# Clinical governance: what it is, what it isn't and what it should be

*Ian Gilmore*

***Clinical governance is as much about setting standards and putting in place management systems to achieve them as it is about poorly performing doctors. Medical Royal Colleges are well placed to support individual hospital doctors in setting and monitoring clinical standards appropriate to their specialty.***

The term clinical governance has no rivals in its rate of rise from obscurity to top of the medical pops. Two years ago it 'appeared' as an extension of corporate governance, placing a statutory requirement on NHS trusts to put systems in place for ensuring quality of clinical care as well as for 'balancing their books' — meeting clinical as well as financial standards. However, it soon developed overtones of very much more.

These statutory obligations on trusts to ensure clinical as well as corporate governance are firmly the responsibility of the Chief Executive, putting him/her and not the clinicians at risk of imprisonment for failure to deliver. However, in practice it has been the clinician, particularly the hospital consultant, who has been the focus of early attention in the 'post-Bristol era', and while this is hardly surprising it is nonetheless unfortunate.

Clinical governance comes at a time when clinicians are feeling ever more vulnerable from rising workload pressures, from a diminishing service contribution by 'post-Calman' junior doctors and from an erosion of individual clinical freedom. When the discussions should have been primarily about systems, they have been hijacked by issues of individual performance — the poorly performing doctor. Add to this the emergence of the National Institute of Clinical Excellence (NICE) and the Commission for Health Improvement (CHI), the related issue of revalidation and the (entirely reasonable) attempts of the General Medical Council (GMC) and the Royal Colleges to take the high ground and the scene is set for resigned confusion within the profession.

I can not claim any particular insight or wisdom, but I can look from two perspectives, that of (until 12 months ago) a Medical Director of a large, acute, University Trust and now an officer of a Royal Medical College (the Royal College of Physicians) in the thick of trying to establish national policies that make sense for the thousands of physicians doing their best to look after their patients.

## THE COMPONENTS OF CLINICAL GOVERNANCE

Clinical governance was defined in the NHS Executive document *A First Class Service* as:

> **'A framework through which all NHS organisations 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 (NHS Executive, 1998).'**

From this it follows that any aspect of service delivery that may affect quality of care is included, and this is a multidisciplinary, multidimensional topic. However, the essential foundations are as follows:

- The setting of realistic and evidence-based standards of care
- The monitoring of performance against these standards
- The implementation of change to ensure that these standards are reached and, if possible, exceeded.

The tools that are used in the achievement of these components are many, and include:

- Multidisciplinary clinical audit
- Clinical effectiveness
- Research and development

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- Lifelong learning
- Risk management and critical incident reporting
- Evidence-based medicine
- Guidelines, pathways and protocols
- Service accreditation
- Individual appraisal and assessment
- Information management.

## STANDARD SETTING

In order to be credible, a standard has to be:

- Important to patients and their care
- Evidence based — there have to be strong grounds for believing that achievement of a standard brings about an improvement in the outcome of care
- Generalizable — it has to apply to different parts of the NHS across the country
- Achievable — if only 10% of units in the country have any chance of reaching a standard, it is not useful.

To this end the standard has to be nationally-agreed. Some may come from National Service Frameworks and Health Improvement Programmes, but the Colleges and specialist societies are ideally placed to devise early and simple standards that the vast majority of clinicians would accept. It must be remembered that there is no point in selecting standards measurable only by an outcome that may be 10–20 years away. This may be appropriate for epidemiologists but it will hardly satisfy the public about the standard of their local hospital.

For this reason it may be necessary to use outcome-validated process measurements. For instance, the numbers of patients being discharged from hospital after myocardial infarction who are taking aspirin may be a reasonable surrogate marker for quality of care that reduces long-term mortality. Standards may be agreed statements of service requirements, such as the need for a minimum of two consultants in a specialty in order to maintain a service for 52 weeks per year.

Within the Royal College of Physicians, we are currently asking the 24 subspecialties for which we have responsibility to identify two or three standards that would meet the above criteria for a credible standard.

## MONITORING STANDARDS

As in setting of standards, achievability is crucial to the monitoring of them. There is no place for standards that cannot be measured with existing information systems and audit methods. Ideally the data should be captured during normal clinical activity such as clinic letters or discharge summaries.

### Monitoring the individual clinician

There are some areas where the individual clinician should be assessed rather than monitoring outcomes of units or services. For instance, each individual should be required to demonstrate that he or she is keeping up to date with their continuing medical education, and this can be checked at the time of the annual review of job plan, already a part of life in most trusts. This assessment should be linked to other obvious clinical governance issues like complaints, medicolegal actions and critical incident reports, but it must be a two-way review in which the clinician may highlight the barriers to improving care in his/her area (such as equipment and other resource deficiencies).

### Monitoring the service

This is an attractive alternative to the above, because there are great concerns about the feasibility of assessing the performance of individual clinicians over a wide range of skills and competencies.

The detailed assessment of clinical skills undertaken by the GMC when a clinician's competence is called into question is simply impossible to implement as a tool to regularly monitor the performance of all practising doctors. However, it may be feasible to examine the performance of a unit or service, with the assumption that if that unit is achieving high scores for competence then the constituent parts, the individual clinicians, are performing well. If a unit or service fails such an assessment then the individual components would require closer scrutiny. This 'peer service review' has been piloted in several medical specialties, particularly in chest medicine by the British Thoracic Society. It has a valuable 'buddying' or mentoring function and the visitors as well as the visited benefit from the exchange of ideas, but it will have to develop a tougher, pass-fail mentality to satisfy managers and politicians in the post-Bristol wake.

Furthermore, the practicality of yet another round of visits, on top of those of the postgraduate deans, the College visits for senior house officer and specialist registrar posts, the task force and the GMC, to name but a few, raises the spectre of everyone's time and energies being expended in visiting and being visited to the detriment of clinical service. The best opportunity would seem to be to roll up together some of these varied activities. However, we desperately need evidence that they work.

## IMPLEMENTATION OF CHANGE

The setting and monitoring of standards outlined is of little value unless the 'loop can be closed' by correcting identified deficiencies.

### Resource deficiencies

This is where clinical governance can and should be to the advantage of the competent and conscientious clinician. First, he/she is obliged to demonstrate that existing resources are being used as effectively as possible, and quite rightly managers no longer respond immediately to 'shroud-waving'. Nonetheless the vast majority of problems in service provision are because of woefully deficient investment in them. The solutions must be innovative, cost-effective and bring about improved care for patients.

### The poorly-performing doctor

This is where the spotlight of clinical governance has been, although the vast majority of hospital doctors work very hard to keep up to date and to deliver a high quality of service. Of course we must take some responsibility for that spotlight, because as a profession we have failed to deal with the small minority who have not lived up to reasonable standards. This is occasionally a straightforward problem of incompetence but is much more often a complex mixture of conduct, personality and performance issues. It is usually not difficult to identify these colleagues, but the problem in the past has been what to do about them.

This has been starkly clarified by the GMC, and no doctor should now be in any doubt about his/her professional responsibility to draw to the employer's attention, usually through the medical director, any concerns about the competence of colleagues. The next step is now the difficult one, and the medical director has to decide if patients are at immediate risk (in which case the doctor must be suspended pending further investigation). He/she must initiate an appropriate investigation and then decide whether the individual's registration should be called into question (in which case the GMC should be informed) or if local resolution is possible. The medical director has a heavy responsibility, but common sense goes a long way in helping to decide the best course of action.

## THE ROLE OF THE UK MEDICAL ROYAL COLLEGES

While clinical governance is primarily the responsibility of individual NHS providers, the Royal Colleges are uniquely placed to assist. Their core function is the maintenance and improvement of clinical standards, and they are by and large respected for their independence by both the NHS and individual doctors. They provide the following potential opportunities:

1. Setting nationally agreed, appropriate clinical standards, in conjunction with other national bodies
2. Monitoring performance against these standards by developing achievable national frameworks for clinical audit
3. Assisting trusts in annual appraisal and assessment programmes through their network of regional and local advisers
4. Arranging continuing medical education and continuing professional development programmes and monitoring the participation and achievement of clinicians in these programmes
5. Arranging multidisciplinary external service reviews from time to time
6. Assisting trusts by sending in a team of independent advisers where there are concerns about the outcomes or performance within a clinical unit
7. Assisting trusts in the mentoring process and arranging retraining if appropriate for individual doctors identified as having difficulties before patients are put at risk.

The case for reviewing doctors' right to practice from time to time through revalidating their registration with the GMC is a powerful one, and the building blocks for this should be the demonstration of success in steps 1–5 above.

## CONCLUSIONS

Clinical governance has as many opportunities as threats, and it is only through early, active and explicit involvement that clinicians can protect themselves from unwarranted slurs as well as improving the care of their patients. HM

*Conflict of interest: None*

NHS Executive (1998) *A First Class Service. Quality in hte New NHS.* NHS Executive, Leeds

### KEY POINTS

- The emphasis of clinical governance should be on ensuring that systems are in place to help clinicians provide high quality care.
- Doctors must take the lead in setting evidence-based, achievable standards that can be monitored in their specialty.
- Medical Royal Colleges, working with specialist societies, are best placed to put together the framework to support clinicians and to allow them to demonstrate their continuing fitness to practice.