

Achieving Improvements through Clinical Governance: A Progress Report on Implementation by NHS Trusts



REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
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executive summary

Clinical governance plays a key role in efforts to deliver improvements in the quality of healthcare

- 1 The aim of clinical governance is to secure better quality care from the £54 billion a year spent on healthcare services and, through improved accountability, to give patients and the general public greater confidence in NHS services.
- 2 In 1997, Sir Liam Donaldson, now the Department of Health's Chief Medical Officer, drew attention to the fact that quality did not seem to be as high on the agenda of the NHS as financial and workload targets and that approaches to quality were very fragmented and lacked co ordination; and pointed out that the management view of quality was very different from the medical view. He called for a programme of change and proposed the concept of clinical governance.¹
- 3 The key principles of clinical governance (Appendix 1) are: a coherent approach to quality improvement, clear lines of accountability for clinical quality systems and effective processes for identifying and managing risk and addressing poor performance. It involves putting in place the information, methods and systems to ensure good quality so that problems are identified early, analysed and action taken to avoid any further repetition. The Department of Health (the Department) expects clinical governance to integrate the previously rather disparate and fragmented approaches to quality improvement, such as clinical audit, risk management, incident reporting and continuing professional development into a single system and to ally it to accountability for quality.



- 4 Clinical governance requires a change in the culture of NHS organisations, to one "where openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received."²

¹ Department of Health website www.doh.gov.uk/cmo/progress/clingov.
² Department of Health website.

- 5 In 1997, the Government introduced a 10 year programme to improve continuously the overall standard of clinical care; reduce variations in outcomes of, and access to, services; and ensure that clinical decisions are based on the most up-to-date evidence of what is known to be effective.^{3 4 5} It introduced new policies, programmes and structures to support a comprehensive and systematic approach towards assuring and improving the quality of clinical services. Clinical governance was designated the centrepiece of this programme.⁶
- 6 The government's strategy has three main strands:
- **Establishing clear national standards** through National Service Frameworks, and *the National Institute for Clinical Excellence*;
 - **Ensuring local delivery of those standards** through clinical governance, underpinned by lifelong learning and strengthened and modernised systems of professional self-regulation. Support is provided through: *the Clinical Governance Support Team*, now part of the NHS Modernisation Agency (provides expertise, information, advice and training to clinical and management teams); *the National Patient Safety Agency* created to implement a mandatory reporting system to collect and learn from data on adverse incidents, and to develop and implement solutions for improving patient safety; and *the National Clinical Assessment Authority* (provides an expert advice and assessment service to NHS employers with concerns over the performance of individual doctors and dentists); and
 - **Effective monitoring** through: *The Department's regional offices*, until March 2002 and, following the reorganisation implementing the Shifting the Balance of Power⁷ programme, through *strategic health authorities*; *the Commission for Health Improvement*, which aims to improve quality by reviewing the care provided and identifying notable practice and areas where care could be improved; *NHS Performance Assessment (star ratings)*; and *the National Survey of Patient and User Experience* which is intended to deliver annual feedback on the things that matter to patients, carers and service users.
- 7 Given the importance of clinical governance to the government's programme for modernisation of the NHS, we examined trusts' progress in putting the required structures in place and progress in improving the quality of patient care. We took into account that the introduction of clinical governance has taken place against the background of considerable organisational change, particularly since 1997, and an increase in regulation and performance monitoring.
- 8 We focused this examination on secondary and tertiary care, where systems have had time to bed in. There are important differences in the implementation of clinical governance in primary healthcare, and because of this and the impact of major organisational changes from April 2002, including the creation of primary care trusts, we propose to examine that sector later.

3 *The New NHS Modern and Dependable: Cm 3807, 1997.*

4 *A First Class Service - Quality in the new NHS, Department of Health, 1998.*

5 *The NHS Plan, Cm 4818 I, 2000.*

6 Donaldson, L. and Halligan, A. *Implementing clinical governance: turning vision into reality. BMJ, June 2001; 322 1413-1417.*

7 *Shifting the Balance of Power is a programme of change that aims to give locally based primary care trusts the role of running the NHS and improving health in their areas. This programme has involved abolishing from March 2002 the Department of Health's regional offices and, from September 2002, the former health authorities; and establishing strategic health authorities.*

- 9 Early identification and remedying of poor performance of clinicians is an integral part of clinical governance. Because this component is allied to disciplinary matters and sometimes suspensions, we have examined this aspect - including the contribution of the National Clinical Assessment Authority to that work - in a separate examination of the management of suspension of clinicians (to be published in autumn 2003). We are planning to examine in 2004 issues surrounding organisational learning as applied to patient safety.
- 10 The main sources of evidence for this report were a census of NHS acute, mental health and ambulance trusts (working with the Manchester Centre for Healthcare Management, University of Manchester); a survey of board members and senior managers at a representative sample of NHS trusts (conducted on our behalf by the Health Services Management Centre, University of Birmingham); a review of reports published by the Commission for Health Improvement; interviews with Department and NHS staff and with other relevant bodies; and through consulting our expert panel. Our methodology is set out in more detail at Appendix 2.
- 11 Given the challenge of changing cultures and embedding new processes throughout trusts, this is very much a progress report on the implementation of clinical governance. Our main findings are summarised in paragraphs 12 to 34 below, and our recommendations are provided in paragraph 35.

Overall conclusions

- 12 Our examination has confirmed that, while each component predated the formal introduction of clinical governance, since 1999 the machinery - the structures and organisational arrangements to make it happen - has been put in place. Virtually all trusts have the necessary foundations, although the components are not fully embedded within all clinical directorates.
- 13 The initiative has had many beneficial impacts. Clinical quality issues are now more mainstream; there is greater or more explicit accountability of both clinicians and managers for clinical performance; and there has been a change in professional cultures towards more open, transparent and collaborative ways of working. Moreover there is evidence of improvements in practice and patient care, though trusts lack robust means of assessing this and overall progress.
- 14 However, our research and the outcome of the Commission for Health Improvement's reviews indicate that progress in implementing clinical governance is patchy, varying between trusts, within trusts and between the components of clinical governance. There is, not surprisingly, scope for improvement in: the support provided to trusts; putting in place overall structures and processes; communications between boards and clinical teams; developing a coherent approach to quality; and improving processes for managing risk and poor performance. There is also a need to improve the way that lessons are learnt both within and between trusts; and to put those lessons into practice. Overall, the key features of those organisations that have been better at improving the quality of care are quality of leadership, commitment of staff and willingness to consider doing things differently.

Support in implementing clinical governance

- 15 NHS trusts have found Departmental and regional office guidance and assistance in implementing clinical governance useful, but many would welcome future support on a wide range of issues, particularly concerning the embedding of clinical governance in healthcare organisations and communities and networks. Following the recent organisational changes associated with Shifting the Balance of Power, the Clinical Governance Support Team now expects to fulfil this role alongside the strategic health authorities.
- 16 The 43 per cent of NHS trusts that have used the Clinical Governance Support Team 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 the Team, though it is not clear how much wider impact the development programmes have in participating organisations. While many NHS trusts have yet to use the programmes, a further 45 per cent indicated that they planned to do so.

Progress in establishing structures and frameworks for clinical governance

- 17 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.
- 18 Clinical governance has delivered a range of achievements, but most NHS trusts still see them in terms of 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. There are doubts whether there has been sufficient progress in improving systems in clinical areas across trusts. And there is substantial scope for improvement in leadership, particularly in communications between boards and clinical teams, and in collaborating with other agencies.
- 19 Funding for clinical governance is largely an intra-trust function, with funding generally provided either centrally or at a directorate level. Likewise, the planning, monitoring and management of clinical governance is also largely trust-driven with relatively little input from other stakeholders such as health authorities and primary care trusts.
- 20 Because clinical governance is, or should be, an integral part of the way in which trusts deliver services it does not lend itself to being costed separately (nor are we suggesting that it should be). There is also ambiguity about what should be included in such costing. However, some 30 trusts have attempted to assess the cost of supporting the implementation, and the average estimate - of around £326,000 per NHS trust a year - suggests the annual cost in secondary and tertiary care is likely to be at least £90 million a year. This probably significantly understates the actual cost because the estimate excludes clinical and managerial staff time and the cost of the main bodies established to support the implementation of clinical governance, which was some £60 million in 2002-03.

Responsiveness to internal and external evaluations of clinical governance and quality

- 21 Reviews by the Commission for Health Improvement, the NHS performance (star) ratings, the Controls Assurance self-assessment process and operation of the Clinical Negligence Scheme for Trusts provide an important focus and stimuli for improvements in clinical governance. Over three quarters of NHS trusts reported taking some action to make change happen following an external review, though the scale and significance of the changes is difficult to gauge.
- 22 NHS trusts acknowledged that the Controls Assurance and Clinical Negligence Scheme for Trusts and the performance (star) ratings have had beneficial impacts on their performance. But trusts assessed the Commission for Health Improvement clinical governance reviews as having the greatest impact on them. While they rarely reveal wholly new information about an organisation, they appear to have the effect of making knowledge about performance more explicit and visible, and thus stimulate meaningful changes in NHS trusts. However, many trusts' progress in implementing their Commission for Health Improvement action plans seems relatively slow. Strategic health authorities, which are now responsible for such follow-up, will need to ensure that trusts take timely action.
- 23 Indeed, the remits of the increasing numbers of inspection bodies that provide external evidence of achievements in clinical governance and quality often overlap. The NHS Reviews Co-ordination Group which was set up voluntarily by its members to improve the efficiency of scrutiny in one area, risk management, has identified scope for improved co-ordination. And the joint Department of Health/Cabinet Office report on inspection of the NHS⁸ proposed a Healthcare Inspection Concordat. That concordat, to be implemented in December 2003, is intended to reduce unnecessary burdens imposed by the inspection process. The reforms of the inspection system, with the creation of the new Commission for Healthcare Audit and Inspection and the Commission for Social Care Inspection should also address some of these concerns.

The contribution made by the components of clinical governance

- 24 Most of the individual components of clinical governance are in place in most NHS trusts, though the coverage of each component within individual trusts varies from those with less than 20 per cent coverage to ones with over 80 per cent. But, for trusts as a whole, there is noticeable progress in the development of a more co-ordinated, coherent and consistent strategy.
- 25 On the whole, those functions which serve some statutory or external requirement (such as risk management, claims and complaints) appear to be most robust. Those which are newer, and which though clearly desirable may not yet be consistently seen as essential (such as patient and public involvement, and knowledge management, including sharing of good practice) are less well developed in many trusts. And, although medical audit was formally introduced some 14 years ago, clinical audit remains underdeveloped in many trusts. As a result clinical directorates and trusts are not exploiting in full its capacity to drive improvements in the quality of care.

8 *Making a Difference - reducing burdens in healthcare inspection and monitoring, Department of Health/Cabinet Office, July 2003; available at www.cabinet-office.gov.uk.*

- 26** Trusts have made limited progress in involving patients and the public in the NHS. The Department has, however, introduced a number of initiatives to increase patient involvement in their care and to enable community involvement in their local health services, including the introduction of the Patient Advice and Liaison Service, Independent Complaints Advocacy Services, Patients' Forums and the Commission for Patient and Public Involvement in Health.
- 27** In contrast, risk management systems have developed substantially since 1999, and are reasonably well established in most trusts. Trusts' performance is taken into account in reviews by the Commission for Health Improvement, in trusts' Controls Assurance self-assessments, in assessments by the Clinical Negligence Scheme for Trusts and in NHS performance (star) ratings. Since the Committee of Public Accounts raised concerns about risk management in their hearing on the Clinical Negligence Scheme in 2001⁹, there has been some progress with most trusts aiming for a higher rating, but one in five trusts have not achieved any level, and most have yet to move beyond level 1.
- 28** In 17 per cent of trusts, the proportion of clinical directorates using clinical risk management is still 60 per cent or below. And, while trusts have improved the recording, collating and review of data, training in risk management is still weak as is performance in moving from identifying risks to taking action to improve quality.
- 29** Effective clinical governance requires trusts to generate, identify and use relevant information. It involves trusts bringing together information generated by the components of clinical governance, so that they can assess quality and performance of services; and obtain the information needed to enable evidence-based clinical decision making. It also involves identifying, disseminating and learning from good practice. A number of recent National Audit Office reports have concluded that the NHS does not perform well in this respect.
- 30** The Commission for Health Improvement also has concerns about trusts' use of information, particularly that trust boards did not have the information they needed to manage strategically. Furthermore, the failure to share learning across and between organisations was one of the six most common themes emerging from the Commission for Health Improvement's clinical governance reports, raised at more than 90 per cent of reviews. They also commented at many organisations on weaknesses in dissemination of national guidance on effectiveness. Their first annual report on the NHS states - "the NHS was not good at learning from itself with examples of good practice often not replicated in the same hospital, let alone the same town".¹⁰
- 31** While there are important sources of information on good practice, such as the Commission for Health Improvement reports, presentations and press releases, the tracking report they maintain is not published, and the examples in it are not highlighted in a concerted manner that would enable trusts to make good use of them. The Clinical Governance Support Team has published a number of articles and examples of good practice which are also available on its website (www.cgsupport.org).

⁹ *Committee of Public Accounts 37th report, 2001-02, Handling Clinical Negligence Claims in England. HC280, 2001-02.*

¹⁰ *Getting better? A report on the NHS by the Commission for Health Improvement. May 2003.*

- 32 To date, few trusts have developed internal indicators of progress in implementing clinical governance. Trusts generally gain assurance through regular updates and reports to the board. The Commission for Health Improvement found that a third of the organisations reviewed had a lack of connection between the policies that the board has agreed and what happens on the front-line. The Clinical Governance Support Team is developing a model form of report that could provide one solution to this issue.
- 33 The clinical governance strategy has changed the way trusts deal with quality of care. To date, most of those changes have been to processes. There are, however, clear indications that there have been changes to the culture of trusts, in that boards have become more involved in clinical concerns; clinicians have begun to see those concerns as corporate rather than professional and personal; and attitudes of staff within trusts have become less defensive and more open. The components of clinical governance have been substantially developed and used more effectively and as a result trusts have made many changes to patient care.

To maintain the momentum, a number of barriers will need to be overcome

- 34 Trusts identified a number of barriers that need to be overcome in achieving further improvements. The most common themes were lack of resources and cultural difficulties. The other main barriers or problems cited were conflicting priorities, particularly the concentration on short term waiting targets, organisational changes and mergers, the size, spread and heterogeneity of trusts and a lack of organisational direction and impetus for clinical governance. It is difficult to unpick the relative importance and merits of these barriers, but improving the rate of progress will require action on all of them.

