometry outside daily practice.

Best practice is not the 'required standard' for optometrists but it most definitely is required in liberal amounts in the profession as a whole. It isn't acceptable that patients in a particular locality should be denied first class treatment by experienced optometrists because there is nobody locally who has the necessary specialist competency.

Best practice is driven by the instinct of true professionals to be better and cover a wider range of tasks. Individuals will inevitably be investing their own resources in improving their reputation, abilities, working practices and becoming a source of experience for others to come to for reference. (In the context of CG we are also looking for optometrists to gain the experience and confidence to become involved in the regulation of the profession.)

Motivation is the key. The situation for owner-optometrists is quite different to that of employees. The former are in a more entrpreneurial environment and can take advantage of additional skills, whereas an employee firstly doesn't have the flexibility to take time out to study, and secondly is unlikely to get any reward except being able to take a different job. This is an example of where a broad outlook on CG (ie maintaining the skills base) is important.

Skills and knowledge cannot be developed in a vacuum. Neither can they be maintained in tip-top condition without frequent hands-on experience. Thus a framework is required which assists the development and maintenance of the skills base in general and an individual's abilities in particular. I call this a Professional Standards Programme. (Note: This is a management approach not an individual's programme.) The PSP comprises a number of elements:

- Recruiting and assisting optometrists to find the training they want
- Ensuring the availability of training resources

- Keeping records of training undertaken
- Developing a best practice culture
- Monitoring the health of the skills base.

Conclusion

Anybody being sent on a course on CG which doesn't include BGB as a fundamental structure should ask for their money back. You will be wasting your time. 5 days of blether! Checklists and 'baseline assessments' are absolutely great for 'being seen to be doing something' but otherwise WOMBAT except in well defined contexts.

CG isn't difficult when you understand it. You can see from this article that there are some things you can be thinking of doing now and some where, although you can prepare hearts and minds today, you'll have to wait until tomorrow for more coordinated action. Finally, any form of CG requires proper record keeping if you can't do that then drop everything until you have.

In the following articles I'll be looking at the far more pressing issues relating to how professionals work together in a NHS which is drifting towards the reef of chaos.