

Clinical Governance : the next hype?

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Introduction

The recent wave of strategies geared at improving the quality of the NHS and combating medicolegal actions in the UK has resulted in the accumulation of a number of hyped-up terms, the latest of which is *Clinical Governance*. Clinical Governance is to be the main vehicle for continuously improving the quality of patient care and developing the capacity to maintain high standards.

As from June 1999, the British Health Act has placed a duty on each primary care trust and each NHS trust to make arrangements for the purpose of monitoring and improving the quality of healthcare provided to patients. A recent update of the NHS Plan (www.nhs.uk/nationalplan/nhsplan.htm), published in July 2000, explains how this move is to be governed by the *National Institute for Clinical Excellence (NICE)* - www.nice.org.uk - which will set standards and evaluate new treatments.^{1,2} The *Commission for Health Improvement (CHI)*, on the other hand, will be the "watchdog" of the system, ensuring that changes are actually being implemented¹. A similar albeit different system has also been implemented in Scotland, with the *Scottish Intercollegiate Guidelines Network (SIGN)* - www.show.scot.nhs.uk - working hand in hand with the Clinical Standards Board.

Clinical Governance may be defined as :

*A framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.*²

The World Health Organisation has divided the approach into four principle aspects³:

- Professional Performance, which covers Evidence-Based Practice, Audit and Continued Professional Development
- Resource use (efficiency)
- Risk Management
- Patient Involvement

This article seeks to explain these terms and their contribution to the whole scenario of Clinical Governance. An overview of the local scene in the light of these concepts is also discussed.

Evidence Based Practice

Evidence Based Practice is about basing one's practice on the best accepted evidence to date. This requires a basic infrastructure which will provide this continuously-updated information. It entails information technology which will enable access to specialist databases such as the Cochrane Collaboration (www.cochrane.co.uk) and facilitated access to updated libraries⁴.

Audit

Assessing whether one's practice is actually up to the required standard relies on audit. All clinicians in the UK are now expected to participate in audit programs, and there is greater emphasis on evidence-based practice and adherence to national frameworks and recommendations made by the NICE. (See the National Centre for Clinical Audit website www.ncca.org.uk). In addition, participation in audit is also becoming a major requirement for advertised clinical posts.

Clinical audit is defined as:

*The systematic critical analysis of the quality of care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient.*⁵

Audit may cover structure, process and outcome. Structure includes personnel, hospital beds, theatre time, equipment and instruments. Process is the way patients are treated – the area most often studied by clinicians. Outcome is judged by the quality of life of the patient as a result of clinical intervention.

The audit process is a cycle which involves the selection of an area suited for study, the setting of achievable targets, data collection, discussion of results and conclusions, implementation of change, and finally re-auditing to establish what improvement has been attained. Achievement of the target set at the onset of the audit study is referred to as *closing the audit loop*.⁶

A suitable topic for audit should be one that has not previously been studied, an important and common intervention, and one that is practical to carry out. Much motivation will be required from the personnel involved, and in other centres this is aided by actually allocating time for audit, having specialized hardware and software specifically designed for data collection

and statistical analysis and the use of coding systems.^{5,6}

A literature review will then enable the establishment of a target standard with which local results are to be compared. Guidelines may also be an adaptation of protocols already set up in the UK, such as those issued by NICE and SIGN. Websites have also been created which continually update the clinician on the latest guidelines issued (www.guideline.gov).

Local practice may be observed either retrospectively or prospectively, with retrospective analysis making the requirement of accurate and complete clinical notes more of a necessity. Discrepancies between actual and expected results are then discussed with all those involved, and a plan for implementation of a change towards the standards expected worked on. Re-auditing this change will then close the audit cycle as described above.

An example of large-scale audit being carried out in the UK is the *National Confidential Enquiry into Perioperative Death (NCEPOD)* - www.ncepod.org.uk - which is based on 5-10% of perioperative deaths. In Scotland, the *Scottish Audit of Surgical Mortality* gathers data from all in-hospital surgical deaths.⁶ Problem areas which have been identified by these audits include:

- Not delaying surgery to normal working hours when more senior staff and backup facilities are available
- Inadequate preoperative resuscitation
- Pre-existing medical conditions being underestimated in severity
- Underprovision of ITU/HDU facilities

Continuing Professional Development

The staff of a healthcare organisation will be the key to how it rises to the challenges of the new agenda. Firstly, good recruitment, retention and development of staff will make a major contribution. Secondly, staff must be supported if they are to practice well: skills training, modern information technology, access to evidence are all important. Thirdly, staff must participate in developing quality strategies and be encouraged to look critically at existing processes of care and improve them. Finally, valuing staff and letting them know that they are valued is a common feature of organizations that show sustained excellence in other sectors⁷.

Risk Management

Risk Management may be tackled from both a departmental and personal level. On a departmental level, policies for critical incident reporting need to be established in order to identify "risk" areas and a register set up which would eventually help identify what may be leading to a less than successful outcome. One example each month of an adverse incident from

which lessons may be learnt should be discussed within the department. Guidelines or protocols may consequently be generated in order to guide clinicians who may find themselves in similar difficulty.^{8,9}

Personal risk management is about identifying areas in one's practice which may later be the source of legal action. The Medical Protection Society has subdivided personal risk management into a number of categories:⁹

Those most relevant to us locally include:

Clear communication: when many people are involved in the care of a patient, all the left hands need to know what the right hands are up to, and written evidence of such communication – such as discharge letters or dictated letters – need to be rechecked as this is "obvious" evidence which may be utilized later.

Contemporaneous records: claims of negligence may not materialize for weeks, months or even years after the events in question, by which time the doctor is unlikely to remember exactly what happened at a given consultation. Thus if case notes are inadequate, the doctor's position may be prejudiced. An adequate medical record is one that enables the doctor to reconstruct the consultation without reference to memory. Records need to be legible and worthy of independent scrutiny as they will be pored over in considerable detail in the event of an investigation.

Patient Involvement

Patient complaints are another source of identification of risk practices and poorly-performing colleagues, and approaches to registering such problems need to be taken into consideration.

The Local Scene

There is an increasing awareness of the need for continued professional development locally. The Department of Surgery, for example, has recently set up the *Surgical Postgraduate Education Committee (SPEC)*. The committee, which is made up of representatives of all strata of the surgical hierarchy from basic surgical trainee to consultant level, is working on the provision of a postgraduate education area which will allow 24-hour access to computer facilities, internet, surgical technique videos, journals and books. A Telemedicine link is also being planned by those who are more than literally on the cutting edge. Most importantly, this will be on the hospital premises. This is in sharp contrast to the Medical School Library which cannot be accessed when we need it most - mainly during on call hours.

From a wider view-point, The Consensus Conference entitled *A National Agenda for Sustainable Health Care* organised by the Foundation for Medical Services in February 2000 sought to address the issues of audit, governance, financing, equity and empowerment. This was a well-acclaimed attempt at introducing these concepts locally. Smaller workshop groups devised means of introducing governance in a stepwise fashion. The workshop on

quality and outcomes suggested adapting existing guidelines adopted from UK organisations to the local scene as a set point. The question of who to involve - depending on whether we are dealing with medical practice alone or overall clinical care - raised much debate, as well as whether the governing body should be an already established association or an independent body of experts. It was concluded that a Department of Audit supported by the government will be needed to provide the necessary technological and manpower backup. A report issued by the working group was presented to the chair and is available for viewing on the Foundation for Medical Services website (www.fms.com). Further meetings stemmed from the conference with the aim of setting the ball rolling in the local governance scene.

The first move is to be a series of seminars for consultants and departmental directors to be carried out by guest speakers from Bocconi University of Milan. However, active plans to introduce audit are not yet high up on the agenda up at Merchants' Street.

Conclusion

The development of Clinical Governance requires considerable cultural shift and reduces clinical autonomy. Its introduction locally will be a lengthy procedure - even the basic data collection devices, staffing and physical space (are there any balconies and waiting areas left to wall off?) are seriously lacking. However our health system will undoubtedly have to go through this growth eventually and it will help reduce the culture shock if clinicians make an effort to understand and follow developments in this very current topic as from now. Hence we all look forward to the

establishment of our own Maltese Institute of Clinical Excellence (MICE)!

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Nurse, get on the internet, go to SURGERY.COM, scroll down and click on the "Are you totally lost?" icon.

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