Making clinical governance work

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Clin Med 2005;**5**:122–5

ABSTRACT – This paper summarises a conference that took place at the Royal College of Physicians about the work of the Clinical Effectiveness and Evaluation Unit (CEEu) and the National Collaborating Centre for Chronic Conditions (NCC-CC). The importance of the clinical standards, audit, and evidence-based guidelines and their contribution to the clinical governance arena was acknowledged. In addition, consideration was given to the fact that information provision alone does not change clinician behaviour. Multifaceted strategies are discussed and lessons learnt examined. The CEEu and NCC-CC have made significant contributions at a national level in the development of clinical governance.

KEY WORDS: audit, clinical governance, chronic conditions, evidence-based guidelines, quality improvement, standards,

The College's Clinical Effectiveness and Evaluation Unit (CEEu) is dedicated to identifying the most effective ways of making clinical governance work. This is an integrated approach that brings together a number of basic processes in order to ensure the continuous improvement of the quality of clinical services (Fig 1).

The CEEu has been wholly committed to developing the major national tools for delivering effectiveness, clinical guidelines and audit. Table 1 shows the conditions and activities that have been or are being addressed.

Through the National Collaborating Centre for Chronic Conditions (NCC-CC), funded by the National Institute for Clinical Excellence (NICE) and housed in the Unit, a programme of nine guidelines has been, or is being, developed for NICE. The stroke guidelines, now in their second edition, were developed by an intercollegiate group facilitated by the CEEu.

National audits of resources and organisation, as well as audits of clinical activity, have been undertaken. Periodic or snapshot audits have been carried out for stroke, chronic obstructive pulmonary disease (COPD) and continence care, for prescribing for older people and for blood transfusion in partnership with the National Blood Transfusion Service. The continence audits were carried out in primary care trusts and care homes, as well as in hospitals. The next stroke audit will have an associated patient survey. Continuous clinical audits for acute myocardial infarction and lung cancer have been implemented in conjunction with the National Clinical Audit Support Programme (NCASP) funded by the Healthcare Commission.

The ethos of the CEEu has been fundamental to the success of its work. Projects are always carried out in partnership with relevant clinical stakeholders and service management so that they accept the validity of the results. Projects and their products are multi-professional aimed at the clinical team rather than the individual physician. Patients are always involved, ensuring that the issues important to them are covered as well as those of interest to physicians.

Key Points

- **Clinical governance is an integrated approach that aims to ensure the continuous improvement of the quality of clinical services**
- **The processes underpinning an integrated clinical governance approach require organisational analysis in order to understand the complex and dynamic methods of success**
- **A key success factor is to ensure that projects are carried out in partnership with relevant multidisciplinary clinical stakeholders and service management to galvanise the end of development buy-in**
- **The principles of evidence-base health care should be fully embraced, that is, patient views should be sought and issues important to people with the condition integrated with those of the clinician and the current research**
- **Information provision alone does not change clinician behaviour and multifaceted strategies will help to change clinical practice and aid implementation.**

Guidelines

The activity with NICE has produced some high quality products but has also identified a number of issues of concern, relating to scoping, methodology and accessibility, that must be addressed to improve the quality and usefulness of the guidelines.

The scope of NICE guidelines excludes service and organisational issues to avoid overlap with recommendations of the National Service Frameworks. However, this is at odds with the development of care guidelines for chronic conditions, which are dependent on the effective organisation of services.

Some of the evidence for the guidelines comes from meta-analyses. Although an analysis itself may be of excellent quality, the studies included in it may have methodological limitations. The hierarchy of evidence grading system accepts a meta-analysis as high quality and does not identify or allow for this phenomenon. A number of the studies considered by clinicians historically to be 'benchmark' studies have been shown, on close systematic review, to have limitations in their methodologies and have thus been given low gradings. This has frequently surprised clinicians on the development groups.

The gradings given to guideline recommendations relate to the type of evidence supporting them and not their clinical importance. The hierarchical method of grading means that randomised control trials are rated above any qualitative studies, regardless of their clinical usefulness. It is the evidence-based question posed that dictates the most appropriate type of research design to answer it. However, based upon the current levels of evidence, research derived from a qualitative paradigm such as a patient survey would only ever result in a D-grade recommendation. In a patient-focused service this imbalance needs to be re-considered.

To be clinically useful, guidelines have to be up-to-date, accessible and of high quality. There are issues that need to be resolved before NICE guidelines fulfil these criteria. The evidence base closes months before a guideline is published. Guidelines are not reviewed until a minimum of two years after publication and the whole guideline process takes about two years, so it is difficult to ensure that the guidelines are truly up-to-date. In addition, there are a multitude of guideline scopes and subsequent publications. This means that some conditions, such as ischaemic heart disease, may be included in the scope of a number of guidelines published at different times, making finding the definitive advice difficult.

Although guidelines are published in a number of different formats, much more thought needs to go into making the advice accessible to clinicians as and when they need it. Currently, there is only the electronic capability of downloading a complete guideline. Access, dissemination and potential implementation would be greatly improved if NICE were to invest in a user-friendly software knowledge management interface that allows both the searching of and linking between guidelines.

Historically, NICE has had no remit for being involved in the implementation of its recommendations, although CEEu experience suggests that the mere publication of guidance does not lead to universal adoption of the recommendations. To compensate for this deficit, CEEu has started implementation activities including educational events associated with the heart failure guidelines and projects to identify best practice for the two chronic neurological conditions.

Audits

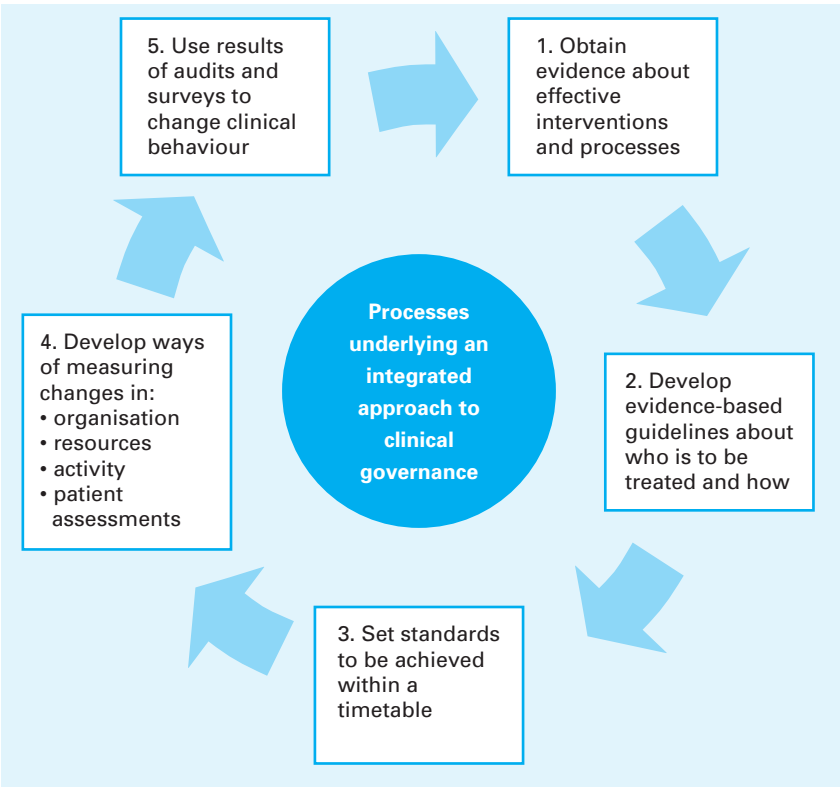
The factors essential to the success of all the clinical audits have been a clinically relevant data set and ease of data collection. With the two continuous audits, MINAP (acute myocardial infarction) and LUCADA (lung cancer), there are additional matters to consider such as developing software for data collection and the testing and rollout of the application.

Two CEEu audits, MINAP and stroke, have achieved 100% coverage of English trusts, while COPD covered 94%. LUCADA aims to have achieved complete coverage by summer 2005. No other national audits have yet reached such levels of involvement, which can only be achieved by a dedicated implementation team encouraging and exhorting clinical engagement with the projects.

The methods of data entry have progressed over the years. For the first stroke audit in 1996, data were collected locally onto forms that could be computer read using text recognition software. The two continuous audits now have web-based software and participants have the options of direct data entry or an upload from their own system, thus avoiding local double entry of data.

The continuous audits have involved partnerships with software developers and support organisations. Such partnership working requires unambiguous arrangements for getting the work done and well-defined areas of responsibility. The organisations involved must share the objectives of audit, which are not solely the implementation of a computer system but the provision of information to

Fig 1. The quality improvement cycle.



change clinical behaviour. Above all, there must be mutual respect between the parties and a realisation of the constraints within which partners may be working.

The early experience of the LUCADA project has demonstrated the inadequacies of the current way that the nationally required methodology (Prince 2) project management has been implemented. An essential prerequisite for successful national audit projects is that the lead organisation in a partnership is a clinical one. It must have the confidence of NHS trusts so that they are assured that their information will be handled sensitively and intelligently. In addition, credibility within the NHS is important so that clinicians and managers know they are collaborating with people who know what they are doing.

MINAP, in its development, suffered from not having its funding assured for more than short periods. It is essential that, when it is decided to set up a national clinical audit, the planning and resources are related to the totality of the requisite activities from development to use of the information, necessitating a time-scale of at least three years.

Table 1. Conditions or clinical activities addressed by the CEEu and NCC-CC.

Condition/ clinical activity	Centre/ commissioner	Implementation/ lead organisations
Guidelines		
Published		
Chronic heart failure	NCC-CC/NICE	Workshop CEEu
Chronic obstructive pulmonary disease	NCC-CC/NICE	See audit below CEEu
Multiple sclerosis	NCC-CC/NICE	Snapshot organisational audit CEEu/MST
Stroke	CEEu/ICSWP	Regional multiprofessional workshops. See audit below CEEu
Type 1 diabetes	NCC-CC/NICE	
In development		
Atrial fibrillation	NCC-CC/NICE	
Anaemia management in chronic kidney disease	NCC-CC/NICE	
Parkinson's disease	NCC-CC/NICE	
Tuberculosis (clinical)	NCC-CC/NICE	
Tuberculosis (service)	NCC-CC/NICE	
Audits		
Acute myocardial infarction (MINAP)	CEEu/HC	Continuous clinical audit CEEu/BCS/DH
Blood transfusion	CEEu/NBS	Snapshot clinical audit CEEu/NBS
Chronic Obstructive Pulmonary Disease (COPD)	CEEu/BTS	Snapshot clinical audit Regional workshops CEEu/BTS
Lung cancer (LUCADA)	CEEu/HC	Continuous clinical audit CEEu/ICLCG/NHSIA/ Cancer Registries/BTS
Prescribing in older people	CEEu/DH	Snapshot clinical audit CEEu
Stroke	CEEu/HC	Snapshot clinical and organisational audits Regional stroke workshops (multiprofessional teaching and learningforums) CEEu/ICSWP
Urinary continence	CEEu/PPP/HC	Snapshot clinical audit CEEu

Notes: BCS= British Cardiac Society; BTS= British Thoracic Society; DH= Department of Health; HC= Healthcare Commission; ICSWP= Inter-Collegiate Stroke Working Party; ICLCG= Inter-Collegiate Lung Cancer Group; MST= Multiple Sclerosis Trust; NBS= National Blood Service; NHSIA= National Health Service Information Authority; PPP = PPP Healthcare.

Changing clinical behaviour

Once audits are established, considerable CEEu time and effort are expended on using the information thus made available to change clinical behaviour where required. Precise mechanisms may differ but a constant theme running across all the work has been ensuring timely access to relevant information and the promotion of educational events in order to get clinical buy-in and to use the best-performing units to encourage the others.

Effective information presentation has been a key success factor. The selection of a few headline indicators has concentrated minds on important clinical areas that require addressing. The presentation of comparative information to individual units as box plots showing their figures in relation to national benchmarks has been found to be very useful and clinically acceptable.

Regional educational events have been another successful ingredient. Three audits have been completed for stroke and each round has been followed by regional multidisciplinary workshops to aid dissemination and foster improvements. Other audits holding a series of regional meetings in 2004 were MINAP, LUCADA, and COPD.

In acute trusts there must be local management arrangements that support the intelligent use of information such as that from national audits. Sticks and carrots may both be required to motivate consultants and trust management. The changes needed to improve care only happen when there is an organisational will, committed clinicians and managers, and the appropriate tools to do the job.

Access by third parties

In the early stages of a project, data are shared only with the clinical teams. When the CEEu are confident in the robustness of the information, consideration can be given to the use of this by third parties. Access is tightly controlled and even the Healthcare Commission, funding the national audits, has only that access agreed by the groups overseeing information use. This control is essential to maintain the credibility that CEEu has with clinicians and ensures that crude national league tables will not be produced from clinical audit data. But as confidence grows, data are shared more widely and information from MINAP, for example, is currently generally available on the College web site in an annually updated public report showing each trust's performance for five headline indicators against the targets set out in the National Service Framework. Trusts are shown as meeting the target, being within 25% of it or being more than 25% from it.

CEEu information is of great importance in changing healthcare practice. Strategic health authorities have a performance management role as well as a leadership role in clinical governance. These two functions need to be sensitively integrated and the publicly available information provided by the audits has been most useful in achieving this.

NHS board members rarely receive any information about clinical issues and to carry out their clinical governance role this deficit must be remedied. The CEEu has collaborated with the National Board Development Team to provide appropriate information for use at board level.

The Healthcare Commission aims to obtain intelligent information, which will allow it to focus its resources available for review on areas where they are most likely to get results. The national clinical audits will form an essential part of this database. Reviews will be targeted to areas of concern and may involve the expertise of other organisations already running peer review systems.

Information for the public is provided both to help them make informed choices about the process of their care and to empower them to manage their own conditions better. The College's Patient and Carer Involvement Unit works to enable patients and carers to become involved in all the clinical governance processes.

Conclusion

The CEEu and the NCC-CC have made major contributions at national level to the development of useful and practical clinical governance. Successful though the work has been, there are important lessons to be learnt by the CEEu and the NCC-CC and its commissioning bodies. If future audits and guidelines are to lead to better clinical services, the development of national products for clinical governance must become, like the approach itself, the subject of continuous quality improvement.