

Chapter 1

Introduction and Background: Clinical Governance and the National Health Service

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Introduction

This chapter briefly describes the term ‘clinical governance’, identifying the key drivers for its inauguration into the National Health Service (NHS). The term ‘clinical governance’ became prominent following the publication of New Labour’s first White Paper on health, *The New NHS Modern and Dependable* (Department of Health 1997). Within this document the government sets out its agenda of modernising the NHS by focusing on quality improvements. Clinical quality is rightfully assigned centre stage by ‘placing duties and expectation on local healthcare organizations as well as individuals’ (DH 1997, p. 34) to provide clinical excellence. The vehicle for delivering clinical quality is termed ‘clinical governance’, which ‘is being put in place in order to tackle the wide differences in quality of care throughout the country, as well as helping to address public concern about well-publicised cases of poor professional performance’ (King’s Fund 1999, p. 1). We believe that a complicated series of multiple factors have contributed to the development of clinical governance agenda within healthcare. These can be distilled and categorised into three main drivers: political, professional and public demands, all attempting to revive a failing NHS and improve the quality of care that the public should rightfully expect in a modern society (McSherry 2004).

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Background

Why the need for clinical governance?

The literature offered by Scally and Donaldson (1998), Harvey (1998) and Swage (1998) attributes the need for clinical governance because of a decline in the standards and quality of healthcare provision, a point reinforced by the government. ‘A series of well publicized lapses in quality have prompted doubts in the minds of patients about the overall standard of care they may receive’ (DH 1997, p. 5). Upon reviewing the early literature (Donaldson & Halligan 2001) on clinical governance we have noted that a key question had not been fully addressed in establishing why there was a perception in the decline of standards and quality. Possible reasons for this perception could be attributed to the following. Firstly, healthcare professionals and the public are better informed and educated and are interested in health-related issues, thus demanding high quality service provision. Secondly, quality and clinical standards have taken a back seat to other financial and resource management issues. Thirdly, political and societal changes have led to a consumerist society where patients and their carers expect to choose where and when they access healthcare. Fourthly, high quality care is seen as a prerequisite. Within this chapter it is our intention to explore the factors that may have contributed to the introduction of clinical governance.

Activity 1.1 Reflective question.

Write down the factors that you feel may have led to the introduction of clinical governance.

Read on and compare your answers with the findings at the end of the chapter.

No single factor has and transformation led to the government’s current position for modernisation, reform. We argue that patients’ and carers’ expectations and demands of all healthcare professionals have significantly increased over the past decade. In the 1980s and early 1990s, public awareness of healthcare provision was increased through target facilitation by the publication of significant documents; notably, *The Patient’s Charter* (DH 1992) and *The Citizen’s Charter* (DH 1993) both of which were readily and freely made available to the public. On the one hand, these charters may have increased patients’ and carers’ expectations of healthcare by offering information about certain rights to care. On the other hand, the responsibilities of the patients to use these rights in a responsible way have been over used, resulting in higher demands

for care and services in an already busy organisation. Between 1990s and 2005, we have seen a huge emphasis placed on patient and public involvement (PPI) in the planning, delivery and quality assessment of care. Public and patient involvement has been targeted at both a national and a local level both directly and indirectly through the establishment of Patient Advisory and Liaison Services (PALS; DH 2000a) within every NHS organisations. Nationally, we have witnessed the establishment of the Commission for Patient and Public Involvement (DH 2003) resulting in the creation of Patient and Public User Involvement Fora. Similarly, the development of the Overview and Scrutiny Committees for Health (HMSO 2002) with the sole purpose of seeking and representing public opinion on the quality of healthcare. Between 2008 and 2009, further reforms have been introduced surrounding patient and public involvement. We have seen the demise of Patient and Public Involvement Fora and the introduction of Local Involvement Networks (LINKs; DH 2008a) which embraces a joined up approach to patient, client, carer and/or user involvement within health and social care and local government. The aim of LINKs as defined by the DH (2008a, p. 1) is

to give citizens a stronger voice in how their health and social care services are delivered. Run by local individuals and groups and independently supported – the role of LINKs is to find out what people want, monitor local services and to use their powers to hold them to account.

In addition, other contributing factors such as changes in health policy, demographic changes, increased patient dependency, changes in health-care delivery systems, trends towards greater access to healthcare information, advances in health technology, increased media coverage of health care and rising numbers of complaints going to litigation have influenced the need for a unified approach to providing and assuring clinical quality via clinical governance (Mc Neil 1998). These will now be debated in further detail under three broad headings and associated subheadings (Fig. 1.1).

Political

Political drivers for governance should be viewed with both a capital and a small 'p'. The capital 'P' refers to those drivers resulting directly from government and policy. The small 'p' relates to organisation and personal factors that influence change and policy decision-making at a local level, a view held by Jarrold (2005)

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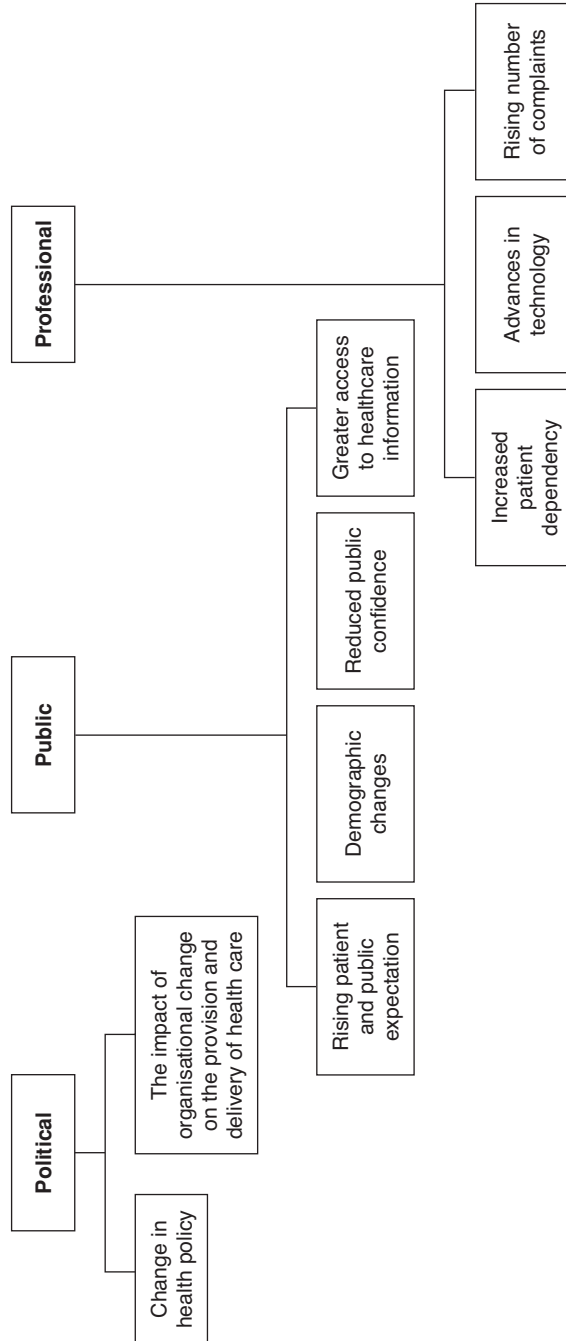


Fig. 1.1 The drivers of clinical governance.

politics with a small p makes the world go round. Getting things done, seeking support, building alliances, compromising – that’s all politics, and inescapable and natural. (p. 35)

The challenge for healthcare professionals is translating policy into practice and keeping up-to-date with changes in healthcare policy.

Changes in health policy

In brief, the NHS was established in 1948 following the passing of the National Health Services Act 1946 which committed the government at the time to financially funding the health service ‘which rested on the principles of collectivism, comprehensiveness, equality and universality’ (Allsop 1986, p. 12). The politicians at the time thought that by addressing the healthcare needs of the public, this would subsequently reduce the amount of money required to maintain the NHS. The assumption being that disease could be controlled. However, this was not the case. The NHS activity spiralled, resulting in uncontrollable year-on-year expenditures to meet the rise in public demand for healthcare. In an attempt to manage this trend, the government introduced the principles of general management into the NHS (Griffiths Report 1983). The philosophy of general management was concerned with developing efficiency and effectiveness of services. The rationale behind this report was to provide services that addressed healthcare needs (effectiveness) within optimal resource allocation (efficiency). It recommended

that general managers should be appointed at all levels in the NHS to provide leadership, introduce a continual search for change and cost improvement, motivate staff and develop a more dynamic management approach. (Ham 1986, p. 33)

Key organisational processes identified as missing in the report.

Absence of this general management support means that there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement. It means that the process of devolution of responsibility, including discharging responsibility to units, is far too slow. (Griffiths Report 1983, p. 12)

This approach, whilst noble at the time, was concerned with organisational, managerial and financial aspects of the NHS, to the detriment of other important issues such as clinical quality. This style of management further evolved with the introduction of the White Paper *Working*

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for *Patients* (1989), culminating in the development of a ‘market forces’ approach to the organisation and delivery of the healthcare services by the creation of a purchaser and provider split. Health authorities and general practitioner fund holders were allocated resources (finances) to purchase care for their local population at the best price. It appears that the purchaser/provider split ‘did nothing more than engender a lack of strategic coordination between healthcare agencies, as they were encouraged to meet their own financial agendas rather than work in partnership’ (Wilkinson 1999, p. 86) or in the maintenance and development of clinical quality. These imbalances led to the introduction of the White Papers *The New NHS Modern and Dependable* (DH 1997) and *Quality in the New NHS* (DH 1998) putting clinical quality on par with organisational, managerial and financial aspects of health care via ‘clinical governance’. A framework ‘which is viewed positively by many healthcare professionals as an ambitious shift of focus by the current government in moving away from finance to quality’ (McSherry & Haddock 1999, p. 114). This approach to providing healthcare services places a statutory duty to match moral responsibilities and harmonises managers and clinicians responsibilities/duties more closely in assuring clinical and non-clinical quality. The impact of these reforms (DH 1989, 1997, 1998a) has enhanced public awareness and expectations for NHS as it places a strong emphasis on achieving clinical quality through restructuring and changing of services.

The DH continued drive for quality improvement through governance and PPI has seen further initiatives introduced by National Health Service Foundation Trusts (DH 2009a), which are ‘a new type of NHS organization, established as independent, not-for-profit public benefit corporations with accountability to their local communities rather than Central Government control . . . [NHS Foundation Trust] give more power and a greater voice to their local communities and front line staff over the delivery and development of local healthcare. NHS Foundation Trusts have members drawn from patients, the public and staff and are governed by a Board of Governors comprising people elected from and by the membership base’ (DH 2009a, p. 1). *Creating a patient-led NHS (2005)* focused on building the NHS capability and capacity for excellence. *Commissioning a patient-led NHS (DH 2005)* builds on creating a patient-led NHS by emphasising the importance of efficient and effective commissioning of high quality care. *World Class Commissioning (DH 2008a)* focused a much needed attention on assuring that commissioning of services reflects the unique needs of each local population whilst seeking to embed a consistent set of performance indicators and patient-related outcomes that demonstrate improvement and comparability of services received across the NHS in England. These recent initiatives seek to increase efficiency and effectiveness and greater PPI at a local level which again have been further consolidated through the publication of *High Quality Care for*

All (DH 2008a) commonly known as the Darzi Report. The essence of the report is as follows:

Of an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe. It will see the NHS deliver high quality care for all users of services in all aspects, not just some. (DH 2008a, p. 8)

Overall, the emphasis of recent government policy (DH 2005, 2008a) has been about increasing the quality of care through seeking out, listening too and responding too the public, health professionals and users of the service(s) by establishing robust systems and processes which demonstrate enhanced patient safety, patient, public and professional involvement, and quality improvement. Furthermore, there is an expectation that has a result of recent reform, patient experience will be improved through having patient-related outcomes that highlights the overall efficiency and effectiveness service.

The impact of organisational change on the provision and delivery of healthcare

With the increases in the numbers of patients admitted with multiple needs, healthcare organisations have had to change the pattern of care delivery in order to accommodate these growing needs, leading to the development of acute medical and surgical assessment units, pre-operative assessment units, multiple needs and rehabilitation units, acute mental health assessment units. Latterly, we have witnessed a rise in the development of services dedicated to maintain individuals in the community, such as Mental Health Crisis Intervention Teams (DH 2001) and the management of patients with long-term conditions, for example diabetes and chronic obstructive pulmonary disease, Fast Response Teams (FRT) such as those jointly provided by Health and Social Care in Harrogate. FRT are designed ‘to prevent avoidable hospital admissions, facilitate early discharge and provide out of hours skilled nursing care, thus enabling service users to maintain an optimum level of independence within their own home or care setting’ (Care Services Improvement Partnership (Care Services Improvement Partnership Health and Social Care Change Agent Team 2009, p. 1)). This style of service provision is about maximising the use of acute and community beds by encouraging collaborative working between primary and secondary care in the management and maintenance of the patient in the most appropriate setting. For example, in the shared care approach to the management of patients who have diabetes,

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where the care is shared between the general practitioner and consultant endocrinologist with the backing of the diabetic team (diabetes nurse specialist, dietitian, podiatrist, ophthalmologist and pharmacist). Initiatives such as hospital-at-home schemes (where possible maintaining the patient in their own home) are beginning to be developed along with public and private sector partnerships (acute illness is managed in hospital, and rehabilitation is continued in private nursing home until the patient is ready for discharge).

The driving force behind these innovations could be attributed to the following. The reduction in junior doctors' hours (DH 1998b) and the possible effects of the European working time directive (DH 2004), culminating in the development of nurse practitioners particularly in highly busy areas such as acute medical admissions and accident and emergency departments. This concept was reinforced recently by the introduction of nurse consultants and therapists (McSherry & Johnson 2005) and by the national education and competence framework for advanced critical care practitioners (DH 2008b) in order to accommodate the increasing demands for healthcare owing to the increase in the life expectancy of people with greater healthcare needs. These changes to healthcare delivery are directed towards enhancing the quality of care and in raising public confidence.

Public

The public has contributed significantly towards the introduction of clinical governance and the ongoing development through direct and indirect ways. These vary in nature from rising expectation to changes in demography.

Rising patient and public expectations and involvement

The Patient's Charter (1992) *Raising the Standards* was distributed to all householders in the United Kingdom (UK) detailing the patients' and carers' rights of healthcare. The main principles behind this charter were that of informing and empowering the patients and this led to patients being viewed as consumers of healthcare. As consumers, they are entitled to certain rights and standards of care. These standards included the right to be registered with a general practitioner, to have a named consultant and qualified nurse as an in-patient along with the right to be seen within 30 minutes of any specified appointment time with a healthcare practitioner. The Patient's Charter reinforced the aims of Citizen's Charter (DH 1993) by empowering the individual to become actively involved

in the delivery of health services by the granting of certain rights. This style of healthcare delivery was unique, as previously, patients tended to be seen as passive recipients of often-paternalistic methods (the ‘doctor knows best’) of providing care. The benefits of these charters have been variable, by the fact that some individuals (both the public and healthcare professionals) are unaware of how they can be used to promote raised standards. Alternatively, many patients/carers are much more aware and informed of certain rights to treatments and healthcare interventions. In general, the majority of healthcare professionals have taken up and accepted the challenges posed by these charters in improving the delivery and organisation of healthcare. This can be evidenced by reviewing outpatient waiting time results, hospital league tables and the introduction of the named qualified nurse within inpatient settings. It could be argued that the Patient’s Charter has led to a public that are more questioning about their rights and expectations of healthcare: What is the problem? How will the condition be treated? What are the alternatives? What are the potential risks and benefits of all treatment options? These are genuine concerns for the public that need addressing.

While raising awareness and expectations of healthcare services has had a benefit, a limitation of the Patient’s Charter is that it has also created a demand which at times has been difficult to satisfy for healthcare trusts. For example, to have a named qualified nurse assess, plan, implement and evaluate care from admission to discharge was impractical and over-estimated. Similarly, it is sometimes difficult for a consultant to see all his or her outpatient attendees personally on every visit. The consequence of raising expectations, which are not achievable, results in dissatisfaction with services and higher incidents of complaints. The principles behind the charters are plausible providing the services are resourced sufficiently. Furthermore, the publication of waiting times and league tables has highlighted inequalities in the provision of health care by demonstrating good and poor performers of services. For example, access to services for day case surgery could be variable according to region or demographic status of the local population and geography.

League tables alone do not provide the public with the background information of the local community health trends or the availability of healthcare services for individual trusts, hence the disparity of service provision between trusts. It could be the case that it may be inappropriate to perform day case surgery for hernia repairs in a hospital situated in a rural area with a large elderly population because accessibility of services and appropriateness of the surgery to the patients’ needs. This is more evident in society today with an ever increasing elderly population with multi-complex physical, social and psychological needs, placing yet further demands on the health service, making the Patient’s Charter standards more difficult to achieve.

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Since the introduction of clinical governance through the White Paper (DH 1997) we have seen a dramatic shift from limited PPI to an almost statutory requirement. NHS organisations are systematically required to involve the patients and users in making decisions about the development, provision and experience of the services they have accessed. The Patient and Public Fora (DH 2003) and PALS were two national examples of the government's commitment to improving services for the patients and the public. A key development of PPI has the replacement of Patient and Public Fora with the establishment of LINks in each local authority to actively seek the engagement of patient, public and service users in health and social care. Another imitative exemplifying the government's commitment to patient involvement is the establishment of the NHS Choices Website (NHS 2009) providing accessible information about where patients may receive care and treatment. The choices initiative offers patients the opportunity of choosing where they may wish to have their inpatient investigations, procedures and treatments. Recently the Health Act (2009) highlighted the importance of patient, public and professional involvement by describing the framework for how the NHS Constitution (DH 2009b) designed to

set out the principles and values of the NHS, It also sets out in one place the rights and responsibilities of patients and staff, and the NHS pledges to patients and staff.

A key outcome of these changes by the government's health polices is seeking to place the patient(s) and service users at the heart of service development, delivery and evaluation. User, patient and professional involvement is critical in a modern consumerist society in ensuring that local services are truly representative and reflective of patient and public needs of that population. This is important in light of changes in demography and dependency.

Demographic changes

Public health policy and findings from national surveys reiterate the government's publication of the *Health of the Nation* (DH 1991) document, which highlighted that life expectancy (National Statistics 2004), would increase for all along with changes in the patterns of mortality and morbidity, for example, an increased prevalence of diabetes and obesity (Press Association 2005). As a consequence of these demographic changes together with changes in morbidity patterns, the NHS needs to provide more acute, continuing care and primary care services for an increasing elderly population and to take into account the changes in the patterns of disease and illness associated with societal change. In an attempt to reduce

healthcare demands, the *Health of the Nation* document set targets for reducing morbidity (disease and disability trends) by concentrating upon health promotion and disease prevention. For example, the reduction of strokes by the active management of high blood pressure (hypertension) and the reduction of deaths attributed to coronary heart disease by promoting healthy eating, exercise and, where necessary, the prescription of 'statins' (cholesterol lowering drugs; DH 2000b). The general population changes indicate there has and will continue to be a large increase in the numbers of people living to and beyond sixty-five, seventy-five and eighty-five. Longevity seems to be on the increase for all DH (1991), reinforcing the growing trends of high-dependency patients. Longevity is not the only demographic challenge facing the future NHS; we have seen widening inequalities in health, wealth and disease. There is growing public health concern about obesity, sexual health, drug- and alcohol-related problems, all which will lead to greater demands on the health service and its employees.

Lack of public confidence in healthcare provision due to media coverage of poor clinical practices

The media continues to play a major role in increasing patients' and carers' awareness of the NHS and social care through the publication of clinical successes and failures in the organisations, for example The Bristol case (The Royal Bristol Infirmary Inquiry 2001) and the Shipman Inquiry (The Shipman Inquiry 2005). The Bristol case related to consultant paediatric cardiac surgeons who were found to have a death-rate for paediatric heart surgery significantly higher than the national average. This only became known as a result of whistle blowing (Lancet 1998). The Shipman case involved a general practitioner in Hyde, Manchester, who was found to have murdered hundreds of his patients mainly by injecting them with an overdose of class A drugs such as morphine and diamorphine. The focus on health and social care failings continues to attract growing media attention. The publication of Care Quality Commission (CQC) 'Review of the involvement and action taken by health bodies in relation to the case of Baby P' (CQC 2009) details failings of child protection agencies across health and social care. Similarly, the Healthcare Commission Report 'Investigation into outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust' (HCC 2007) highlighted inadequacies with healthcare-associated infection policies and procedures and governance arrangements resulting in increased mortality figures.

The continued impact of these major failings and others has resulted in a lack of public confidence in the health service with a rise in the numbers of complaints proceeding to litigation (Wilson & Tingle 1999).

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Trend towards greater access to healthcare information

Advances in information technology, for example the internet have resulted in an easier access to information by the public. Individuals are able to access the same information as healthcare professionals, for example The Cochrane Library and the Department of Health website empowering and informing the public with specific information relating to their condition. This ability to access information, which was perhaps difficult to obtain, previously is fuelling the public's demands and expectations for quality care. Healthcare professionals need to be aware of these rising expectations along with the Freedom of Information Act (DH 2003), which has made access to healthcare information easier. Furthermore, websites such as Doctor Foster (www.drfooster.co.uk) and the National Electronic Library for Health (NeLH) (www.nelh.nhs.uk) reinforce the need for professionals to be aware of giving, receiving and signposting patients and carers to the relevant sources of information. Healthcare professionals also need to be aware of other important factors that may impact on accessing and sharing information such as increased patient dependency and advanced technology.

Professional

Several factors are emerging that may impact on or compromise healthcare professions' accountability. These are associated with increased patient dependency, advanced technology and the rise in litigious activities.

Increased patient dependency

The increasing number of an aging population means that patients are being admitted into acute and community hospitals with far more multi-complex physical, psychological and social problems (McSherry 1999) than ever before, requiring timely appropriate interventions from a wide range of health and social care practitioners. For example, the average length of stay in acute hospital following total hip replacement surgery is around 7 days compared to 14 days, attributed to multi-disciplinary and cross agency collaborative working. A further example is in the advances in stroke care and rehabilitation and in the establishment of specialist stroke units where the evidence (Stroke Unit Trialists' Collaboration 2007) clearly demonstrates that recovery is better if these patients are managed in a specialist unit and not on acute general medical ward. The major effect of rises in dependency levels has resulted in the need for greater efficiency, for example in maximising length of stay and maintaining high levels of acute bed occupancy. However, the shorter average

length of patient stay seems to suggest that effective discharge planning is lessened due to staff having less planning time (particularly in complex social cases). Re-admission rates may have increased and certainly higher and greater demands are being made on the community nursing services, hospital-at-home schemes, continuing and long-term care facilitates, as more patients with complex physical and social needs require continued healthcare.

Advances in healthcare designs technology

Advances in healthcare designs technology have made inroads in improving the quality and standards of nursing care delivery, for example pressure relieving equipment, moving and handling equipment, medical administration and monitoring equipment and wound care management. All having the potential for enhancing the quality of care delivered by healthcare professionals. However, credentialisation (demonstrating the evidence that staff have the knowledge, competence and skills to use the equipment safely) may be questionable. The downside is allowing the staff time and resources for education and training to use the equipment in an ever demanding and stressful clinical environment. The latter should not be the case if clinical governance is implemented successfully. These identified pressures being placed upon healthcare professionals to deliver a high quality service based upon appropriate evidence have the potential to create a conflict between balancing efficiency, effectiveness and maintaining quality and standards. These aspirations cannot be achieved for all patients and carers without adequate resourcing and government backing and by some cultural changing.

Rising numbers of complaints going to litigation

Over the past decade there has been a huge rise in the number of formal complaints made by patients and carers about hospital and community services proceeding to litigation. The National Health Service Litigation Authority (NHSLA) statistics demonstrate rising trends in the number of claims and the total value of claims made between 2003/2004 and 2007/2008 of around £470 million (NHSLA 2005). These rising trends could be attributed to

- Increased activity levels of healthcare
- Greater complexity in treatments and interventions culminating in higher risks associated with increased morbidity
- Greater propensity to pursue and complaint to litigation

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- Increased compensations for negligence claims (more likely to seek redress when something goes wrong) if outcome the can result in Monterey gain

It is worth noting here that the vast majority of complaints are resolved at a local level, often with clarification, explanations and the occasional apology for when things have gone wrong. Honesty and openness are the key principles to deal with complaints, as well as developing robust mechanisms for the sharing of information to deal issues before they become problems (McSherry 1996). Management needs to encourage a learning culture, which proactively rather than reactively responds to seek redress when something goes wrong. The ultimate aim is to have a fair blame culture that encourages healthcare professionals to openly report, discuss and learn from clinical incidents or clinical complaints. In many instances, complaints arise from system failures rather than the actions or omissions of individuals. Healthcare professionals need to be made aware of this situation and have the knowledge, skills, competence and confidence to deal positively with complaints.

Summary

Activity 1.1 Feedback.

The contributing factors that lead to and the continuing need for clinical governance can be attributed to the following:

- Changes in health policy
- The impact of organisational change on the commissioning; provision and delivery of healthcare
- Rising patient and public expectations and involvement
- Demographic changes
- Lack of public confidence in healthcare provision due to media coverage of poor clinical practices
- Trend towards greater access to healthcare information
- Increased patient dependency
- Advances in healthcare design technology
- Rising numbers of complaints going to litigation

A closer review of the above factors demonstrates three primary drivers that collectively originate from the 'three p' approach to clinical governance: political, professional and public.

It is clear from Activity 1.1 that there are many contributing factors that influenced the introduction of clinical governance within the NHS. Undoubtedly, more factors will continue to arise reinforcing the need for

clinical governance in the future. It is therefore important that organisations and individuals embrace the concept of clinical governance in the pursuit of clinical excellence. The latter can only be achieved by having an understanding of where clinical governance originated and what it means in daily clinical practice as outlined in Chapter 2.

Key points

- The reason for introducing clinical governance into the NHS was a perceived decline in clinical standard, service provision and delivery. This was reinforced by media coverage of major clinical failures notably the Bristol case and the Shipman inquiry resulting a general lack of public confidence in their NHS.
- A more informed consumer-orientated public with greater expectations of the NHS attributed to the different charters.
- A more questioning and litigious society.
- A combination of political, professional and public factors lead to the introduction of clinical governance and the pursuit for quality in the NHS.
- Greater and easier access to information.

Suggested reading

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