Clinical governance: setting the scene

Phil Ayres

The concept of clinical governance was first introduced to the NHS in late 1997. Since then, it has become a commonly used term, but there is still a great deal of uncertainty about what it means and how it should be implemented. This paper places clinical governance in the context of previous quality initiatives, and considers the roles of both managers and clinicians.

Clinical governance first appeared as part of official UK Government policy on the publication of the White Paper *The New NHS: Modern, Dependable* in December 1997 (NHS Executive, 1997). Further guidance was issued in the publication of *A First Class Service* (NHS Executive, 1998) in July 1998 and, more recently, direct guidance on clinical governance from the NHS Executive was published (NHS Executive, 1999). There is still, however, uncertainty about what clinical governance means and how it should be implemented.

This paper describes the origins of clinical governance by referring to previous quality initiatives in the NHS. It demonstrates how these have been joined together in a single focus for quality improvement under the new banner of clinical governance. The paper concludes with the notion that the clinical governance bandwagon should be carrying as many managers as clinicians.

HOW DO WE KNOW IF A SERVICE IS ANY GOOD?

Clinical services may be seen by health professionals as a product of daily activity. To patients they are a series of meetings and acquaintances, interventions and outcomes that may lead to a 'good' or 'bad' result. A crude example of a service is shown in *Figure 1*.

In this example a patient experiences chest pain and hopefully ends up in good health. The journey of the patient runs through primary care, ambulance services, acute and rehabilitation departments of a hospital, outpatient follow-up, return to work and eventually discharge from the health services' attention.

Deciding whether or not the service which the patient experiences is any good has become a complex task. In the past 20 years we have attempted to address issues of quality through a number of different initiatives. These are shown in *Figure 2*.

Each of these initiatives has attempted to focus on different aspects of the patient journey. Unfortunately they are now seen with some scepticism as failures. But the need for quality and control in these areas remains, and it is for this reason that they have all effectively been amalgamated in the guise of clinical governance. Each of the initiatives will be discussed briefly in turn.

RESOURCE MANAGEMENT

The Resource Management Initiative (RMI) was a popular approach with NHS managers in the

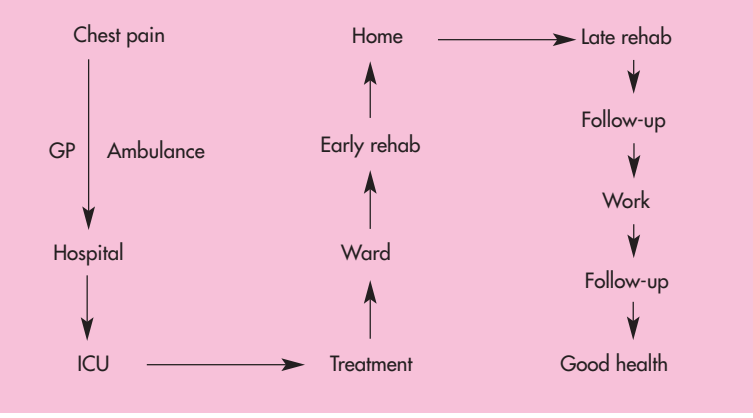

Figure 1. Example of a clinical service.

Resource Management	Mid 1980s
Quality	1990
Clinical Audit (originally Medical)	1991
Patients' Charter	1993
Clinical Guidelines	1993 onwards
Clinical Effectiveness	1995
Clinical Governance	1997

Figure 2. History of clinical governance.

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mid–late 1980s. It legitimized the role of managers in asking questions about how effectively resources (financial, facilities, personnel) were being used. Demonstration sites were established in different parts of the UK and groups where there was access to high quality information. This information was used to liaise directly with clinicians on how to change resource use. Some useful work was undertaken but wholesale change in the way the professions and managers approached the whole agenda of health-care provision did not materialize. With the NHS reforms of 1990, the quality agenda and medical audit were about to take over.

QUALITY

Quality was made everyone's business with the 1990 reforms. Directors of quality, or an explicit role for quality resting with the Chief Nurse, became commonplace in NHS trusts and directly managed units (DMUs). No overall approach to the management of quality was openly commended to the NHS by the NHS Management Executive. In many trusts and DMUs, useful work in partnership with professionals was undertaken by management groups, in the name of quality. However, fully integrated approaches to understanding and managing the quality agenda were not commonplace and clinicians (particularly medical) were about to have the quality agenda refocused in terms of medical audit.

MEDICAL AUDIT

Medical audit was initially designed as a peer review process which would be mandatory for doctors. Time was allocated for the pursuit of medical audit projects. Large amounts of cash were made available to hospitals to develop audit departments. Newly appointed audit facilitators helped to oil the wheels. Over time, medical audit changed to clinical audit and the other professions were brought in, not only to have access to the funds, but also to participate actively with doctors in taking decisions about quality.

But there was little enthusiasm for change and many have reported on the inability of the clinical audit process alone to deliver significant improvements in health services (NHS Confederation, 1997). However, although the demise of clinical audit has long been forecast, health professionals still regard it as a useful tool in the management of quality. Subsequent initiatives (see below) have reinforced the need for a high quality clinical audit programme and this is also evident in current clinical governance policy.

PATIENTS' CHARTER

A further dimension to the quality agenda was introduced in terms of statutory duties for trusts for certain aspects of care delivery (e.g. waiting lists). Targets were set and chief executive performance was managed taking into account how far Patients' Charter targets had been met. Also the subject of much criticism, the Patients' Charter movement was represented by a series of highly focused activities which culminated in 'returns' which were scrutinised by managers and administrators elsewhere. The emphasis on patient choice and patient-focused decision taking was lost.

CLINICAL GUIDELINES

The evidence-based medicine movement (Sackett and Haynes, 1995) and a desire (largely in America) to see that health resources were spent wisely, resulted in a massive effort to generate and implement clinical guidelines in the early and mid 1990s. The National Institute for Health in the USA set up bodies specifically to develop guidelines by which the practice of clinicians could be codified and judged.

The movement quickly spread to the rest of the world and the guidelines movement in the UK, coupled with other international initiatives such as the Cochrane Collaboration, provided an evidence base for some aspects of clinical practice.

Researchers began to conduct studies which looked at how to successfully implement clinical guidelines and much of this evidence has recently been summarized (NHS Centre for Reviews and Dissemination, 1999). We now know what to do to change professional practice when there is clear evidence that we should do so.

CLINICAL EFFECTIVENESS

Clinical effectiveness was widely seen as the successor to clinical audit. It involved a more comprehensive approach (Ayres et al, 1996) which encompassed many other determinants of outcome. The building blocks of clinical effectiveness are shown in *Table 1*.

In reality a much narrower definition was implied by much of the activity underpinning clinical effectiveness programmes. These were:

1. Evidence-based practice activities (Sackett and Haynes, 1995)
2. The development of (but often failure to implement) clinical guidelines
3. More clinical audit.

PUTTING IT ALL TOGETHER

A summary of characteristics of all the initiatives described so far is shown in *Table 2*. By putting all of these together, we demonstrate

how, individually, they contributed to a better understanding of the overall patient care process (*Figure 3*).

But it was becoming increasingly clear that only a strong government policy, which emphasized a comprehensive approach to quality, was required. Given increasing trends towards consumerism generally, an overarching policy was bound to emerge. It is not surprising that when clinical governance appeared in NHS policy documents, its first point was to suggest the coordination of quality initiatives as well as other tasks (*Table 3*).

THE EMERGENCE OF CLINICAL GOVERNANCE

The term clinical governance was coined in the White Paper published by the Labour government in December 1997. Professor Liam Donaldson, now the Chief Medical Officer, is largely credited as the originator of the term and the overall shape of the policy.

If to coordinate quality initiatives is one task of clinical governance, then the other tasks should fall into place (*Table 3*). The resulting programme of work would be expected to be driven by management. Indeed, the overall responsibility for clinical governance rests with trust chief executives: increasing the notion that this is a management agenda (even though this will ultimately mean managing clinical staff). But the emergence of the policy has coincided with a series of very public and acrimonious engagements between the medical profession, the General Medical Council, the media and some patients or their carers. As a result, a lot of emphasis has been placed on the medical profession's role in the delivery of clinical governance. The role of management remains unclear, but implications for the 'policing' of the medical and other professions have been widely reported in the professional and lay press. Suspicion about the NHS management's motives for the clinical governance agenda is growing.

SUPPORTING THE INITIATIVE

Lack of clarity about the role of management has therefore become a two-edged outcome. On the one hand, few components of government policy have been as well-publicized, and few clinicians have escaped at least hearing about clinical governance. On the other hand, the steps which management must take to support the development of clinical governance are being developed in an ad hoc fashion, not on a national basis.

Managerialism is, however, taking an ever-higher profile in the NHS, and sooner or later we will see the NHS Executive introduce guidance

TABLE 1.
Clinical effectiveness

Accessing the evidence: proper use of libraries
Applying the principles of evidence-based health care to clinical practice
Using information technology to improve clinical decisions
Developing clinical audit
Clinical guidelines — appropriate use
Clinical risk management
Effective professional education
Research and development
Promoting dialogue between primary and secondary care and public health
Involving patients
Effective senior management

TABLE 2.
Summary of initiatives looking at quality

RMI	To develop, in conjunction with clinical staff, local management processes for planning and controlling the use of resources
Quality	'Directors of Quality' created
	'Total quality management' of importance
	Patient satisfaction given high priority
Clinical audit	The audit cycle of reviewing practice
	Setting standards
	Making changes
	Reviewing practice brought into common use.
Patients' Charter	Rigidly defined criteria (e.g. number of patients waiting 18 months)
	League tables
	CEO performance managed by this
	Charter Units developed
Clinical guidelines	Formal standard setting
	Uses rigorous processes
	Evidence based methods
	Seen as controlling local clinical activity
	Local ownership of process required
	Known to be effective at improving outcomes
	Development and implementation costs high
Clinical effectiveness	Seen as successor to clinical audit
	An organization goal in itself
	Barriers to successful implementation not clearly understood
	Sometimes criticized as manipulating professionals

RMI = resource management initiative

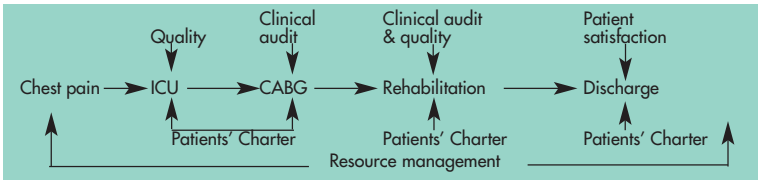

Figure 3. Putting it all together.

TABLE 3.
Clinical governance

Coordinate quality drives
Develop leaders of clinical services
Evidence-based practice
Dissemination of good practice and innovation
Clinical risk management
Clinical performance management
Professional development programmes
Information systems needed to support clinical governance

on management effectiveness. Models abound, but a favourite is thought to be that of the European Foundation for Quality Management: the Business Excellence Model (*Figure 4*). This model was developed by a collaboration of industry-based concerns, which realized that getting quality right not only provides the competitive edge, but is actually the key to survival.

The challenge for NHS management becomes twofold:

1. To set clear goals and national standards for management effectiveness
2. To engage clinical staff using methods of support, rather than sanction, to achieve the aims of the clinical governance agenda.

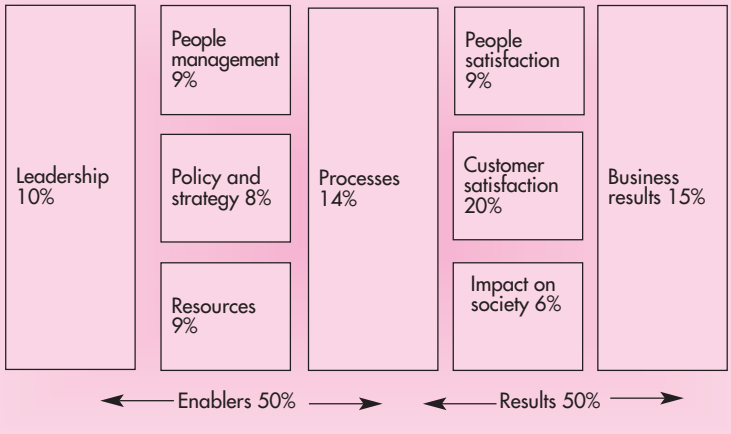

Figure 4. European Foundation of Quality Management: Business Excellence Model.

KEY POINTS

- Clinical governance has grown from a number of NHS policy initiatives over the last 10 years.
- Clinical governance is about quality.
- Effective management involvement is essential, especially in a supporting role.
- Clinical governance is not an option: eventually we will all be 'measured' under its auspices.
- Focusing clinical teams on the patient's perspective will deliver much of what is intended.

MONITORING PROGRESS

Nationally, two new institutions are being created to support clinical governance. The first, the National Institute for Clinical Excellence, will produce rigorous guidance for clinicians, using evidence-based methods. It is likely that these reviews and guidelines will be collated from existing sources, so a huge bureaucracy is unlikely.

The second, the Commission for Health Improvement, will help to ensure that organizations perform the way they should. This massive agenda will inevitably focus on how far chief executives have a grip on quality. To determine this the Commission will use annual reports, and other documentation.

In future, trusts will have to report in public on how well their clinical governance arrangements are working. These reports will include the arrangements for managing clinical risk and monitoring professional performance. That patients have a 'right to know' is ever prevalent in policy making: a position that is proving difficult to argue against.

CONCLUSION

We have seen clinical governance develop from the first efforts of the NHS to create policy which controls resource use and satisfies the public's demand for ever greater access to, and quality of, health care. Historical initiatives have met with limited success, but each of these has been brought together in the guise of clinical governance to form a global approach to quality management which clinicians and managers are not permitted to opt out of.

The agenda is complex, requiring action at the team, local, district, regional, and national levels. The work to be done is not yet as clear as it needs to be, but the change is coming. Effective action by managers to support clinicians is vital.

The inevitable conclusion is that the key to success is organisational focus. Together, managers and professionals need to focus on the patient's perspective in everything that they do. Achieving that is another story all together. HM

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