Clinical Governance in the NHS: a briefing

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What is Clinical Governance?

Clinical Governance is the term that has come to be used to encompass those elements of the government’s drive to “rebuild the NHS” which are directed at improving the quality of care and treatment. It is the flagship policy within its NHS reforms, together with the changes to the pattern of primary care. This briefing is primarily concerned with the implications of Clinical Governance for the practice of clinical psychologists working in the NHS. It both follows the language used in government publications, and also explains the meaning of key acronyms and terms.

Psychological concepts and procedures are applicable to many of the issues raised by Clinical Governance. Hence, while this briefing has been prepared by the Division of Clinical Psychology of the British Psychological Society, most of the issues discussed are equally applicable to other applied psychologists working in the NHS, many of whom will be members of the Divisions of Counselling or Health Psychology, or the Division of Neuropsychology, within the Society. In addition, many psychology graduates work in the NHS in managerial or non-clinical posts, such as health promotion. It is hoped that this initial briefing will be followed by other documents representing the interests of all those Divisions and members of the Society concerned with the provision of health care.

- renew the NHS as a genuinely national service;
- create a system of national standards of healthcare and audit their implementation;
- get the NHS to work in partnership with other agencies, particularly local authorities;
- improve financial efficiency to maximise patient care;
- shift the focus on to the quality of care so that excellence is guaranteed;
- rebuild public confidence in the NHS, through the Commission for Health Improvement (CHI) and other means.

For any government to bring about major change in public services requires time and resources. The government has directed most initial effort to the second and the fifth of the above principles.

The term Clinical Governance was introduced in the consultation document *A First Class Service*, published in July 1998. The document described Clinical Governance as:

> a framework through which NHS organisations 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.

The key elements of Clinical Governance were spelled out as:

- clear national standards for services and treatments, through National Service Frameworks (NSF) and a new National Institute for Clinical Excellence (NICE). This means the preparation of a range of standards for clinical practice, involving health professionals working with the Department of Health.
- local delivery of high-quality health care, through Clinical Governance underpinned by modernised professional self-regulation and extended life long learning. This means the creation of local management procedures to ensure that high quality services are provided, and ensuring that the NHS workforce is trained to acquire and maintain the relevant skills, and that professional bodies exercise adequate control over professional practice.
- effective monitoring of progress through a new Commission for Health Improvement (CHI). The Government will be inspecting the clinical performance of the NHS much more closely than before.

Clarifying and improving accountability is the most important principle underpinning all the changes. Under Clinical Governance, the Board and Chief Executive of each NHS Trust are ultimately accountable for the quality of the care it delivers, and they are required to establish a Clinical Governance committee, to appoint a lead executive director or directors, and to produce an
annual Clinical Governance report. They have been required (by Health Service Circular 1999/065) to conduct a Clinical Governance Baseline Assessment within their Trust, to analyse their Trust's current clinical practices and organisational strengths and weaknesses, and, for example, to identify any risk or problematic services. Each Health Service Region has adopted its own approach to the conduct of these baseline assessments.

A First Class Service views Clinical Governance as the centre of delivery of high-quality services, guided by national standards of services, supported by professional self-regulation and continuing professional development, and effectively monitored. A continuing stream of NHSE circulars, such as that issued in May 1998 on clinical effectiveness indicators, are supplementing these central ideas. So the term Clinical Governance has become all-embracing, including everything which might improve the quality of care, such as:

- risk management;
- clinical effectiveness;
- team development;
- organisational change;
- developing integrated care pathways;
- improved complaints procedures.

Clinical Governance is both service-driven and politically driven, with a number of imperatives behind the public rhetoric, such as the failures of medical self-regulation, the political need to contain costs in a publicly funded healthcare system and the continuing wide variations in clinical practice without evidence-based justification. Health professions are involved through membership of the Partners Council set up as part of the NICE structures; Professor Louise Wallace is the Society’s nominee. User involvement is given high priority, and representative national surveys of users’ experience will eventually be required.

The use of the term Quality in Clinical Governance documents is significantly different from the accepted use of the term in the NHS over the past 10 years or so. It has in the past been associated with such concepts as “total quality” and “quality circles”, emphasising the vehicle of delivery of healthcare. The term is now more focused on the clinical and cost-effectiveness of treatments and interventions, and the minimisation of both clinical and managerial risk.

“What is the outcome?” is now a key question. This encompasses the idea of evidence-based care, where attention is paid to the use of treatments based on the best available research evidence – which may or may not include randomised control trials. The main tasks of NICE are the collection and dissemination of evidence, in the form of guidelines and audit tools, the management of major national confidential enquiries and the appraisal of diagnostic and interventive technologies.
As the National Service Framework for Mental Health, published in 1999, shows, achieving a balance between attainable and affordable targets is not easy, just as producing usable clinical practice guidelines is not easy. As individual Trusts continue to work with their local Health Authorities and offices of their Regional NHSE, within the context of continuing prescriptive guidance from the Department of Health, Clinical Governance is emerging as a process with the clear purpose of changing clinical practice to make it more effective, with both a positive emphasis on clinical excellence and the ultimate sanction of external monitoring by CHI.

Another purpose is to reduce variations in levels of health status across the country. The Black Report in 1980 demonstrated inequities in the delivery of health care across social groups, so efforts to target resources to high risk areas, as in the Health Action Zones, should come as no surprise.

The process will require changes to continuing professional development, more systematic awareness of clinical effectiveness information, more emphasis on demonstrated outcome, more awareness of risks to care and more engagement with users and carers at every point. In practice locally, this means that a comprehensive review is needed both of management and professional structures, such as the purpose and membership of a Trust’s education and training committee, and of processes, such as the reporting of “untoward incidents”, like assaults on members of staff and suicides by inpatients or outpatients. This does not mean that totally new structures must necessarily be created; it does mean that new sets of clinical management objectives are set, and that these will be monitored more closely than before. The Clinical Governance executive directors, working with any other appointed Clinical Governance lead or managers (who could include clinical psychologists) are responsible for the effective functioning of these processes.

The implications of Clinical Governance are potentially large, but should not be surprising. The growth in the cost of healthcare rises faster than the rate of national growth, so that simply to maintain existing standards of care in a publicly funded healthcare system requires greater efficiency and effectiveness. A concern to make clinical practice more based on evidence of effectiveness has been apparent for a number of years, as evidenced by the multinational Cochrane Centre systematic reviews. Nurses will be required to show evidence of continuing professional development as a condition of professional registration from 2002.

Implications of Clinical Governance for clinical psychologists
For Clinical Governance to work as a framework for quality, there must be an evidence base for services, an integrated system of risk management, a continuing educational programme linked to improving practice, and excellent means of monitoring service quality. These elements thus apply to all professions.

Clinical psychology, as a profession, has a major contribution to make to Clinical Governance, drawing on our understanding of principles of audit and user-friendly monitoring (Firth-Cozens, 1993; 1996). The multidisciplinary
clinical team or unidisciplinary psychology service has to be the basic organisational unit for the delivery of clinical quality, with the associated need to understand team and group processes, and the need for training in clinical leadership. Systems theory is one highly applicable approach to risk management, which encompasses organisations as well as patients and their families (Vincent, 1995).

There is plenty to be done for all of this to be achieved. The hearts and minds of colleagues have to be engaged in this process to create a culture which enhances effective team-working, within an open communications culture which respects staff at all levels. This involves moving from a blame culture to a learning culture, and asking questions such as:

- What can go wrong and why?
- How do we learn from this?

**What does it mean for me...**

The implications of these needs and opportunities will vary for different groups of clinical and other applied psychologists working in the NHS.

*All psychologists* should be concerned that their practice is based on the best available evidence. They should ensure that they access, appraise and apply the research evidence effectively when developing and evaluating health policy and health services. Those in clinical contact should make sure that they (or someone in their service with that specific role) are able to appraise research literature for clinical implications, for example by doing a *Critical Appraisal Skills Programme* [CASP] course, accessible through their Regional R&D structures. They should also make sure that they possess the necessary clinical skills and that they critically apply NICE guidelines and other clinical practice guidelines where they exist. They should examine how they ensure that their treatment is effective by the use of routine or sample evaluations of outcome, with outcome measures being carefully selected to be relevant to presenting clinical problems. All psychologists should identify the local within-Trust professional and managerial structures where Clinical Governance decisions are made.

*Clinical psychologists with managerial responsibilities for clinical teams* (for example, in a multidisciplinary community learning disability team, or in a psychologist-led eating disorders programme) will need to ensure that any psychological procedures used by their colleagues are effective, that systems exist to recognise problems early and that training for their teams matches service need. They may need to ensure that all members of a team are consistently following protocols by initiating internal audits and by ensuring monitoring data is available, and by these and other means ensure that their teams learn from their experiences.

*Clinical psychologists with managerial responsibilities at a clinical directorate or clinical centre level* will need to review structures and processes within their directorate to ensure that clinical governance requirements are met. This may require involvement in visiting clinical teams and supporting effective team-working,
examining the equity of access to services for members of ethnic communities and writing guidance for staff from all disciplines

Clinical psychologists with managerial responsibilities at or near Trust Executive or Senior Management Board level may themselves become prime movers in Trust-wide clinical governance reviews, possibly becoming accountable for some aspect of Clinical Governance, most obviously evidence-based treatment.

Clinical psychologist researchers need to review the way in which they prepare research reports with a view to effective dissemination and implementation of findings, including sending them to NICE.

Clinical psychologists as members of the DCP should be concerned to ensure they are aware of and follow its professional guidance, such as the 1995 Professional Practice Guidelines and the 1998 Continuing Professional Development Guidelines. The main DCP committee and three of its subcommittees (Service Development, Continuing Professional Development, and Quality and Effectiveness) will be keeping Clinical Governance matters on their agendas as standing items.

Clinical Governance assumes the existence of a range of skills. Where these do not exist, training will be needed. Training will be required in several different areas, and delivered in a number of different ways. Lifelong Learning is the term used in the Clinical Governance literature to describe this broad approach to continuing professional development (CPD). The principles underlying CPD should be an integration of legitimate aspirations of individual health professionals, and a response to local service development needs and patient expectations. There should be better links between CPD, audit, clinical effectiveness and R&D. Each NHS professional should have a Personal Development Plan, agreed in collaboration with local colleagues, which may be undertaken on a multiprofessional or team basis, and which takes full account of learning on the job without necessarily going on courses.

Another aspect of improving quality is the attention paid to professional self-regulation. The moves to protect patients by the appraisal and reaccreditation of doctors will indirectly affect psychologists as members of clinical teams, and may well contribute to raised expectations of similar mechanisms for other professions, including psychologists.

For clinical psychology services (and other psychological services managed within a clinical psychology department) the major change issues presented by Clinical Governance may include:

- implementing clinical practice guidelines;
- appraising and implementing research (exploiting NHS R&D support structures);
- measuring and learning from outcomes;
- increasing meaningful involvement with users;
- sharing Governance with other professions, with potentially significant changes in profession-specific roles being clearly on the change agenda;
making continuing professional development linked to service needs a reality;
ensuring professional regulation procedures are understood and employed where necessary;
increasing involvement in the management of challenging and disturbed behaviour, as a consequence of the increased attention paid to risk assessment and management; and
“contributing to the creation of an environment for clinical quality”.

Reading and Resources

*A First Class Service* is a readable document, with summaries, so the detail of the document is not repeated here. Similar documents to those prepared for England have been prepared for Northern Ireland (*Fit for the future, 1998*), Scotland (*Designed to care: renewing the NHS in Scotland, 1997*) and Wales (*NHS Wales: putting patients first, 1998*), and the consultations so far undertaken suggest that a very similar approach will be taken to that adopted in England.

There are now several other summarising and explanatory publications, such as the Department of Health’s own information pack (1999), Lugon and Secker-Walker’s (1999) practical guidance book, the Sainsbury Centre’s briefing (1999) on the implications for mental health services, and articles commenting on specific aspects of Clinical Governance, such as Owen’s (1999) comment on implications for psychotherapy services. A number of advisory and research units have been set up by professional bodies and universities, and the addresses of some of the most relevant are given below.

Up-to-date information both on reading and on professional and academic support units, is given on the NHS website:

www.wisdom.org.uk/clingov.html

**Bibliography**


**Professional Units**

British Psychological Society Centre for Outcomes, Research and Effectiveness (CORE), Sub-department of Clinical Health Psychology, UCL, Gower Street, London WC1E 6BT; tel: 0171 391 1785; e-mail: core@ucl.ac.uk; Website: http://www.psychol.ucl.ac.uk/CORE/home.html

Royal College of General Practitioners Effective Clinical Practice Unit, University of Sheffield, Regent Court, Sheffield S1 4DA; tel: 0114 222 0811

Royal College of Nursing Clinical Governance Project Office, DQI Department Rcn Institute, 20 Cavendish Square, London W1M 0AB

Royal College of Physicians Research Unit, 11 St Andrews Place, Regents Park, London NW1 4LE; tel: 0171 935 0332

Royal College of Psychiatrists Research Unit, 11 Grosvenor Crescent, London SW1X 7EE; tel: 0171 235 2351

**National Units**

National Centre for Clinical Excellence (incorporates the National Centre for Clinical Audit) 90 Long Acre, Covent Garden, London WC2E 9RZ; tel: 0171 849 3444; website: www.nice.org.uk

Association for Quality in Healthcare, 47 Southgate Street, Winchester SO23 9EH; tel: 01962 877700

Centre for Health Information Quality, Highcroft, Romsey Road, Winchester SO23 5DH; tel: 01962 863511

Institute of Health Care Management, 7-10 Chandos Street, London W1M 9DE; tel: 0171 460 7654

**Academic Units**

Clinical Governance Research and Development Unit, Department of General Practice and Primary Health Care, University of Leicester, Gwendolen Road, Leicester LE5 4PW; tel: 0116 258 4873

Joint Programme for Research into Clinical Governance, Nuffield Institute for Health, Leeds University, 71-75 Clarendon Road, Leeds LS2 9PL; tel: 0113 233 6983

Unit for Evidence-Based Practice and Policy, Royal Free and University College London Medical School, Archway Campus, Highgate Hill, London N19 5NF; tel: 0171 288 3244

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