Introducing clinical governance in an acute trust

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The introduction of clinical governance is a major imperative for the NHS. This paper describes the initial actions taken in a large acute trust to prepare for the clinical governance process. While this description is particular to one trust, it is hoped that it offers some generalizable lessons.

Clinical governance can be defined as a framework through which NHS 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 (Department of Health, 1998). This definition of clinical governance encompasses two distinct elements — the mechanistic element of ensuring systems are in place, and the more philosophical element of producing a culture in which clinical quality can flourish.

This paper describes the approach to these challenges used by a large acute trust which provides acute services to a population of over 300 000, tertiary services to a population of about 1 million and employs more than 4 600 staff, of whom 170 are consultants. Our aim was to take a snapshot of the trust as it is at present, and to use the results to ask two questions: do we have the right culture, and do we have the right structures?

DO WE HAVE THE RIGHT CULTURE?

South Tees Acute Hospitals Trust was a second-wave trust which has prided itself in its commitment to quality. What is the evidence for this? Four elements stand out: the Trust's mission statement, its definition of its core values, the use of the European Quality Foundation model for developing excellence and the commitment of key staff to quality improvement.

The Trust's mission statement

To many, mission statements are seen as examples of the discredited 'business' approach to health care produced by the White Paper (Department of Health, 1989). However, our own mission statement 'striving for the best in health care' is a surprisingly accurate encapsulation of our Trust's approach. We do strive — we are always on the look out for a better way — and we do unashamedly see the best as our goal.

Core values

In 1994/5 the Trust set out to explicitly state its core values. From an initial working party the project was spread throughout the organization and eventually had direct participation from more than 1000 members of staff. As a result of this exercise we defined our core values as to:

- Offer the best possible clinical care by sustaining staff skills and technology at the leading edge
- Give patients the opportunity to play a real part in their own care
- Ensure all staff exchange mutual respect and support
- Deliver services in the way most convenient to patients
- Provide an environment that promotes patients' comfort and wellbeing
- Run the Trust in a way that empower staff to work effectively in the patients' interests
- Protect each patient's right to courtesy, dignity, and their own spiritual and cultural needs.

Developing excellence

The European Quality Foundation (Reed, 1998) model has been the engine of change in the Trust. Although predicated on achieving 'business excellence', it has been used increasingly in public service, where it has been found to be equally applicable.

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The commitment of key people

One consequence of becoming a Trust is the unequalled influence of the Chief Executive. Our Trust's Chief Executive has a strong commitment to quality in all aspects of the Trust's performance. His personal commitment has been allied to a devolved management style which involves key personnel, especially consultants, in the management process, and enables their own intrinsic drive for clinical excellence.

The Trust appears, therefore, to be extremely well placed culturally to respond to the challenge of clinical governance. However, there are some aspects of our performance which give cause for concern. These include the problem of quantity *vs* quality, equality of opportunity in the workforce, and research and development.

Quality *vs* quantity

Over the last few years, the NHS has placed an enormous premium on quantity. In common with others, our Trust has responded by increasing workload at an inexorable rate. This has been at the expense of two aspects of quality. First, on occasions patient care has been less good than we would wish. Rushed consultations and overstretched nurses have been too frequent features of our work.

Second, there has been an enormous pressure on the staff — too many members of all professions are working too hard for too long. The pressures have been significantly exacerbated by the tendency of the centre to give inadequate time for responses to important questions. The feeling that our political and civil service masters are either out of touch with, or oblivious to, the destructive effects of their actions is having an alienating effect on staff and a corrosive effect on morale.

Inequality of opportunity

Many aspects of professional development are well supported in our Trust, but the gap between the 'study leave' opportunities of doctors and nurses, for example, is wide and is a source of discontent.

Research and development

For a Trust of our size and span, our research and development output is smaller than it should be. This partly reflects a relatively late development from a district general hospital (DGH) to a fully fledged tertiary centre, and partly the inexorable pressure of our clinical workload. There is increasing student teaching taking place in the Trust which we know, from feedback and external appraisal, is of very high quality, but the inequities of the service increment for teaching (SIFT) means that the rewards are meagre and the main resource is, yet again, extra work provided by already overburdened staff.

On balance we have concluded that our culture prepares us well for clinical governance, but there are significant areas in which we must improve.

DO WE HAVE THE RIGHT STRUCTURE?

We examined our structures in two ways, first the management structure of the Trust, and second by examining the list of characteristics of a quality organization contained in the White Paper *The New NHS: Modern. Dependable* (Department of Health, 1997).

Management structures

When the Trust was formed there was a wide-ranging debate regarding its future structure. It was agreed that the management should be based around individual patient teams. The result was 34 clinical directorates, either revolving round individual diagnostic groups, such as rheumatology, or individual patient groups, such as paediatrics. Each of these is managed by a consultant acting as clinical director and a clinical manager, who is usually, although not exclusively, a nurse.

In order to give each a voice on the management group the directorates are aggregated into divisions, each led by a consultant who is chief of service supported by a divisional manager — these people have diverse clinical and non-clinical backgrounds. The management group comprises the nine chiefs of service plus the corporate directors of the trust.

There are two important factors concerning this structure. First, there is a majority of doctors on the management group. Second, although the structure looks similar to that of many trusts which have clinical directors with equivalent spans to our chiefs, and sub-directors or lead clinicians where we have clinical directors, there are significant differences between these structures. Our own gives a high degree of autonomy to the directorates and a powerful clinical involvement, both medical and non-medical, in the directorate teams. Every directorate has budgetary responsibility, produces its own business plans and manages its own operation. This equates well to the statement in the White Paper:

> **'It is important that these arrangements for Clinical Governance engage professionals at ward and clinical level.'**

It is central to our concept of clinical governance that it will succeed, or fail, at this clinical level and it is our belief, based on the track record of our directorates, that they will be equal to, and managerially equipped for, the challenge.

Characteristics of a quality organization

The White Paper listed the characteristics which are considered essential to ensure clinical quality. We evaluated the structures which we have in place to meet these criteria, using the matrix produced by the British Association of Medical Managers (BAMM, 1998). The first phase of the evaluation was to ask the chiefs (*n*=9) and clinical directors (*n*=18) in which areas they perceived our current practices to be robust. The result is shown in *Table 1*.

There are several important messages in this. Obviously we have systems in place for all these aspects of the service, although the extent to which they might be considered 'robust' varies. Equally obvious is the diminishing confidence as the right-hand side of the matrix is approached — we are less good at explicit monitoring and reporting, and our levers and sanctions appear to be very weak.

Two areas produced particular anxieties. There was a high degree of dissatisfaction with our information services. These are less well developed than in some trusts, but further analysis showed that questions of definitions, varying interpretation by different parts of the service, and the inappropriate use of figures of dubious relevance and accuracy in such politically-motivated arenas as 'league tables' were greater causes of concern than our own in-house shortcomings. The ability to detect and deal with significant deficiencies in clinical performance was also a source of anxiety.

Our conclusion was that our organization did contain all the necessary attributes of a quality service, but that there were significant needs for strengthening them all and coordinating them better. One early role of the clinical governance committee will be to oversee these developments.

WHAT HAVE WE DONE?

Our stocktaking has led us to a series of actions designed to capitalize on our strengths and address our weaknesses. It was considered important that the medical director should lead the clinical governance process in the Trust and chair the clinical governance committee. The greatest strength of the Trust was felt to be its clinically led management structure, and it was agreed that this must be the fundamental building block on which all clinical governance activity should be built. Further analysis of our strengths and weaknesses is being undertaken, with, for example, all consultants

TABLE 1.
Quality audit: a checklist for clinical governance

System	Process established	Process explicit within organization	Process amenable to monitoring?	Reporting arrangements?	Implementation of findings/ lessons monitored?	Levers and sanctions in place to make it work?
Adverse events detected investigated, lessons learnt translated into change in practice	*****	****	***	***	**	*
Systematic learning from clinical complaints, with translation into change in practice	****	***	**	*	*	*
Poor clinical performance identified early and dealt with, skill, and speed and sensitivity, to avoid harm to patients	**	*	*	*	0	0
Continuing professional development programmes in place reflecting principles of clinical governance	***	**	*	*	0	0
Quality of data for monitoring clinical care of consistently high standard	**	*	*	0	0	0
Quality improvement processes (clinical audit) integrated into organizational quality programme	****	***	**	*	*	0
Leadership skills developed at clinical team level	****	***	**	0	0	0
Evidence based practice and infrastructure in place and used	***	**	*	*	0	0
Clinical risk reduction programmes in place and of high quality	***	**	**	*	*	0

Medical managers' responses to question 'do we have robust systems in place?' ***** = 100%; **** = 75%; *** = 50%; ** = 25% +; * = < 25%; 0 = 0; Number of respondents: Chiefs *n*=9; Clinical directors *n*=18.

being asked for their view through filling in the BAMM matrix; and more than 90% have done so.

Nurses and professions allied to medicine are being involved at all levels of the organization, but with encouragement to deliver through the directorate teams. There has been wide debate throughout the organization, and communication has been enhanced by production of a clinical governance newsletter and by setting up an intranet site. Because of the importance of lifelong learning, an associate medical director with specific responsibility for that area has been appointed. A guide to practical implementation of clinical governance for directorates has been developed containing a set of questions enabling directorates to benchmark themselves and plan their own development in an appropriate way.

ARE THERE LESSONS FOR OTHERS?

This article has described a single acute trust's initial response to the challenges posed by clinical governance. Others will recognize some aspects of their own organization, but none will be identical. Are there any messages for everyone? I believe there are four.

Look critically at what you do now

There is more than one way of delivering clinical governance. Each organization must base its response on an honest analysis of its own style, strengths and weaknesses, and develop from there.

Bed clinical governance into day-to-day management

If clinical governance becomes some sort of parallel universe detached from day-to-day management and practice, it is likely to produce a resented bureaucracy that fails to deliver. It is only by embedding its principles and practice into everyday care delivery and organization that it will succeed.

Involve everyone

Management and professional divides, squabbling between professions and internecine professional disputes have all occurred and are all counterproductive — we are all in this together!

Provide the right culture

There is an understandable tendency to concentrate on the mechanisms needed to deliver individual aspects of clinical governance. It is also likely that organizations such as the Commission for Health Improvement (CHIMP) will concentrate in this way. Some influential organizations are promoting their own methodologies, firmly based on a tick-box mind-set. For clinical governance to raise standards in a genuine and lasting fashion it must be developed in a supportive, blame-minimizing, educational atmosphere. The politicians' delight in 'name and shame' must not be allowed to flourish at the expense of creating a truly supportive, high quality, clinically driven organization. HM

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KEY POINTS

The introduction of clinical governance should be based on:

- A structured analysis of present strengths and weaknesses
- Embedding it into everyday management and clinical structures
- Involving everyone in a supportive fashion
- Concentrating on providing the right atmosphere in which excellence can flourish, rather than simply developing mechanisms.