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FOR HEALTHCARE MANAGEMENT

The implementation of clinical governance: a survey of NHS trusts in England

FINAL REPORT

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1. Introduction

This report presents the findings of an analysis of a survey of NHS trusts in England which was designed to assess their progress in implementing clinical governance and the impact of the clinical governance initiative. The report is divided into six main sections, as follows:

- The survey methodology and response rates
- Support provided to NHS trusts to implement clinical governance
- Structures and frameworks for clinical governance
- Resources and processes for clinical governance
- External evaluations of clinical governance and quality
- Chief executive's perspectives on the progress of clinical governance

At the end of each section, a number of key conclusions are highlighted. The final section of the report draws these conclusions together to provide a summary of the main messages emerging from the survey.

2. Methodology and response rates

The National Audit Office (NAO) provided MCHM with a database of 284 NHS trusts, which it had previously established and validated. Our aim was to undertake a census survey of all NHS trusts in England, but not to include primary care trusts (PCTs). The task was complicated by the level and pace of local and national organisational change in the NHS, particularly the rates of mergers and restructurings among NHS trusts, the creation of new partnership NHS trusts to run mental health services, and the abolition of community service NHS trusts as their services transferred to new PCTs from April 2002. For these reasons, NAO staff had already contacted each NHS trust in the database to validate the data and to seek contact details of a lead person for clinical governance to whom the survey should be directed, and most NHS trusts had responded.

We commenced the survey in July 2002. Questionnaires and covering letters were mailed out to all 284 NHS trusts on the database. Where we knew the name of the clinical governance lead, we mailed the questionnaire and letters to that person but wrote at the same time to the trust chief executive to inform him/her of the survey; where we did not have contact details, all the papers were mailed to the chief executive. NHS trusts were asked to confirm that they had received the survey and would be returning it. Those who did not confirm and/or respond were then followed up over the following months, and a total of three rounds of follow-up contacts were made. Of the 284 NHS trusts mailed, 14 were found to be duplicate records (resulting from recent mergers) or community services NHS trusts (now part of one or more PCTs) and so should not have been included in the survey. Of the 270 NHS trusts remaining, completed surveys were received from most (232, 85%) by September. However, we made continuing efforts to secure completion by non-respondent NHS trusts with support from the National Audit Office and the Department of Health, and we eventually secured completion by all NHS trusts (270, 100%) in February 2003.

Because the questionnaire collected a high volume of qualitative data responding to open questions, a coding framework was developed to group and categorise those responses, and each questionnaire was then coded and the data was entered on an Access database. Data analysis was undertaken using SPSS for Windows and Access.

This report is based on 270 questionnaire returns (100% of NHS trusts surveyed) which had been received and coded by February 2003. Not all tables total to 270 because some NHS trusts did not answer some questions. For the analyses of themes in qualitative data from open questions, respondents could and did raise multiple themes and so again the tables do not total either to 270 or to the number of respondents to each question.

In the sections which follow, numbers in square brackets like this [1.3] can be used to relate tables and analyses to the questions in the questionnaire from which the data is drawn.

3. Support provided to NHS trusts to implement clinical governance

The questionnaire asked NHS trusts about the support they had received in implementing clinical governance from the Department of Health, their NHS Executive Regional Office, and the Clinical Governance Support Team at the Modernisation Agency.

In general terms, most NHS trusts (90%) reported that guidance from the Department of Health had been fairly or very useful; they tended to rate guidance and assistance from their Regional Office somewhat less highly, with most (76%) regarding it as not very useful or fairly useful (see table 3.1).

	[1.1] How useful has guidance from DH been?		[1.2] How useful has guidance/assistance from Regional Office been?	
	Count	%	Count	%
Not at all useful	3	1.1%	15	5.6%
Not very useful	22	8.2%	85	31.7%
Fairly useful	163	60.8%	120	44.8%
Very useful	78	29.1%	43	16.0%
Extremely useful	2	.7%	5	1.9%
Total	268	100.0%	268	100.0%

Table 3.1

NHS trusts were asked whether problems had emerged on which they would welcome external assistance or guidance – 119 (44%) responded, and an analysis of the problems they raised is shown in table 3.2 below. It can be seen that trusts raised a wide range of quite diverse specific problems or issues – from the safety of medical devices to the confidentiality of clinical records and data. However, some common specific themes also emerged – particularly the embedding or linking of clinical governance within organisations and between them; the resourcing of clinical governance amid many competing claims on resources; and clarification of the requirements to report on clinical governance through an annual report, to the Department of Health, to health authorities, and to the Commission for Health Improvement.

[1.3] Problems on which further guidance or assistance from the Department of Health or elsewhere would be welcome

	Theme
	Count
[1.3-1] Dealing with organisational mergers/restructuring effects on CG	3
[1.3-2] Linking clinical governance to other systems/processes in trust	29
[1.3-3] Linking to other organisations eg StHAs, PCTs	25
[1.3-4] Training and development in clinical governance	3
[1.3-5] Specific issues eg medical devices, information requirements etc	54
[1.3-6] Resources for clinical governance	21
[1.3-7] Reporting/monitoring of clinical governance to/by DH, CHI, etc	19

Note: a total of 119 trusts (44%) identified one or more problems.

Table 3.2.

Trusts were asked a number of questions concerning their use of and views on the development programmes provided by the Clinical Governance Support Team (CGST) at the Modernisation Agency. The questions focused on two types of programmes – those aimed at NHS boards, and those aimed at clinical teams.

The returns showed that about 1 in 5 NHS trusts had used the board development programme, and about 4 in 10 of NHS trusts had sent at least one clinical team on the CGST team development programmes. Of those who had not used the programmes, many expressed a plan or aspiration to do so in the future – relatively few indicated that they had not used CGST programmes either because they had not been able to get onto them or because they did not want to use them (table 3.3).

	[1.4] Used the CGST board development programme?		[1.6] Used the CGST team development programmes?	
	Count	%	Count	%
Yes, have used it	52	20.0%	110	42.6%
Not yet, but plan to and dates arranged	20	7.7%	9	3.5%
Not yet, but plan to - CGST has not had capacity	17	6.5%	9	3.5%
Not yet, but plan to in the future	108	41.5%	99	38.4%
No, and do not plan to use it	63	24.2%	31	12.0%
Total	260	100.0%	258	100.0%

Table 3.3

Of the NHS trusts who had used the CGST development programmes, most rated the usefulness of both board and team development programmes highly (see table 3.4). In particular, over half (51%) saw the clinical team development programme as very or extremely useful. The board development programme was somewhat less well regarded.

	[1.5] How useful was the CGST board development programme?		[1.8] How useful was the CGST team development programme?	
	Count	%	Count	%
Not at all useful	3	5.7%	2	1.8%
Not very useful	10	18.9%	7	6.4%
Fairly useful	20	37.7%	45	40.9%
Very useful	18	34.0%	49	44.5%
Extremely useful	2	3.8%	7	6.4%
Total	53	100.0%	110	100.0%

Table 3.4

NHS trusts were asked which of the different CGST clinical team development programmes they had used, and the results are presented in table 3.5. Respondents found this question difficult to answer because they did not necessarily identify the programmes they attended with the choices offered – in particular, we had not given them the option of a general team development programme which many wrote in on their questionnaire. This data should therefore be interpreted with some caution.

[1.7] Which CGST team development programmes have been used?

	No/no answer		Yes	
	Count	%	Count	%
Health economy	256	94.8%	14	5.2%
Zero star/team development	246	91.1%	24	8.9%
Stroke	250	92.6%	20	7.4%
Obstetrics	245	90.7%	25	9.3%
Protected time	251	93.0%	19	7.0%
General team development	253	93.7%	17	6.3%

Table 3.5

NHS trusts identified a wide range of changes which had occurred as a result of their participation in the CGST programmes. Of 133 NHS trusts which reported they had used one, other or both development programmes, 101 NHS trusts (76%) identified at least some changes, and a thematic analysis of their responses is shown in table 3.6.

[1.9] Key changes which happened as a result of taking part in the CGST development programme(s)

	Theme
	Count
[1.9-1] Team building or improved team working	22
[1.9-2] Production of action plans for improvement/clinical governance	7
[1.9-3] Better understanding/awareness of clinical governance	37
[1.9-4] Greater frontline staff engagement/awareness	22
[1.9-5] More patient involvement in clinical governance	5
[1.9-6] Dissemination/spread of good practice in clinical governance	7
[1.9-7] Specific improvements in services/care produced	28
[1.9-8] Review, change or reorganisation of specific services	37

Note: a total of 101 trusts (76% of those who have used CGST programmes) identified one or more changes.

Table 3.6

Many of the changes reported were specific improvement to particular services or areas of care from which the clinical teams taking part in the programme had been drawn, or wider reviews or organisational changes in those areas. The other main forms of change reported were an increase in staff awareness and understanding of clinical governance, greater engagement with the ideas and the process, and improved teamwork.

There were 124 NHS trusts (46%) which had not taken part in any of the CGST development programmes yet. They were asked to explain this situation, and an analysis of their responses is presented in table 3.7. The main reason seemed to be that they had not seen the programmes as relevant, necessary or appropriate for their organisation. There was little indication that their stance reflected problems with the content or quality of the programmes, or capacity or resource constraints either on CGST or on the NHS trusts concerned.

[1.10] Reasons for not using the CGST development programme(s)

	Theme
	Count
[1.10-1] New or merged organisation, restructuring	6
[1.10-2] Not considered it at all (not discussed at board etc)	
[1.10-3] Considered, but not felt to be necessary	22
[1.10-4] CGST cancelled or postponed programme	1
[1.10-5] Problems releasing staff/making time to participate	8
[1.10-6] Used board development but not clinical team development	1
[1.10-7] Not appropriate to/developed for our organisation (eg ambulance trusts)	6

Note: a total of 35 trusts (28% of those who have not yet used CGST programmes) identified one or more reasons.

Table 3.7

In conclusion, the key points to draw from this analysis are:

- NHS trusts have found Department of Health and Regional Office guidance and assistance in implementing clinical governance moderately useful, and many would welcome future support on a wide range of issues, particularly concerning the embedding of clinical governance in healthcare organisations and communities/networks. Following recent organisational changes, it is not clear who is tasked with providing this kind of external guidance, assistance and support to NHS trusts now and in the future.

- NHS trusts which have used the CGST development programmes have generally found them very useful, and rate them quite highly, particularly those aimed at clinical teams. They report a significant level of change resulting from their involvement with CGST, though it is not clear how much wider impact the CGST development programmes have in participating organisations. However, many NHS trusts have yet to use the programmes, despite indicating that they would like to do so and that there are no significant resource or capacity constraints preventing them from doing so. Action may be needed to bring the benefits of the CGST development programmes to a wider audience both across and within NHS trusts.

4. Structures and frameworks for clinical governance

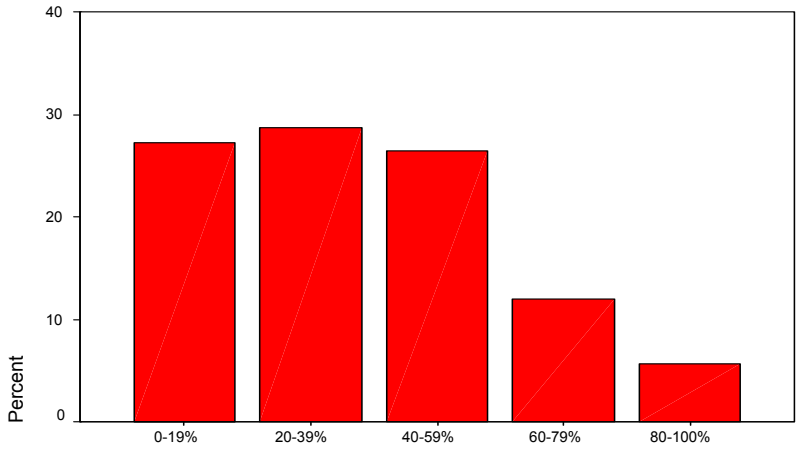
The questionnaire sought information from NHS trusts about the structures and organisational arrangements they had in place to implement and manage clinical governance. While such structures do not of themselves assure the progress of clinical governance, they are probably a necessary foundation for most organisations.

Most NHS trusts (234, 87%) have a named non-executive director on their board who has responsibility for clinical governance, and almost all (95%) have a single named executive director who has lead responsibility for clinical governance at board level. As table 4.1 below shows, this is most commonly the medical director, or the director of nursing.

	[2.3] Who has lead executive responsibility for clinical governance?	
	Count	%
Chief executive	16	6.0%
Medical director	148	55.6%
Director of nursing	71	26.7%
Director of human resources	2	.8%
Other executive director	17	6.4%
Shared responsibility	12	4.5%
Total	266	100.0%

Table 4.1

Lead executive directors for clinical governance mostly (91%) have this responsibility explicitly stated in their job description, and trusts report that they spend a significant proportion of their working time on clinical governance, as graph 4.2 shows – the median percentage of time spent on clinical governance is 35% though reports ranges from 5% to 100%. Asked whether this is sufficient time for the director concerned to fulfil his/her clinical governance responsibilities, about two thirds of NHS trusts (67%) believed it was, while 33% felt that more input was needed.



[2.5] Proportion of time spent by lead on CG responsibilities

Graph 4.2

Virtually all trusts (256, 96%) reported that they had a written plan or strategy document for clinical governance. Again, virtually all NHS trusts (267, 99%) reported that they had a clinical governance committee, and most committees met relatively frequently – the median was 6 times a year, but less that 7% met less than quarterly, and most met every two months or every month. The great majority (229, 86%) reported that the minutes of their clinical governance committee were routinely sent to the trust board. On average, trust boards were reported to have clinical governance as a formal agenda item 6 times a year, and to receive a written report (often the minutes from the clinical governance committee or related papers) 6 times a year.

NHS trusts were asked to describe the achievements or successes of their clinical governance committee, and an analysis of their responses is contained in table 4.5 below. Most NHS trusts (255, 94%) cited at least one thing, and the most frequently cited types of achievement concerned changes to systems or processes within the trust (such as incident reporting, complaints handling/monitoring, patient information/communication, etc); structural changes within the organisation (such as restructuring of clinical directorates, reorganisation of service structures etc), and the creation of corporate commitment, direction and momentum for clinical governance (see table 4.3 and 4.4).

[2.10] Main achievements or successes of the clinical governance committee since it was set up

	Theme
	Count
[2.10-1] Structural changes to organisation, services etc	101
[2.10-2] Changes to existing systems and processes	163
[2.10-3] Sustaining focus on clinical governance through merger/organisational change	6
[2.10-4] Dealing with CHI review and resulting action plan	35
[2.10-5] Making specific improvements to particular services or areas of care	19
[2.10-6] Building relationships with and reporting to Trust board	24
[2.10-7] Raising awareness of clinical governance within the Trust	65
[2.10-8] Providing corporate focus, strategic direction and momentum for clinical governance	136

Note: a total of 255 trusts (94%) cited one or more achievements.

Table 4.3

- "Directed action on specific issues eg cytotoxic drug administration" [5]
- "Changes to clinical practice in relation to oxygen use and temperature measurement" [7]
- "Strengthening of subcommittee structures, development of clinical performance and effectiveness committee, links to performance management, special interest for non executive directors, vehicle for resource investment" [11]
- "Monitoring implementation of key clinical governance projects and priorities eg CHI action plan, complaints improvement plan. Raising the profile of clinical governance and evolution of a 'converged model' for governance and risk in the organisation" [12]
- "successfully managed the CHI review process, implementing the CHI action plan" [13]
- "Preparing for CHI visit, setting up committee structures, improving response to serious untoward incidents, focusing clinical activity and priorities" [17]
- "The committee has developed the clinical governance strategy and framework which is used to implement clinical governance – incorporation of patient quality, risk and clinical effectiveness issues into the agenda as standing items has assisted the trust in developing a more integrated approach to addressing these issues on a trust wide basis" [19]
- "Bringing together risk, audit and complaints – systematic reports from clinical directorates on performance, successful CHI visit and review" [20]

Table 4.4. Examples of the reported achievements of NHS trust clinical governance committees

Trusts were also asked who was involved in both setting and monitoring their clinical governance plans and strategies, and the results are shown in table 4.5 and 4.6 below. It can be seen that both planning and monitoring the implementation of clinical governance was seen as very much a trust-led process, with relatively little involvement from outside stakeholders such as PCTs, health authorities or local authorities.

[2.14] Who is involved in developing trust's written plan for clinical governance development

	No/no answer		Yes	
	Count	%	Count	%
Trust board	91	33.7%	179	66.3%
Clinical governance committee	23	8.5%	247	91.5%
Lead for clinical governance	21	7.8%	249	92.2%
Local PCTs	208	77.0%	62	23.0%
Health authority	202	74.8%	68	25.2%
Social services authority	235	87.0%	35	13.0%

Table 4.5

[2.15] Who is involved in monitoring progress of trust's written plan for clinical governance development

	No/no answer		Yes	
	Count	%	Count	%
Trust board	63	23.3%	207	76.7%
Clinical governance committee	18	6.7%	252	93.3%
Lead for clinical governance	37	13.7%	233	86.3%
Local PCTs	208	77.0%	62	23.0%
Health authority	178	65.9%	92	34.1%
Social services authority	250	92.6%	20	7.4%

Table 4.6

Over 75% of NHS trusts have some form of central clinical governance function – a department, directorate or unit at trust level responsible for managing and coordinating clinical governance activities across the trust. Many combine this with some clinical governance responsibility placed at directorate or department level. However, a minority of NHS trusts do not have a central clinical governance function, and devolve responsibility for clinical governance wholly to directorates or departments (table 4.7).

	[2.1] How is clinical governance managed?	
	Count	%
Centralised clinical governance directorate	90	33.6%
Individual directorates/departments	43	16.0%
Other structure	23	8.6%
Combination of central directorate and individual depts	112	41.8%
Total	268	100.0%

Table 4.7

The size and resource costs of the clinical governance function in most NHS trusts appear considerable. NHS trusts were asked to indicate how many staff spent a substantial part of their time on clinical governance (such as leads, managers, facilitators, support staff, etc). While interpretations varied among trusts, it was apparent that most trusts had a medium-sized or large team of people working on clinical governance, as table 4.8 shows.

	[2.7] What staffing infrastructure is there for clinical governance?	
	Count	%
Large team (6 or more named staff)	105	39.5%
Medium team (3-5 named staff)	111	41.7%
One or two named staff	47	17.7%
None of the above	3	1.1%
Total	266	100.0%

Table 4.8

Only 31 (11%) NHS trusts indicated that they were able to estimate the annual costs to the trust of implementing clinical governance, and their estimates varied widely, partly because of differences in organisational size and nature but also because of definitional differences in the costs which were included. For example, some counted only the cost of the clinical governance manager/facilitators while others included costs of risk management, complaints, clinical audit and other staff. The median estimated cost of clinical governance was £326,000pa, though this figure should be used with some caution (the estimates given ranged from a few thousand pounds to over £1.3 million). Trusts were asked how resources for clinical governance were provided, and most reported that they came from within the trust – both at a trust level (55%) and from directorate and departmental budgets (78%). Only 20% indicated that their commissioners (PCTs) provided an explicit allocation for clinical governance (see table 4.9).

[2.12] How are resources for clinical governance provided?

	No/no answer		Yes	
	Count	%	Count	%
Funded by departments and directorates from own budget	59	21.9%	211	78.1%
Trust wide budget for clinical governance	121	44.8%	149	55.2%
Trust gets an allocation from commissioners for clinical governance	217	80.4%	53	19.6%

Table 4.9

Trusts were asked to describe how they had consulted or involved clinical staff in the development of clinical governance, and as table 4.10 below makes clear, a wide variety of mechanisms including specific consultations or communications as well as existing arrangements like committee or group structures and performance review mechanisms had been employed.

[3.45] How clinical staff have been consulted and involved in the development of clinical governance

	Theme Count
[3.45-1] Through strategic approach (eg action plans/directorate reviews etc)	121
[3.45-2] Through development of systems processes eg audit, complaints	11
[3.45-3] Through CG lead at dept/clinical team level	66
[3.45-4] through specific initiatives eg intranet, staff questionnaire, staff meetings	151
[3.45-5] Through involvement in clinical governance projects	8
[3.45-6] Through involvement in CHI review process	26
[3.45-7] Through membership of CG committees or groups	114

Table 4.10

Trusts were asked to report whether clinical governance had contributed to any changes in culture which had taken place, and many responded by indicating that there had been a movement towards a more open, less defensive and more as table 4.11 below shows.

[3.46] How has clinical governance contributed to any change in culture within the trust

	Theme Count
[3.46-1] Changing attitudes (less defensive, more open etc)	193
[3.46-2] More integrated strategy, structures or focus	84
[3.46-3] Greater involvement of clinicians	15
[3.46-4] Increased recognition of personal responsibility/accountability	27
[3.46-5] Improved levels of staff and patient engagement in decisionmaking	52
[3.46-6] More training and development for staff	12
[3.46-7] Audit and guidelines changing practice patterns	9
[3.46-8] Too many organisational changes to measure	3

Table 4.11

In order to understand whether trusts based their reports of culture changes on empirical data or on more subjective and anecdotal sources of information, we asked whether they had measured or assessed changes in culture, and if so how they had done it. As table 4.12 below shows, most had not undertaken any formal measurement beyond the staff survey which they are required to undertake, and many relied on views expressed in their CHI review report or on indirect evidence like incident reporting rates.

[3.47] How, if at all, has the trust measured or assessed any changes in its culture since introduction of clinical governance

	Theme Count
[3.47-1] Not assessed or too many organisational changes to measure	24
[3.47-2] Staff survey	96
[3.47-3] Internal assessment	49
[3.47-4] External assessment (eg CHI, regional office, CNST)	52
[3.47-5] Staff involvement	20
[3.47-6] Use of clinical governance and annual report	29
[3.47-7] Recruitment and retention	3
[3.47-8] Increased reporting of incidents	21

Table 4.12

In conclusion, the key points to draw from this analysis are:

- Clinical governance is well established and embedded in the corporate systems of the vast majority of NHS trusts, with board level executive and non-executive leadership, trust wide committee structures, and a strong executive function in the form of a clinical governance department or unit.

- Most NHS trusts still see the achievements of clinical governance at trust level in terms of systems, structures and processes – which though important and very necessary to the objective of improving patient care, are not necessarily sufficient in themselves to ensure that objective is achieved.

- Clinical governance is largely an intra-trust function – funding is generally provided within NHS trusts either centrally or at a directorate level, and the planning, monitoring and management of clinical governance is largely trust-driven with relatively little apparent input from other stakeholders.

- The costs of clinical governance are not generally known, partly because there is definitional ambiguity about what to count, but also because NHS trusts have mostly not concerned themselves with knowing what clinical governance costs. The cost estimates given – of around £326,000 per NHS trust pa, which equates to £88 million pa across all the NHS trusts surveyed – probably significantly understate the actual cost because they do not include clinical and managerial staff time.

5. Resources and processes for clinical governance

The survey gathered a very substantial volume of data about the structures, systems, functioning and perceived effectiveness or impact of a number of components or strands of clinical governance: arrangements for patient and public involvement; clinical audit; clinical risk management; adverse incident reporting; patient complaints; clinical negligence; continuing professional development; and knowledge management. In each of these components of clinical governance, a broadly similar set of quantitative and qualitative data was collected, with the intention that comparisons across these components as well as between organisations would be facilitated.

This section of the report presents these findings grouped and summarised around six main themes: structures and systems; coverage; perceived effectiveness; barriers; progress since the introduction of clinical governance; and impact. It then goes on to look at some of the specific issues concerning some components of clinical governance in more detail.

Structures and systems

NHS trusts were asked about whether they had some basic structural mechanisms in place for each component of clinical governance, and the results are presented in table 5.1 below. It can be seen that these arrangements were probably best established for areas like clinical risk management and patient complaints, and least well established for patient and public involvement and knowledge management.

	Proportion of NHS trusts with…		
	Written strategy in place	*Trust wide committee*	*Named lead person*
Patient and public involvement	63%	54%	88%
Clinical audit	64%	76%	92%
Clinical risk management	92%	93%	96%
Adverse incident reporting	92%	88%	95%
Patient complaints	90%	71%	98%
Clinical negligence claims	60%	54%	96%
Continuing professional development	67%	65%	88%
Knowledge management	66%	71%	88%

Table 5.1

Coverage

NHS trusts were asked to estimate what proportion of clinical directorates or departments had arrangements for each component of clinical governance in place, or were regularly involved in these activities. The purpose of these questions was to estimate the coverage, extent or "reach" of each component, and the results are shown in table 5.2 below. It can be seen that coverage was best for adverse incident reporting, fairly good for clinical audit and clinical risk management, and much less extensive for patient and public involvement. It should be noted that for some components of clinical governance – patient complaints and clinical negligence – the essentially statutory nature of the function made it less meaningful to ask about coverage. The coverage of continuing professional development and knowledge management arrangements were addressed separately, and are discussed later.

	Proportion of NHS trusts with…				
	0 to 20% coverage	*21 to 40% coverage*	*41 to 60% coverage*	*61 to 80% coverage*	*81 to 100% coverage*
Patient and public involvement	13	18	28	22	18
Clinical audit	2	7	15	24	51
Clinical risk management	3	5	9	19	64
Adverse incident reporting	0	0	3	3	93
Patient complaints	-	-	-	-	-
Clinical negligence claims	-	-	-	-	-
Continuing professional development	-	-	-	-	-
Knowledge management	-	-	-	-	-

Table 5.2

Effectiveness

Each NHS trust was asked to rate the effectiveness of each of the different components of clinical governance, in terms of their contribution to bringing about changes in practice and improvements in patient care. The purpose of the questions was to establish a broad and comparable picture of the perceived effectiveness or impact of each component. Trusts ranked effectiveness on a five point scale, from "not at all effective" to "extremely effective". The results are presented in table 5.3 below.

	Proportion of NHS trusts assessing component of clinical governance as…				
	Not at all effective	*Not very effective*	*Fairly effective*	*Very effective*	*Extremely effective*
Patient and public involvement	0	16	71	12	0
Clinical audit	0	17	61	20	1
Clinical risk management	0	9	61	29	2
Adverse incident reporting	0	8	55	34	3
Patient complaints	0	10	56	29	4
Clinical negligence claims	2	22	53	21	3
Continuing professional development	0	5	61	31	2
Knowledge management	1	18	64	15	2

Table 5.3

Unsurprisingly, NHS trusts were relatively cautious in their assessments – very few used either of the endpoints of the rating scale, and in each case the modal value was "fairly effective". However, some interesting differences between components can be observed. Risk management, adverse incident reporting, continuing professional development and patient complaints were seen as the most effective components of clinical governance; patient and public involvement and knowledge management as the least effective, with clinical audit and clinical negligence not rated much better.

Barriers

For most components of clinical governance (excluding patient complaints and claims for clinical negligence) NHS trusts were asked to describe the main barriers to progress in implementation or development. Their free-

text responses were coded and grouped into themes for each component, and the results are summarised in table 5.4 below.

Component of clinical governance	*Main barriers to progress identified by NHS trusts*
Public and patient involvement	Lack of resources – staff time, finance, materials etc (135) Difficulty getting patients to participate, identifying appropriate patient groups (80) Lack of strategy, processes or co-ordination in organisation (64) Lack of expertise, knowledge and skills in methods for seeking patients views (48) Nature of service or patient/client group makes it difficult (36) Culture, behaviour or attitudes of staff/organisation (34) *(251 trusts identified one or more barriers)*
Clinical audit	Lack of resources – staff time, finance, materials etc (199) Lack of strategy, processes or co-ordination in organisation (82) Culture, behaviour or attitudes of staff/organisation (78) Problems of information/information technology and data collection (61) Lack of expertise, knowledge and skills in clinical audit (32) *(258 trusts identified one or more barriers)*
Clinical risk management	Lack of resources – staff time, finance, materials etc (169) Culture, behaviour or attitudes of staff/organisation (94) Lack of strategy, processes or co-ordination in organisation (73) Lack of expertise, knowledge and skills in risk management (46) Problems with information/information technology (30) *(254 trusts identified one or more barriers)*
Adverse incident reporting	Culture, behaviour or attitudes of staff/organisation (151) Lack of strategy, processes or co-ordination in organisation (83) Lack of resources – staff time, finance, materials etc (63) Lack of expertise, knowledge and skills in reporting/use of reporting (52) Problems with information/information technology (38) *(236 trusts identified one or more barriers)*
Continuing professional development	Lack of resources – staff time, finance, materials etc (233) Lack of strategy, processes or co-ordination in organisation (46) Culture, behaviour or attitudes of staff/organisation (26) Limited availability of suitable courses/providers (25) *(251 trusts identified one or more barriers)*
Knowledge management	Problems of information/information technology (131) Lack of resources – staff time, finance, materials etc (95) Lack of strategy, processes or co-ordination in organisation (64) Geography of organisation – numbers and locations of sites etc (41) Lack of expertise, knowledge and skills (40) *(228 trusts identified one or more barriers)*

Table 5.4

It can be seen that some broadly similar barriers or problems emerge across all areas or components of clinical governance, most notably resource constraints (which refers both to financial and to non-financial resources); the culture, behaviour and attitudes of staff and their commitment to or motivation for clinical governance; and

the lack of strategic direction or of fundamental systems and processes within NHS organisations to "make it happen". Some examples are set out in table 5.5.

Lack of resources – staff time, finance, materials etc	"Small numbers of staff, particularly medical; low level of administrative support; competition with service workload" [4] "Pressures of wider agenda – service reconfiguration, modernisation, access targets" [5] "Trust main focus on national targets performance indicators thus other areas such as clinical risk seen as less of a priority, lack of ownership and resources at directorate level" [12] "Lack of time confirmed by trust wide survey, clinical audit relegated in priority when clinical team coping with excessive workload/insufficient bed/staffing levels etc" [33]
Culture, behaviour or attitudes of staff/organisation	"Concern re reporting incidents by some staff groups eg consultants – fear of the media/government/public who don't see the context of the issues and their willingness to apportion blame" [5] "Changing core beliefs and values (the culture) of the trust to enable learning to take place in an open and blame free environment" [16] "There is a lack of clinical commitment to incident reporting at a local level… lack of training and education about the value of clinical incident reporting and lack of understanding of the principles of incident investigation and root cause analysis" [19] "Reluctance on the part of some staff to accept the importance of risk management" [23] "Commitment from all staff groups – difficulty fully engaging all medical staff. Cultural issues regarding openness and honesty etc" [24] "Changing culture to encourage clinicians and organisations to be open about performance – threat of litigation and fear of blame" [31]
Lack of strategy, processes or co-ordination in organisation	"Lack of cohesive agenda for clinical teams/departments. Parochialism with regards to multiprofessional audit and lack of focus in assessing priorities for audit." [11] "Previously no coordinated corporate strategy – now greater recognition of its importance and clear corporate trust objectives and work streams in place" [12] "Lack of effective processes and infrastructure to ensure audits across all specialties are prioritised in accordance with national and local clinical problem areas." [19] "A rather fractured approach to priority setting in relation to audit topics to be pursued/supported, fracturing of systems for clinical and non clinical risk" [22]

Table 5.5. Examples of the main barriers to clinical governance cited by respondents.

Changes since implementation of clinical governance

NHS trusts were also asked to describe how their approach to each component of clinical governance had changed since the introduction of clinical governance in 1999. All these components predated the introduction of clinical governance, and our intention was to explore how the additional "layer" of clinical governance had affected or changed them. Again, their free-text responses were coded and grouped into themes for each component, and the results are summarised in table 5.6 below.

Component of clinical governance	*Main changes in approach since introduction of clinical governance in 1999, as reported by NHS trusts*
Public and patient involvement	Developed more coordinated and strategic approach (204) Culture, behaviour, attitudes of staff/organisation more positive (88) Specific changes (patient forums, patient membership of groups, etc) (66) Increasing direct patient involvement in clinical governance (63) *(258 trusts identified one or more changes)*
Clinical audit	Developed more coordinated and strategic approach (219) Culture, behaviour, attitudes of staff/organisation more positive (55) More multidisciplinary, multiprofessional or team based audit (49) Greater involvement of other stakeholders/groups in audit (24) Increase in the volume or scale of audit activity (22) *(239 trusts identified one or more changes)*
Clinical risk management	Developed more coordinated and strategic approach (223) Culture, behaviour, attitudes of staff/organisation more positive (100) Increased feedback to/awareness of staff and others (45) Specific changes (new IT, health records changes, etc) (27) *(251 trusts identified one or more changes)*
Adverse incident reporting	Developed more coordinated and strategic approach (187) Culture, behaviour, attitudes of staff/organisation more positive (100) Increased feedback to/awareness of staff on incidents (74) Increasing volume of incidents being reported (38) Improved information and IT systems (34) *(247 trusts identified one or more changes)*
Continuing professional development	Developed more coordinated and strategic approach (205) Developed greater in-house capacity to support/plan/provide CPD (73) Culture, behaviour, attitudes of staff/organisation more positive (47) More multidisciplinary approach to CPD planning/provision (29) Appointment of dedicated staff to support CPD (25) *(234 trusts identified one or more changes)*
Knowledge management	Changes to systems and processes to disseminate information (158) Access to information/IT increased (126) Arrangements to disseminate NICE guidance (50) Culture, behaviour, attitudes of staff/organisation more positive (31) Developed more coordinated and strategic approach (24) *(247 trusts identified one or more changes)*

Table 5.6

In almost all areas, NHS trusts report that the key changes have been an increasing systematisation of methods, processes and arrangements, bringing together, aligning and co-ordinating activity across the trust; and a growing acceptance by staff of the purpose and nature of these components of clinical governance and their place in a modern healthcare organisation.

Impact

NHS trusts were asked to describe what improvements in patient care had resulted from each of the components of clinical governance already enumerated. Again, their free-text responses were coded and grouped into themes for each component, and the results are summarised in table 5.7 below.

Component of clinical governance	*Major improvements in patient care which have resulted, as reported by NHS trusts*
Public and patient involvement	Specific examples of changes in practice/care at a micro level (197) Improved communication and information for patients (77) Patient involvement at a strategic level in organisation (60) Increased resources to improve patient care experience (27) *(240 trusts identified one or more major improvements)*
Clinical audit	Specific examples of changes in practice/care at a micro level (200) General statements about quality improvement achievements (72) Changes to policies, procedures or processes (37) *(252 trusts identified one or more major improvements)*
Clinical risk management	Specific examples of changes in practice/care at a micro level (146) General statements about quality improvement achievements (73) Changes to policies, procedures or processes (72) Better supervision and training of staff (31) Improved communication within and between depts/organisations (24) *(237 trusts identified one or more major improvements)*
Adverse incident reporting	Specific examples of changes in practice/care at a micro level (151) Development of a more coordinated and systematic approach to reporting (77) Improvements in staff training and development (44) General statements about quality improvement achievements (43) Improvements in culture, behaviour and attitudes of staff (20) *(240 trusts identified one or more major improvements)*
Patient complaints	Specific examples of changes in practice/care at a micro level (146) Improved information/communication to patients and carers (87) Development of a more coordinated and systematic approach to complaints (82) Improvements in culture, behaviour and attitudes of staff (63) General statements about quality improvement achievements (32) *(241 trusts identified one or more major improvements)*
Claims for clinical negligence	Specific examples of changes in practice/care at a micro level (114) Development of a more coordinated and systematic approach to claims (61) Improvements in culture, behaviour and attitudes of staff (39) Improvements in information to patients and consent procedures (22) *(174 trusts identified one or more major improvements)*
Continuing professional development	Specific examples of changes in practice/care at a micro level (108) General statements about quality improvement achievements (90) Improved staff satisfaction and retention (18) *(195 trusts identified one or more major improvements)*
Knowledge management	General statements about quality improvement achievements (113) Specific examples of changes in practice/care at a micro level (69) Development of care pathways, protocols and guidelines (36) *(182 trusts identified one or more major improvements)*

Table 5.7

The responses were highly diverse, and described a wide range of different forms or types of improvement. As the table shows, most NHS trusts were able to name specific examples of changes in practice or care which had happened and which they attributed to the component of clinical governance, though they were more able to do this in some areas (clinical audit, patient and public involvement) than in others (like knowledge management and continuing professional development). Many other responses described general improvements in quality in terms which were much less specific and whose significance was thus often hard to gauge. Although NHS trusts had been asked to outline improvements in patient care, many of the examples cited were in fact changes or improvement to services, staff, or other attributes of the healthcare system or organisation, rather than to patients and the services they received. Some examples of direct changes affecting patients are cited in table 5.8 below.

"Development and implementation of mandatory CTG training for all disciplines of staff working on delivery suite" [256]
"Changes in training for nursing staff on drug administration" [257]
"Contact cards provided for patient queries following treatment" [258]
"Introduction of protocol to treat GI bleed" [258]
"Improved compliance with Mental Health Act requirements in relation to sectioning patients" [263]
"Improved ECT services in consequence of improved risk assessment" [263]
"Change in prescribing habits – greater use of atypical anti-psychotics" [265]
"Introduction of 24 hour recovery nurse in theatres" [267]
"Introduction of monitoring and training to prevent falls in the elderly" [267]
"Improvement of facilities for parents on childrens' wards [267]
"Trust wide pressure prevalence study has resulted in purchase of range of pressure relieving mattresses and cushions thereby increasing the range of equipment available to staff and the appointment of a tissue viability nurse specialist to improve education and training and to advise on the management of individual patients" [269]
"Stopped the practice of putting eight beds in some six bedded ward bays" [269]
"Treatment of individuals with chest pain – tangible improvements across a whole range of indicators" [272]
"Improvements in communication, clinic scheduling and patient leaflets generally" [273]
"Changes in the way in which nurses assess and manage pain, including reassessment" [274]
"Audiotaped patient information in Bengali piloted successfully in antenatal clinic according to patient review – to be followed in other languages" [275]
"Medical health record management – introduction of a new system to improve tracking of notes with bar codes" [275]

Table 5.8. Examples of changes resulting from clinical governance which impact directly on patient care, as cited by respondents.

Some further specific questions were asked about aspects of clinical audit and knowledge management, and are reported below. Trusts were asked about their participation in national clinical audits, and while 65 (24%) said they took part in a few such initiatives, most said they participated in some (98, 36%) or many (97, 36%) of them. Hardly any did not take part in such national clinical audits.

For knowledge management, trusts were asked whether clinical staff had access to a number of information sources at their normal place of work in order to make some assessment of their information infrastructure, and the results are shown in table 5.9

[3.39] % of trust with access to information sources at place of work

	No/no answer		Yes	
	Count	%	Count	%
Medline	62	23.0%	208	77.0%
CINAHL	88	32.6%	182	67.4%
Cochrane Library	63	23.3%	207	76.7%
Trust intranet	34	12.6%	236	87.4%
The internet	30	11.1%	240	88.9%

Table 5.9

In order to make some further assessment of trusts's knowledge management arrangements, they were asked whether there were formal systems in place to distribute a number of key types of information to those within the trust who would need to see and act upon them. As table 5.10 below shows, most trusts claimed to have such systems in place, particularly for material such as NICE guidance.

[3.40] % of trusts with arrangements for distributing information from sources

	No/no answer		Yes	
	Count	%	Count	%
Effective Health Care bulletins	43	15.9%	227	84.1%
Guidance from NICE	18	6.7%	252	93.3%
Reports from NCEPOD/confidential enquiries	43	15.9%	227	84.1%
Findings from public inquiries (Bristol etc)	43	15.9%	227	84.1%
Findings from CHI investigations	37	13.7%	233	86.3%
Findings from Health Service Ombudsman investigations	74	27.4%	196	72.6%
NAO and Audit Commission reports	51	18.9%	219	81.1%

Table 5.10

This analysis has presented a highly summarised and condensed account of what is a very substantial data set, and a number of further analyses might be undertaken and reported. However, at this stage the following key points can be drawn from the analysis:

- Most of the components of clinical governance reviewed in this section are relatively well established in most NHS trusts, though there is some variation. On the whole, those functions which serve some statutory or external requirement (such as clinical risk management, claims and complaints) appear to be most robust. Those which are newer, and which though clearly desirable may not be as essential (such as patient and public involvement, and clinical audit) have a rather more fragile and peripheral position in NHS trusts.

- NHS trusts are cautious in rating the effectiveness of the components of clinical governance in bringing about improvements, and few are willing to assert unambiguously that their systems are clearly effective. Again, those functions which serve some external requirement tend to be more highly rated for their effectiveness than those which do not.

- Despite recent increases in NHS resourcing, NHS trusts still overwhelming blame failure to progress in clinical governance on resource constraints – a lack of finance, staff support, clinical staff time, materials, etc. The other two main barriers or problems commonly cited are the culture, behaviour and attitudes of staff (particularly clinical professionals, and often doctors), and a lack of organisational direction and impetus for clinical governance. It is difficult to unpick the relative importance and merits of these three reasons, but improving the rate of progress may require action on all three of them.

- Many of the components of clinical governance predate the clinical governance initiative, and one objective of clinical governance has been to promote the integration of previous separate and uncoordinated initiatives. Respondents' descriptions of the progress made since 1999 suggests that the development of a more co-ordinated, strategic, coherent and consistent approach has been a key priority for many NHS trusts. It also indicates that an improvement in the attitudes of staff to clinical governance and their willingness or motivation to participate has been observed. This is encouraging, given that these two areas are two of the main barriers identified above.

- Assessing the impact of the components of clinical governance is difficult, and highly subjective. Asked to describe improvements in patient care, many NHS trusts were able to do so but many also or instead reported changes to the healthcare organisation itself.

6. External evaluations of clinical governance and quality

The survey collected information from NHS trusts about both how they had fared in a number of external reviews or ratings of their performance in clinical governance, and how they had responded to the review or rating process and what changes it may have produced in their performance. This section of the report presents these findings for each external review/process in turn: the Commission for Health Improvement and its clinical governance reviews; the NHS performance ("star") ratings; the Controls Assurance self-assessment process; and the Clinical Governance Scheme for Trusts (CNST) risk management accreditation.

Most NHS trusts – about 62% - had already been reviewed by the Commission for Health Improvement as table 6.1 shows. Only 7 (4%) of these reported that they were reviewed in 2000 or before – most had been reviewed quite recently in 2001 (73, 43%) or in 2002 (84, 49%). Indeed, a substantial number were still in some stage of the review process, either with a future review visit scheduled (54, 20%) or with the visit completed but the report still being produced (40, 15%).

	[4.1] Been subject to a Commission for Health Improvement review?	
	Count	%
Yes, and report is completed	124	46.6%
Yes, but report not yet completed	40	15.0%
No, but one is scheduled	54	20.3%
No, and none is scheduled yet	48	18.0%
Total	266	100.0%

Table 6.1

Even taking into account the relatively recent nature of many CHI reviews, it was still notable that no NHS trusts indicated that the action plan resulting from their CHI review had been completely implemented, and only 22 (19%) said that most actions within the plan had been implemented (table 6.2). When this data was analysed by the length of time elapsed since the review, we found that after a year had passed, 46% of trusts reported that most or all of their action plan had been implemented.

	[4.3] Status of CHI review action plan	
	Count	%
Action plan not finalised yet	50	33.8%
Plan done but no actions completed yet	3	2.0%
Plan done and some actions completed	67	45.3%
Plan done and most actions completed	28	18.9%
Total	148	100.0%

Table 6.2

NHS trusts were asked to describe what they had learned from the CHI clinical governance review. Most indicated that the process had largely confirmed or reinforced their own perceptions of the areas for development and need for change (96), or their own assessment of their position (43). Surprisingly, relatively

few (29) indicated that the review had raised the profile, awareness or priority of clinical governance and only 25 mentioned positive feedback on their achievements and areas of good practice (see table 6.3).

[4.3] Areas of learning from the CHI clinical governance review

	Theme Count
[4.3-1] Raised profile, awareness of and priority attached to clinical governance	29
[4.3-2] Confirmed organisations self-assessment of position	43
[4.3-3] Identified or reinforced areas for development and need for change	96
[4.3-4] Emphasised need for and importance of communication within organisation and with others	18
[4.3-5] Provided positive feedback on achievements and areas of good practice	25

Note: a total of 164 trusts had undergone a CHI review at time of survey

Table 6.3

NHS trusts were also asked what actions they had taken or planned to take as a result of the CHI clinical governance review. As table 6.4 shows, the commonest actions concerned reviews or changes either to structures and processes within the trust (such as incident reporting, or complaints handling) or reviews or changes of specific service areas like orthopaedics, accident and emergency and so on. Many indicated that the CHI review had caused them to review the strategic direction and development of the trust.

[4.4] Actions taken or planned as a result of CHI clinical governance review

	Theme Count
[4.4-1] Develop and implement patient, public or user involvement strategies	20
[4.4-2] Undertake reviews or changes to specific services	39
[4.4-3] Review or change structures and processes of care/organisation	66
[4.4-4] Review or change staffing/human resources	28
[4.4-5] Increase/improve staff development and training	14
[4.4-6] Review strategic direction/development	59
[4.4-7] Improve intra and interorganisational communication	21

Note: a total of 135 trusts reported taking one or more actions.

Table 6.4

Trusts were asked whether preparing for the CHI review had involved them in any extra work. Only 2 (1%) said it had involved little or no extra work, while 41 (23%) indicated it had caused some extra work and the great majority (134, 76%) said it had involved a great deal of extra work. Most trusts were not able to make any quantified estimate of the costs of preparing for the CHI review, but 45 trusts were able to do so. Their estimates ranged up to £250,000, with a median value of £50,000 and a mean value of £61,831. Extrapolated across all trusts in the survey and taking account of the fact that CHI reviews are currently scheduled every four years, this data suggests that the annual costs of preparing for CHI reviews among NHS trusts are around £4.2 million pa.

NHS trusts were asked both about how they had fared in the NHS performance ratings (commonly known as the “star ratings”) and what they had done as a consequence of their rating. About two weeks after the survey was issued to trusts, but before many respondents had returned it, the Department of Health released the 2002/03 star ratings for all

NHS trusts. While our survey asked what star rating trusts had received "in 2001/02", we suspect that some trusts will have returned their more recent ratings received in 2002/03. With that proviso, table 6.5 below shows the distribution of star ratings.

	[4.7] NHS performance (star) rating received in 2001/02	
	Count	%
Three stars	52	21.0%
Two stars	115	46.4%
One star	30	12.1%
Zero stars	12	4.8%
Not included in ratings	39	15.7%
Total	248	100.0%

Table 6.5

As table 6.6 shows, some NHS trusts reported that they had taken actions in response to their star ratings, including making specific service changes or improvements (62), taking more general actions aimed at sustaining or improving their performance (24), and making staffing or human resource changes (15).

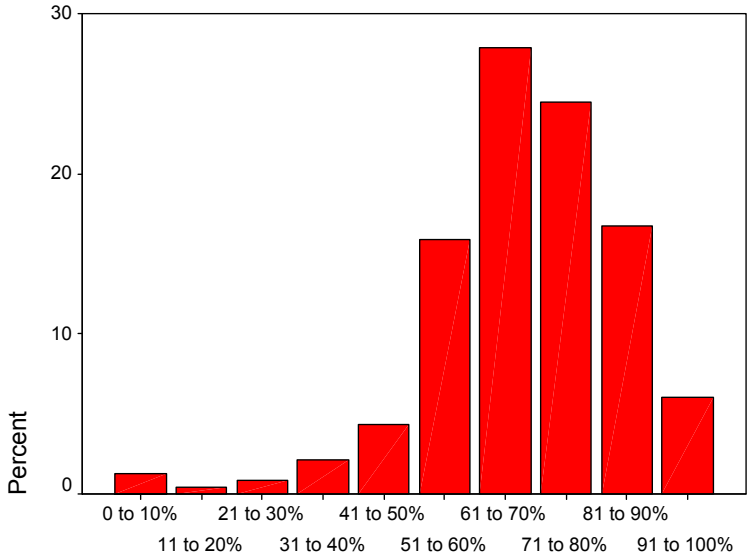
[4.8] Actions taken by trust in response to NHS performance ratings (star ratings)

	Theme
	Count
[4.8-1] Specific service improvements	82
[4.8-2] Changes to staffing/human resources	20
[4.8-3] Recognise/reward staff achievement of rating	9
[4.8-4] Changes to performance management/review systems	23
[4.8-5] Involve/link with external agencies for improvement	11
[4.8-6] Changes to management/organisational structures	14
[4.8-7] Ensure that trust sustains performance to maintain/improve rating	27

Note: a total of 135 trusts reported taking one or more actions.

Table 6.6

NHS trusts were also asked to report on the score which they had given themselves on the Controls Assurance self-assessment. Graph 6.7 below shows the distribution of responses. The median rating was 70%. These self assessments had most commonly been undertaken by the trust's risk manager (73, 35%) or by a committee such as the risk management committee (41, 20%). About 39 trusts (19%) reporting using their internal auditors in undertaking the assessment.



[4.9] Controls Assurance self-assessment score

Graph 6.7

Once again, NHS trusts were asked to report what actions they had taken as a result of the Controls Assurance self-assessment. By far the commonest reported action was the revision or development of their risk management strategy or plans, though some reported specific changes to processes or procedures (like incident reporting, or risk profiling) and many made mention of the introduction or development of risk registers (see table 6.8).

[4.11] Actions taken in response to Controls Assurance score

	Theme Count
[4.11-1] Revision/development of risk management strategy/plans	138
[4.11-2] Changes to processes or procedures	98
[4.11-3] Update/review risk register	82
[4.11-4] Provide/extend training and development in risk management	47
[4.11-5] Integrate clinical and non-clinical risk arrangements	10
[4.11-6] Specific service changes/improvements	25
[4.11-7] Review/revision of committee or staffing for risk management	42

Note: a total of 231 trusts reported taking one or more actions.

Table 6.8

NHS trusts reported the current level of risk management assessment which they had been awarded by the Clinical Negligence Scheme for Trusts (CNST). As table 6.9 shows, a small number of trusts (6, 3%) have yet to achieve accreditation by CNST, and the great majority (185, 79%) have Level 1 accreditation. A few have progressed to level 2 (42, 18%) and a couple report reaching level 3 (2, 1%). Most trusts reached their current level of accreditation some time ago – only 45 (19%) report doing so in 2002 and 43 (19%) in 2001. This, and the preponderance of NHS trusts at level 1 suggests that improvement over time may not be taking place very quickly.

	[4.12] Level of CNST risk management assessment achieved	
	Count	%
0	6	2.6%
1	185	78.7%
2	42	17.9%
3	2	.9%
Total	235	100.0%

Table 6.9

Asked what changes had been made or actions taken as a result of its CNST risk management assessment, trusts reported a wide range of changes to policies, processes and procedures (105) such as incident reporting, drug administration, equipment maintenance, etc), some specific changes in areas like health records management (53) and patient consent procedures (26), and increased training and development activity particularly related to risk management (64) (see table 6.10).

[4.14] Actions taken in response to CNST assessment

	Theme
	Count
[4.14-1] Improving health records systems/management	53
[4.14-2] Implementing training and development	64
[4.14-3] Updating/improving patient consent procedures	26
[4.14-4] Changes to policies, processes or procedures	105
[4.14-5] Creation of new staff positions/roles (eg medical devices etc)	15
[4.14-6] Working towards achieving higher level of assessment	50

Note: a total of 220 trusts reported taking one or more actions.

Table 6.10

The responses from NHS trusts to questions about the actions they have taken after different forms of external review are brought together in table 6.11. It can be seen that about 85-90% of trusts reported taking some form of action following or in response to a CHI review, CNST assessment or Controls Assurance assessment. Rather fewer, around 63%, reported taking action in response to their NHS performance rating.

	No		Yes	
	Count	%	Count	%
Action taken after CHI clinical governance review	7	5.6%	117	94.4%
Action taken after NHS performance rating	77	36.8%	132	63.2%
Action taken after Controls Assurance self-assessment	22	9.4%	211	90.6%
Action taken after CNST risk management assessment	36	15.3%	199	84.7%

Table 6.11

Drawing conclusions from these various reports on external reviews and their impact on NHS trusts is not straightforward, but a number of important emerging themes can be identified:

- Of all the external influences covered by the survey, CHI clinical governance reviews seem to have the greatest impact on NHS trusts. It appears that they rarely reveal wholly new information about an organisation, but they do have the effect of making knowledge about performance more explicit and visible, and they seem to stimulate meaningful changes in NHS trusts, though they are also very resource intensive and result in a great deal of extra work for NHS trusts.

- On the whole, over three quarters of NHS trusts report taking some action to make change happen following an external review, though the scale and significance of the changes reported is difficult to gauge. There was rather less evidence that the NHS performance ratings had led to change.

- There is some evidence that follow-up and completion of actions resulting from external reviews is needed. Many trusts progress in implementing their CHI action plans seems relatively slow, and the rate of improvement in risk management resulting from the CNST inspection process appears minimal.

- The profusion of different and overlapping forms of external review and assessments of NHS trusts is amply demonstrated by the fact that clinical risk management arrangements in NHS trusts are considered in all four of the external review processes considered above. There is certainly some duplication, and potential for conflict or confusion.

7. Chief executive's views of the development of clinical governance

The final section of the questionnaire was completed personally by chief executives of NHS trusts, who recorded their own perceptions of the progress and impact of clinical governance and also "signed off" the rest of the questionnaire return on behalf of the trust.

Chief executives were asked to assess, in very broad terms, the success of their own trust in implementing clinical governance. Their responses showed some caution about the claims they made – 159 (63%) responded "fairly successful" and 82 (32%) "very successful", but few used the extremes of the scale (see table 7.1).

	[5.1] Chief Executive's assessment of success in implementing clinical governance	
	Count	%
Not at all successful	1	.4%
Not very successful	8	3.1%
Fairly successful	159	62.6%
Very successful	82	32.3%
Extremely successful	4	1.6%
Total	254	100.0%

Table 7.1

Chief executives were asked what they saw as the main barriers to progress in implementing clinical governance in their trust, and their responses largely confirm the views of clinical governance leads reported earlier in sections 4 and 5 of this report. The most commonly cited problem was the availability of time and other resources to make clinical governance happen, especially when it has to compete with other urgent priorities such as increasing workload, access targets, etc. They also wrote of problems concerning the culture, behaviour and attitudes of staff and the organisation, and difficulties caused by the pace and scale of organisational change in the NHS in recent years, particularly related to NHS trust reconfigurations, mergers and dissolutions (table 7.2 and table 7.3).

[5.2] Chief executives views of barriers to progress in clinical governance

	Theme Count
[5.2-1] Time and resources	196
[5.2-2] Culture, behaviour and attitudes of staff/organisation	66
[5.2-3] Geography or organisation of trust - size, heterogeneity, spread	16
[5.2-4] Conflicts between clinical governance and other priorities	37
[5.2-5] Size of priorities agenda and number of demands	19
[5.2-6] Clinician attitudes to/support for clinical governance	29
[5.2-7] Lack of clarity, intangibility of clinical governance aims/concept	14
[5.2-8] Organisational change, merger etc	55

Note: a total of 251 chief executives reported one or more barriers.

Table 7.2

"The extent of organisational change 99-2001, bringing staff together from 9 organisations restricted capacity and focus on clinical governance… organisational stability is now important" [6]
"There have been significant changes and a long period of uncertainty at the senior management level in the trust for the last two years – this is now resolved" [18]
"The substantial organisational change faced by the trust during the last twelve months has slowed down the development of clinical governance for acute services. The two former trusts merged on 1 April 2001, the demerger of mental health and primary care services was managed throughout the year and services were transferred into four new organisations on 1 April 2002" [34]

"Size of organisation, complexity and links to university" [2]
"The trust covers 85 sites and has service spread over the entirety of [major city] – spread and diversity are challenging" [27]
"Difficulties of working across organisational boundaries in respect of joint working with other NHS providers and social care" [37]

Table 7.3. Organisational barriers to clinical governance cited by chief executives

Asked to describe the changes which had been brought about by clinical governance, most chief executives noted a shift towards a more corporately owned and managed approach to clinical quality issues, and a shift in cultures and attitudes to be more receptive to the ideas of clinical governance and more centred on patients and their needs (see tables 7.4 and 7.5).

[5.3] Chief executives views of the changes resulting from clinical governance

	Theme Count
[5.3-1] Greater corporate ownership of quality issues/agenda	205
[5.3-2] More open culture, and improved relationships and attitudes of staff	142
[5.3-3] Greater patient focus in service provision/delivery	49
[5.3-4] Specific changes or improvements to practice	41
[5.3-5] Improved communication - internal and external	18
[5.3-6] Improved training, education and development of staff	25

Note: a total of 249 chief executives reported one or more changes.

Table 7.4

"More systematic and effective means of dealing with poor performance, effective clinical and non-clinical risk management" [13]
"Much greater level of board awareness and ownership of clinical governance issues, greater buy-in from clinicians" [5]
"The trust board has a much greater involvement in clinical quality issues than was the case prior to the introduction of the concept of clinical governance" [22]
"Incorporating clinical governance within all directorate service plans and meetings" [30]
"Bringing together the various clinical governance resources into a dedicated, integrated team supporting and guiding clinicians and managers across the whole spectrum of clinical governance activities" [31]
"Improved consent process, more coherent and consistent practice standards, shift in culture to see clinical issues as 'corporate' and not professional and personal" [43]
"The most important change has been the commitment from the trust board and the structured way in which service management teams have developed their annual clinical governance programmes" [46]

Table 7.5. Examples of changes resulting from clinical governance cited by chief executives.

The view that NHS boards were now better informed about and involved in clinical governance was supported by information we gathered about how boards assured themselves that clinical governance was making progress. Most (221, 82%) used regular updates at and reports to board meetings, but many also used direct non-executive participation in clinical governance committee meetings and other board subcommittees, and specific visits by, presentations to or other engagement for board members.

Asked whether the implementation of clinical governance had changed the accountability of clinical staff for the quality of care, the overwhelming view of chief executives (211, 84%) was that it had made clinicians more accountable. About 16% thought there had been no change in accountability, and no-one thought clinical staff had become less accountable.

Chief executives were also asked to indicate whether a range of quite specific examples of change had come about through the implementation of clinical governance, and the results are presented in table 7.6. It can be seen that there was widespread agreement that NHS boards were now better informed about quality issues, that there had been positive changes in organisational culture, and that clinicians and managers were working together more closely. Most chief executives also believed that there had been documented changes in clinical practice and specific improvements in patient care through clinical governance. However, rather fewer asserted that clinical governance had reduced the use of ineffective investigations and therapies, or had had any impact on patient satisfaction, and very few believed that clinical governance had led to fewer patients complaining.

[5.6] Whether clinical governance has produced specific changes

	No/no answer		Yes	
	Count	%	Count	%
Fewer patient complaints	231	85.6%	39	14.4%
Less unjustified variation in clinical practice	115	42.6%	155	57.4%
Less use of ineffective investigations and treatments	178	65.9%	92	34.1%
Better use of resources	164	60.7%	106	39.3%
Increased patient satisfaction	190	70.4%	80	29.6%
Documented changes in clinical practices	65	24.1%	205	75.9%
Specific improvements in patient care	77	28.5%	193	71.5%
Closer working between clinicians and managers	65	24.1%	205	75.9%
Positive changes in organisational culture	55	20.4%	215	79.6%
Better at managing changes in clinical practice	107	39.6%	163	60.4%
Board now more informed about quality of care	36	13.3%	234	86.7%

Table 7.6

From this analysis of chief executives' perceptions of the progress and impact of clinical governance we might draw a number of conclusions:

- Chief executives see clinical governance as having been moderately successful, and having brought about real changes within NHS trusts in the way that clinical quality and performance issues are addressed. They indicate that NHS boards are now better informed, that quality is higher on the corporate agenda, that clinicians are more accountable for the quality of care that they provide, and that cultures and attitudes have become more receptive to the ideas of clinical governance and more willing to tackle

- However, chief executives are cautious about overclaiming – few of them regard clinical governance as a complete success, and many cite barriers and problems which have inhibited progress, most notably resource constraints, staff and organisational cultures and attitudes, and the wider pace of organisational change in the NHS. While they think that clinical governance has brought about important changes in clinical practice and service improvements, they do not think those changes have impacted on patients' perceptions of the service they receive.

8. Summary of conclusions

At the end of each section of this report, a number of conclusions have been noted. They are brought together below, to provide a concise summary of the messages emerging from this report:

Support in implementing clinical governance

- NHS trusts have found Department of Health and Regional Office guidance and assistance in implementing clinical governance moderately useful, and many would welcome future support on a wide range of issues, particularly concerning the embedding of clinical governance in healthcare organisations and communities/networks. Following recent organisational changes, it is not clear who is tasked with providing this kind of external guidance, assistance and support to NHS trusts now and in the future.

- NHS trusts which have used the CGST development programmes have generally found them very useful, and rate them quite highly, particularly those aimed at clinical teams. They report a significant level of change resulting from their involvement with CGST, though it is not clear how much wider impact the CGST development programmes have in participating organisations. However, many NHS trusts have yet to use the programmes, despite indicating that they would like to do so and that there are no significant resource or capacity constraints preventing them from doing so. Action may be needed to bring the benefits of the CGST development programmes to a wider audience both across and within NHS trusts.

Structures and frameworks for clinical governance

- Clinical governance is well established and embedded in the corporate systems of the vast majority of NHS trusts, with board level executive and non-executive leadership, trust wide committee structures, and a strong executive function in the form of a clinical governance department or unit.

- Most NHS trusts still see the achievements of clinical governance at trust level in terms of systems, structures and processes – which though important and very necessary to the objective of improving patient care, are not necessarily sufficient in themselves to ensure that objective is achieved.

- Clinical governance is largely an intra-trust function – funding is generally provided within NHS trusts either centrally or at a directorate level, and the planning, monitoring and management of clinical governance is largely trust-driven with relatively little apparent input from other stakeholders.

- The costs of clinical governance are not generally known, partly because there is definitional ambiguity about what to count, but also because NHS trusts have mostly not concerned themselves with knowing what clinical governance costs. The cost estimates given – of around £326,000 per NHS trust pa, which equates to £88 million pa across all the NHS trusts surveyed – probably significantly understate the actual cost because they do not include clinical and managerial staff time.

Resources and processes for clinical governance

- Most of the components of clinical governance reviewed in this section are relatively well established in most NHS trusts, though there is some variation. On the whole, those functions which serve some statutory or external requirement (such as clinical risk management, claims and complaints) appear to be most robust. Those which are newer, and which though clearly desirable may not be as essential (such as patient and public involvement, and clinical audit) have a rather more fragile and peripheral position in NHS trusts.

- NHS trusts are cautious in rating the effectiveness of the components of clinical governance in bringing about improvements, and few are willing to assert unambiguously

that their systems are clearly effective. Again, those functions which serve some external requirement tend to be more highly rated for their effectiveness than those which do not.

- Despite recent increases in NHS resourcing, NHS trusts still overwhelming blame failure to progress in clinical governance on resource constraints – a lack of finance, staff support, clinical staff time, materials, etc. The other two main barriers or problems commonly cited are the culture, behaviour and attitudes of staff (particularly clinical professionals, and often doctors), and a lack of organisational direction and impetus for clinical governance. It is difficult to unpick the relative importance and merits of these three reasons, but improving the rate of progress may require action on all three of them.

- Many of the components of clinical governance predate the clinical governance initiative, and one objective of clinical governance has been to promote the integration of previous separate and uncoordinated initiatives. Respondents' descriptions of the progress made since 1999 suggests that the development of a more co-ordinated, strategic, coherent and consistent approach has been a key priority for many NHS trusts. It also indicates that an improvement in the attitudes of staff to clinical governance and their willingness or motivation to participate has been observed. This is encouraging, given that these two areas are two of the main barriers identified above.

- Assessing the impact of the components of clinical governance is difficult, and highly subjective. Asked to describe improvements in patient care, many NHS trusts were able to do so but many also or instead reported changes to the healthcare organisation itself.

External evaluations of clinical governance and quality

- Of all the external influences covered by the survey, CHI clinical governance reviews seem to have the greatest impact on NHS trusts. It appears that they rarely reveal wholly new information about an organisation, but they do have the effect of making knowledge about performance more explicit and visible, and they seem to stimulate meaningful changes in NHS trusts, though they are also very resource intensive and result in a great deal of extra work for NHS trusts.

- On the whole, over three quarters of NHS trusts report taking some action to make change happen following an external review, though the scale and significance of the changes reported is difficult to gauge. There was rather less evidence that the NHS performance ratings had led to change.

- There is some evidence that follow-up and completion of actions resulting from external reviews is needed. Many trusts progress in implementing their CHI action plans seems relatively slow, and the rate of improvement in risk management resulting from the CNST inspection process appears minimal.

- The profusion of different and overlapping forms of external review and assessments of NHS trusts is amply demonstrated by the fact that clinical risk management arrangements in NHS trusts are considered in all four of the external review processes considered above. There is certainly some duplication, and potential for conflict or confusion.

Chief executives perceptions of the progress of clinical governance

- Chief executives see clinical governance as having been moderately successful, and having brought about real changes within NHS trusts in the way that clinical quality and performance issues are addressed. They indicate that NHS boards are now better informed, that quality is higher on the corporate agenda, that clinicians are more accountable for the quality of care that they provide, and that cultures and attitudes have become more receptive to the ideas of clinical governance and more willing to tackle

- However, chief executives are cautious about overclaiming – few of them regard clinical governance as a complete success, and many cite barriers and problems which have

inhibited progress, most notably resource constraints, staff and organisational cultures and attitudes, and the wider pace of organisational change in the NHS. While they think that clinical governance has brought about important changes in clinical practice and service improvements, they do not think those changes have impacted on patients' perceptions of the service they receive.