



Doctors' Policy Research Group

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Clinical Governance: is  
it really embedded in  
the NHS?

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Dr Christoph Lees, Dr Mark  
Slack & Dr Paul Charlson

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28<sup>th</sup> August 2013

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**For those unfamiliar with it, the term Clinical Governance arose in the late 1990s and was defined by a previous Chief Medical Officer for England and Wales as: *A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.* Clinical Governance is comprised of seven ‘pillars’: clinical effectiveness, risk management, patient experience and involvement, communication, resource effectiveness, strategic effectiveness, and learning effectiveness.**

How is it that over a decade of events, public inquiry reports and media exposés have highlighted endemic problems with safety in parts of the NHS? It will be no surprise to anybody working within it that these problems are widespread. It is clear that the NHS needs to move further towards a clinically-led, safe system. The NHS is not alone amongst healthcare systems in this; arguably its governance structures are in fact more robust than many European comparators. But this is not an excuse for complacency: resistance to change is part cultural and historic, but in a safety-critical environment similar to the airline industry, standing still is not good enough. Safety systems and reporting in the airline industry has evolved highly in just one or two decades: the same cannot be said for the NHS. To achieve the goal of a safe system, those within the NHS management structures must understand how the tools of clinical governance work and empower clinicians to use them. We can cite recent examples to illustrate that this does not always happen - seemingly innocuous remarks or processes that belie a misunderstanding of the rationale for clinical governance.

The first is in relation to audit: an audit is a mechanism through which - for example - a patient pathway or treatment episode is compared to the ‘gold standard’ through analysing patient notes or questionnaire feedback. This data is then analysed to highlight any deficiencies or simply points where improvements could be made. Once this is done, a re-audit is normally carried out to assess whether the changes improved outcomes or patient experience. During a meeting with a senior trust manager, they stated “We need more audits”. On being pressed exactly what these audits might measure, beyond the bold statement the executive was unable to suggest anything cogent - nor did they appear to understand the audit process. Similar statements: ‘Patient Safety is our first concern’; ‘Quality is not negotiable’ and other platitudes are frequent in the language of the NHS executive - it is rare that depth is added to these comments.

The second is the process of incident reporting itself. In many Trusts, the reporting system for significant events is so long-winded and detailed that only the very motivated would not be deterred from reporting anything. This may explain why comparisons of significant events and near misses to those actually reported shows a yawning gap. The third follows on from this: health care managers often fail to understand that it is good for a diverse range of incidents and numerous significant events to be reported. In a healthcare setting where thousands of patients are treated per day, there are bound to be incidents - in the majority of cases not due to staff errors. But when an event is reported, this is often seen as a criticism of an individual and the first response is a disciplinary sanction rather than treating the report as a learning opportunity or a systems issue. This is of course more likely to deter rather than encourage further reporting.

Whilst these day-to-day examples are apparently trivial, they illustrate some of the current hurdles to providing good clinical governance at a very basic level. Once the proper handling of significant event reporting and clinical audit results becomes commonplace, there will be less need for ‘whistle-blowers’ and all the legislation that has necessarily grown up around them. A prerequisite for this is a change to the bullying culture currently frequently experienced by clinicians. Such an environment simply leads to an unhealthy cycle of despondency, poor performance and an air of resignation and detachment from providing quality patient care.

President Obama's health advisor, Don Berwick, has called for a duty of candour and making it a criminal offence to fail to report significant events. We believe that this is not the correct route to take, simply creating further sanctions for what should be voluntary acts. What is required and will be far more effective is to develop a safety culture that is positive rather than negative: where reporting is easy, and considered 'good', not difficult and considered 'bad'. To take this step would require a shared understanding of the goals of clinical governance by clinical and non-clinical staff alike.

Achieving a safer system is going to be difficult. The reason is obvious; it takes time and costs money, both of which are in short supply. In our experience, most working within the NHS are motivated to do better and provide patients with excellent care. Changing a culture takes time and is a "soft" solution. A harder and more robust element, hand in hand with effecting culture change, is that of inspections. For too long inspections have focussed on patient information sheets, handwashing and inspecting guidelines whilst ignoring clinical outcomes. Many inspections lead to the generation of reams of meaningless papers that are frequently too generic to be appropriate. We have all experienced the sudden appearance of files of protocols and posters just prior to inspections. We know of nursing homes that have good inspection reports due to immaculate paperwork but are hopeless at looking after residents.

This mechanistic approach to inspection - rather than a 'common sense' approach where patient care was the priority - started about a decade ago when routine hospital inspections by doctors and nurses under the auspices of the relevant Royal Colleges were stopped by the Department of Health. One part of the answer to the current malaise is to introduce a more focussed inspection of clinical environments; this should be focussed on feedback, event reporting and audit and should be carried out by people who are experts in the relevant areas. Of course the result of this process may mean that more staff are required to run a safe service, resulting in an upward pressure on tariffs. But if this is the price for patients being more confident in their treatment, and the NHS Litigation Authority's annual settlements reduce rather than inexorably rise, that can only be a good thing.

## About Us

Doctors' Policy Research Group is the first and only UK think tank led by doctors. Formerly known as Doctors Think Tank, it pooled resources and expertise with Civitas in June 2013 with the aim of contributing to public debate about the provision of NHS services. It is not a union and - like Civitas - has no allegiance to any political party.

Its members wish to encourage a vigorous discussion about the future of the UK's healthcare, and how it can be provided to the very highest standards, while always ensuring comprehensive provision remains free at the point of need and with the patient's interest the foremost consideration at all times.

The group's dedicated page can be found [here](#), while its work pre-dating its association with Civitas can be found at its own website [here](#).

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## Dr Christoph Lees

Christoph is a NHS Consultant in Obstetrics and Fetal-Maternal Medicine. He has a longstanding interest in health policy and funding reform, having sat on the Civitas Health Policy Consensus Group (2002). He was one of the founding members of Doctors for Reform (2003), where notable campaigns included 1000 doctors writing to the then Prime Minister to rethink the UK's purely tax-based health funding and raising funds to support judicial review of the position of some Strategic Health Authorities on cancer co-payments. He has been involved in the funding debate with politicians from all parties in the UK and overseas.

He is also a clinical researcher having published over 100 papers in Fetal-Maternal medicine and has a visiting Chair at The University of Leuven, Belgium. Christoph supervises higher degrees and directs a subspecialty training programme, having been the Royal College and Obstetricians first Ultrasound Training Officer (2009-2012).

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## Dr Mark Slack

Mark is currently head of Urogynaecology at Addenbrooke's Hospital, University of Cambridge Teaching Hospitals Trust, Cambridge. He is also a fellow of the Royal College of Obstetricians and Gynaecologists.

He runs an active research unit in Cambridge. His research interests include the use of alloplastic materials in surgery, innovations in pharmacology, urodynamic testing and surgery for pelvic organ prolapse. More recently he has developed a new testing system for the measurement of urethral pressure and has just published the results of a novel treatment for pelvic organ prolapse.

He was appointed the Ethicon travelling Professor in 2004 as well as the Sims Black Professorship of the Royal College of Obstetricians and Gynaecologists for 2005/6. In 2006 he was awarded a travelling Professorship to the Royal Australian and New Zealand College of Obstetrics and Gynaecology.

Other appointments have included membership of the British Society of Urogynaecology (BSUG) executive committee, the RCOG audit and guidelines committee, chairmanship of the BSUG guidelines committee and membership of the research committee. He is on the education committee of the International Urogynaecology Association (IUGA) and the chair of the IUGA observership scheme that has recently introduced fellowships allowing members to visit internationally renowned centres. More recently he has joined the scientific committee of the IUGA.

He is a reviewer for the British Medical Journal, the British journal of O&G, Neurology and Urodynamics, the International Urogynaecology Journal and The Journal of Rehabilitation and Research.

Mark qualified in Johannesburg at the University of the Witwatersrand. He then completed his postgraduate training at the University of Cape Town and Groote Schuur hospital. He graduated from the College of Medicine of South Africa winning the Daubenton Gold Medal as the most successful candidate for the Fellowship in Obstetrics and Gynaecology. After leaving South Africa he trained under John Sutherst in Liverpool.

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**Dr Paul Charlson**

Paul has worked as a GP in Yorkshire. He is a Portfolio Doctor, a GPwSI (GP with Special Interest) in Dermatology, a Cosmetic Doctor, a Quality Assurance (QA) tutor with the Yorkshire Deanery, a Local Medical Director at Quayside Open Access Centre, the Chair of Conservative Health and an RCGP Clinical Commissioning Champion. His interests include healthcare policy, service development and innovation.