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EDITORIAL

Clinical governance

The title may convey little to readers outside the United Kingdom, but to those working here, it is likely to mean something different to each one. Clinical Governance was introduced in a document published by the NHS Executive in March 1999, and is 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' [1]. It is seen as part of a 10-year plan to improve the quality of patient care throughout the NHS, and applies to both primary and secondary care. In fact, most of the elements of Clinical Governance are not new, but have simply been gathered together under a new banner and awarded a greater prominence by a government keen to be seen to be responding to the adverse publicity generated by recent high profile failures in the NHS. The best known of these was the 'scandal' at the Bristol Royal Infirmary, in which paediatric cardiac surgery was recognisably substandard, but about which nothing was done until one of the clinicians involved – an anaesthetist – broke the unwritten code of silence which, it is claimed, so often surrounds poor medical practice. Other embarrassments in recent years have involved pathology or screening services [2], and also practice in the independent sector (which resulted in a consultant gynaecologist being struck off the Medical Register). But other factors have also played a part in the introduction of Clinical Governance. An increasingly critical and litigious public is less tolerant than formerly of medical inadequacy or error (although interestingly, doctors are still the most highly regarded professionals by the population at large). The professions in general are no longer held in the same respect as they were even 20 years ago, and improving education and increasing availability of medical knowledge, not least via the Internet, has eroded the mystique of medicine. This wind of change does not blow in the United Kingdom alone; other countries and health systems. including the United States of America, Canada and Australia, have been subject to similar changes and indeed, are more advanced than the UK in certain areas.

So what *is* Clinical Governance? It is an umbrella term which includes processes designed to improve the quality of care, a systematic approach to Clinical Risk Management, the identification and correction of poor performance, and the establishment of clear lines of accountability for standards within a Trust (or Primary Care Group).

Quality of care is supported by audit, the use of evidence-based medicine and the development of guidelines and care pathways (i.e. standardized patterns of management). Audit is, of course, well-established in the NHS, although its success to date is a moot point [3]. It is probably fair to say that, in general, it has not been applied systematically, and lessons learnt have not always been effectively disseminated. A notable exception has been the National Confidential Enquiry into Perioperative Deaths (NCEPOD). By looking in detail at various patient groups in turn, and collating data on an anonymized national basis, the Enquiry has generated a series of reports over the years which have clearly identified areas of concern in perioperative care. The reports are authoritative, command respect, and have been a force for change [4].

Evidence-based medicine is in many respects still in its infancy. Much of medical practice lacks a secure evidence base, and in any case, there remains the problem of ensuring that the relevant information is readily available. Guidelines and care pathways can partially overcome this problem, but even their application is more complex than superficial consideration would suggest.

Most Trusts should by now be confident in managing risk, which includes the monitoring and regular review of incidents and complaints, etc., with, wherever possible, action being taken to prevent or minimize recurrence. Critical incident reporting by

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speciality should feed into the same system, but in practice may prove difficult to establish.

Management of performance deserves an editorial to itself. It is yet another complex and difficult area, and although seen as directed principally at doctors, includes all staff groups. For medical staff, it encompasses revalidation, continuing professional development and continuing medical education, appraisal, and the management of doctors whose performance is giving rise to concern. Finally, the development of clear lines of accountability depend on the organization concerned. Most Trusts have established a Clinical Governance committee and lead, and set up an appropriate bureaucracy to ensure that all aspects of Clinical Governance are covered. A 'baseline assessment' of capability was required by the NHS Executive last year, describing systems and activities already in place in the Trust to support Clinical Governance.

However, of greater interest are the implications of Clinical Governance. Prima facie, it is difficult to fault. It is, after all, a strategy designed to improve the quality of care provided by the NHS and more importantly 'to prevent the kind of incident, crisis and serious failures in standards of care which, although not common, have been a very visible feature of the past' [1]

Its key feature – and the one that should drive it forward above all else – is that Trust Chief Executives and Boards now have a *statutory* responsibility for the quality of care provided in their institutions. They must ensure that Clinical Governance is being effectively implemented and maintained within their organizations.

Nonetheless, a number of questions present themselves. Firstly, there is the obvious one of resource. Setting aside the issue of funding for the moment, there is the matter of finding the time necessary to implement these changes. More time spent in audit, appraisal and discussion of the evidence base of practice will mean less time available for treating patients. Furthermore, these requirements are being imposed on a workforce which has already seen a considerable increase in workload and patient throughput over the last few years, and in the setting of potential hours restrictions in line with the European Working Time directives. How are these conflicting demands to be reconciled? From a financial viewpoint, if detailed audit and performance data are to be collected on a regular basis, then a fundamental requirement will be reliable, secure and integrated information technology networks. These are expensive, and their installation carries other requirements – maintenance and support costs, the need for staff training, data validation and so on. So far, no significant additional funding has been announced. Presumably therefore, this will need to be found by economies elsewhere. But it is a widely held view that the NHS has little fat left to trim, and indeed, it is perceived by many, including the public, to be underfunded.

Another area of concern is the potential legal implications of Clinical Governance. If the Chief Executive carries final responsibility for the standard of care within his Trust, then it would imply a much greater 'interference' by management in medical practice, in order to provide assurance that practice was standardized and safe. Ultimately, significant deviation from standard practice might have to be 'approved' before it could be applied, other than in an emergency. A much greater readiness to suspend 'problem' doctors – whether proved guilty or not – is likely to become manifest as Trusts seek to protect themselves. While this may be an understandable reaction, it is unlikely to engender loyalty among professional staff. Ultimately, could the situation arise in which a Chief Executive was a co-defendant with a doctor accused of negligent practice, particularly if earlier signs of inadequacy in the doctor had not been detected or acted upon? And if multiple patients suffered, as in Bristol, then one wonders if an action analogous to corporate manslaughter might be brought against a Trust. These possibilities are of course matters for speculation, but they can no longer be considered to be on its wilder shores.

Clinicians' acceptance of the full implications of Clinical Governance has also yet to be tested. No reasonable person could oppose improvement in the standard of clinical care – what is at issue is *how* that improvement is effected. For many doctors, Clinical Governance is still a rather vague concept, with little real change yet seen at shop-floor level. However, the potential demands on time and effort, the inevitable cramping of clinical style with the introduction of guidelines etc., and the obsessive monitoring of individual doctors may alienate the profession. 'Telling clinicians how to do everything in detail is not the

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best way to gain [their] commitment' [5]. How to achieve the appropriate change in culture and attitude is likely to test the best Trusts and the best managers.

In the final analysis, there are two questions which must be asked. Firstly, will Clinical Governance achieve what is intended? It is perhaps impossible to pilot, but its wholesale imposition on the NHS, however well-meant, is no guarantee of success. Audit was similarly introduced late 1980s and in spite of the expenditure of many millions of pounds in terms of staff, equipment and time, it failed to deliver any discernible improvement in overall standards. Indeed, its value was already being questioned within a few years of its introduction by Maynard [6] and others [7]. How shall we know that if standards improve in the NHS, the improvement is necessarily attributable to Clinical Governance? Secondly, will the time and effort (and indirectly money) being devoted to all aspects of its implementation produce a *proportionate* improvement in standards? A less charitable person may be tempted to invoke the Law of Diminishing Returns, and perceive the whole exercise as designed more to control staff and costs, with only a possibility of improved quality of care. Perhaps it is churlish to be critical at this stage, but after years in which the only constant in the NHS has been that of further change, enthusiasm for yet another initiative is bound to be muted. Staff have seen too many grandiose schemes come and go – will Clinical Governance be any different?

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