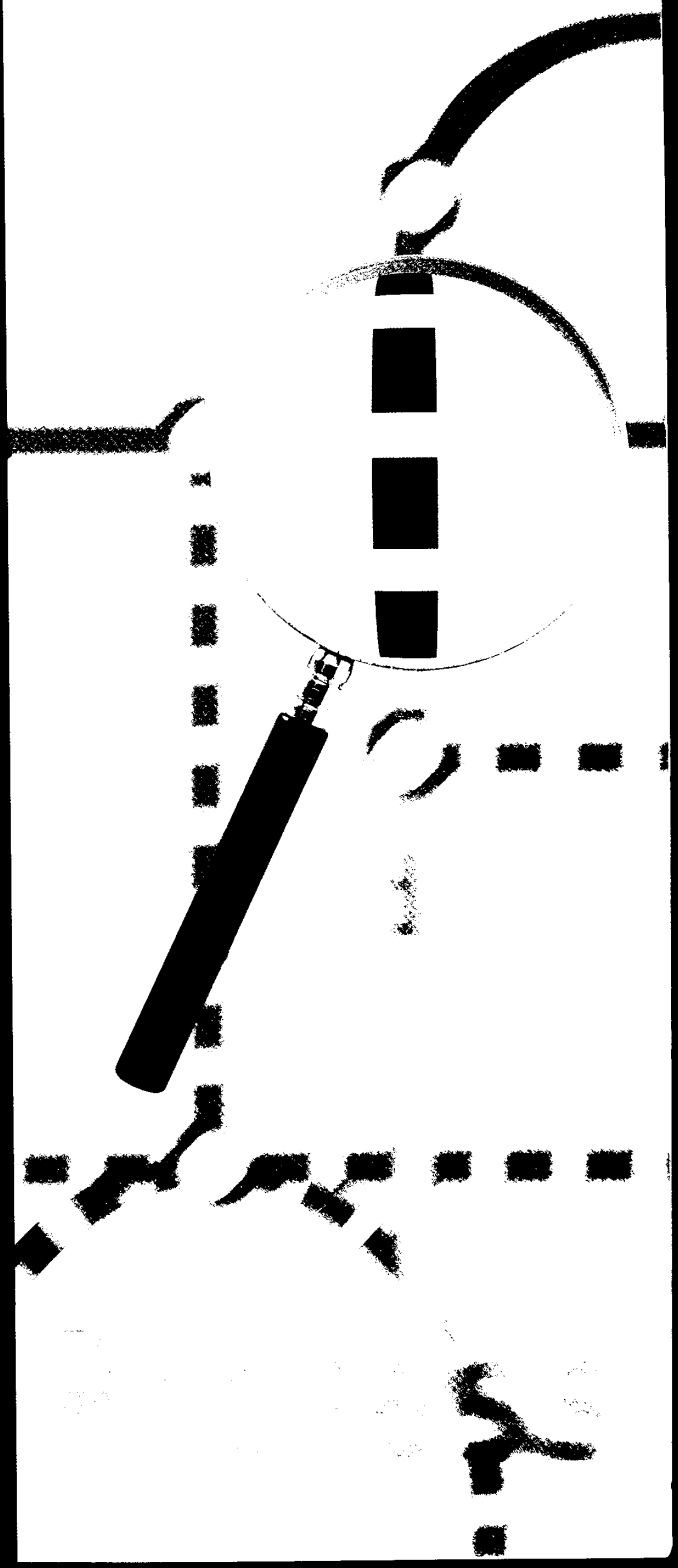
King's Fund

Clinical Governance Under Construction

Problems of Design and Difficulties in Practice

Steve Dewar



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Contents

Summary

This paper is for chief executives and clinical governance leads in Trusts, policy makers and academics. The paper:

- simplifies clinical governance as a policy and identifies the questions that need answering if policy aims are to be met (Chapter 1);
- reports on the development of clinical governance on the ground and highlights gaps between policy and practice (Chapter 2);
- puts clinical governance in context and maps out who is accountable to whom for what (Chapter 3).

Chapter 1 identifies possible problems. Chapter 2 looks to see if these problems are real and Chapter 3 takes a wide view of responsibilities across the NHS for effective governance. The development of clinical governance within Primary Care Groups is not considered here and will be tackled in future publications.

Chapter 1 simplifies clinical governance into five new themes (see box 1 below). The analysis raises a number of questions such as:

- Will the Department of Health oblige Trusts to implement all national guidelines on clinical quality or allow local choice?
- Local commissioners have detailed knowledge of Trusts and will manage some resources for audit and clinical governance – how will this role fit with Regional Office responsibilities for performance managing Trust implementation?
- Who will co-ordinate and fund professional plans and Trust systems to ensure local arrangements for managing poor performance work as an effective whole?
- How can the NHS introduce accountability for the multi-disciplinary teams who provide clinical care when different professions have different professional standards and different mechanisms for assuring clinical quality?
- Who will have access to information on health outcomes for patients treated by different doctors or different clinical teams?

Box 1

1. The policy emphasis on *national consistency* in the implementation of evidence based practice and the introduction of new health care innovation is new.
2. The concern with establishing mechanisms for authoritative guidance and ensuring implementation is new. *Accountability* is at the heart of this approach.
3. Pushing forward work on audit, clinical effectiveness, complaints, risk management and information is not new. The wish to co-ordinate and link this work within an over-arching and coherent system of *quality improvement and assurance* is new.
4. Placing a responsibility for clinical governance on chief executives, requiring appraisal systems within trusts, establishing an inspector to visit trusts, obliging all hospital doctors to take part in national audit, and modernising self-regulation - these developments in the *management of poor performance* and the promotion of clinical quality are new.
5. Policy documents emphasise the value of professional *collaboration* and teamwork.- this is new

Chapter 2 reports on interviews held with senior staff such as chief executives, medical directors and quality leads in nine health care organisations in London. This provided an early snapshot of the opinions and approaches of senior staff. Key challenges for successful clinical governance derived from these interviews are listed in box 2 below.

As a result of these interviews four gaps were identified between practice and policy.

1. *As a policy clinical governance provides mechanisms for the delivery of national standards. On the ground clinical governance is focusing on local priorities.*
2. *Policy confers on Trust chief executives the responsibility for clinical governance. On the ground the practice of clinical governance is delegated to clinical teams.*
3. *Policy states that clinical governance should be cost neutral. On the ground everyone knows that it will cost money.*
4. *The stated purpose of government policy is to bring an end to unacceptable variation. On the ground variation will continue to thrive.*

Box 2

- Ensuring all staff understand clinical governance and have ownership of the work
- Getting across the message that clinical governance builds on existing work
- Delegating the implementation of clinical governance to clinical teams
- Supporting the varied capacity of these teams to respond to the challenge
- Setting up effective performance management to ensure effective clinical governance
- Managing poor performance through systems of appraisal for all staff
- Dealing with policy overload - the main barrier to effective clinical governance

Clinical governance presents a challenge to all parts of the service. ***Chapter 3*** maps out who is accountable to whom for doing what. This final chapter identifies areas where accountability arrangements will be tested.

1. Improving the quality of clinical care has to be done by individual clinicians and clinical teams. Chief Executives will be accountable for quality. How might they find the authority to deliver?
2. The development of local public involvement means power to set local priorities and action. How will conflicting priorities that may arise from meaningful public participation be balanced with national directives?

1. Simplifying policy

The purpose of this chapter is to consider clinical governance as a set of simple policy themes and to identify the main barriers to successful implementation. Each theme brings new aspirations and new problems that need to be solved if clinical governance is going to be successful. Our analysis of each theme concludes with the questions that will need to be answered if policy aims are to be met.

Within the context of A First Class Service (Department of Health 1998a) clinical governance is central to a number of separate inter-related policy aims (see figure 1). Many of these aims are similar (see figure 2). Figure 2 illustrates the five overlapping policy themes within clinical governance: national consistency; accountability; quality improvement and assurance; the management of poor performance; and collaborative working.

National consistency

> *'All patients in the National Health Service are entitled to high quality care. This should not depend on the geographic accident of where they happen to live'.*
>
> A First Class Service

The government seeks to achieve this consistent and equitable service by ensuring that clinical care conforms to national evidence based standards. The emphasis on national standards is new. The National Institute for Clinical Excellence (NICE) will set these standards. NHS Trusts are under an obligation to ensure that they are implemented. Policy documents describe clinical governance as 'making sure standards are met'.

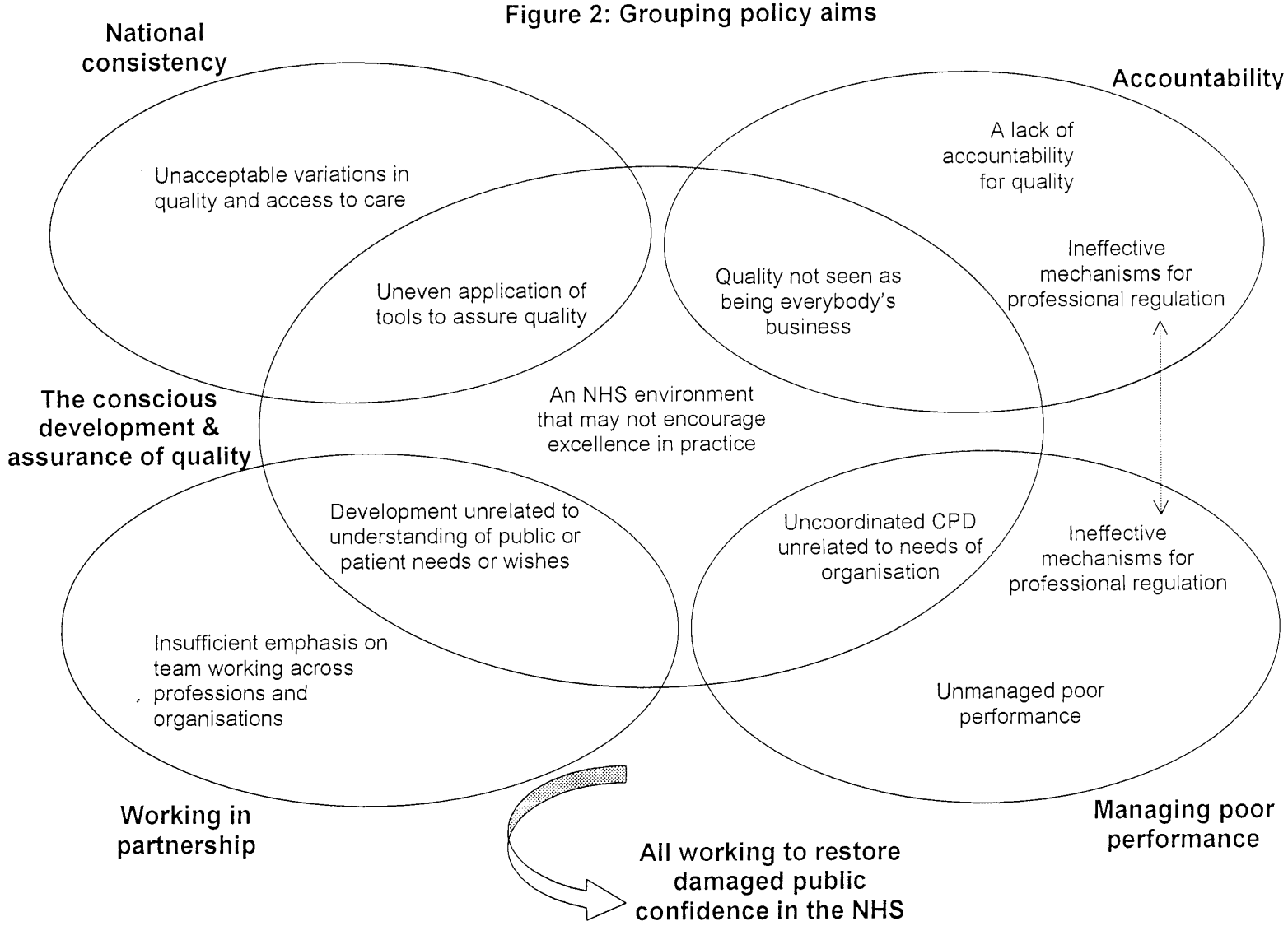
A First Class Service makes it clear that the application of guidance from NICE is a part of clinical governance, and Trust chief executives are under an obligation to ensure the effective implementation of clinical governance arrangements. However, the status of guidance from NICE needs be clarified. A recent Health Service Circular reminded health authorities that the department's interim guidance on sildenafil (Viagra) was merely guidance and therefore action could not be taken against clinicians prescribing Viagra (Department of Health 1999a). Local Trusts will have to decide if the obligation to implement guidance from NICE means restricting clinical freedom. The Department of Health will have to decide if it is able to back such action.

Experience and research emphasises the complexity of the change management task required to put evidence into practice (Dunning 1997, 1999; Humphris 1998; NHS Centre for Reviews and Dissemination 1999). This work highlights the need to provide time, support and status to experienced staff in order to facilitate success. National guidance will need to be converted to local programmes addressing educational, financial and organisational support for change.

Figure 1: A First Class Service - eleven policy driven transformations

Unacceptable variations in quality of care *(First Class Service paragraph 2.1)*	→	Consistent quality standards applied across the service
Uneven application of tools to assure quality *(First Class Service paragraph 3.3)*	→	Greater consistency of application of quality assurance tools
An NHS environment that may not encourage excellence in practice	→	An environment in which excellence may flourish *(First Class Service page 33)*
Damaged public confidence in the NHS	→	Restored public confidence in the NHS *(First Class Service paragraph 3.4)*
Quality not seen as being everybody's business	→	Making it clear that quality is everybody's business *(First Class Service paragraph 3.8)*
A lack of arrangements for accountability	→	Proper arrangements for accountability *(First Class Service paragraph 3.14)*
Insufficient emphasis on team working across professions and organisations	→	Care provided in partnership between professionals and organisations *(First Class Service paragraph 3.9)*
Development unrelated to understanding of public or patient needs or wishes	→	Involvement of patients and wider public in individual and service decision making *(First Class Service paragraph 3.10)*
Outdated mechanisms for professional regulation	→	Modernised and strengthened self regulation *(First Class Service paragraph 3.11)*
Unsupported process for tackling poor performance	→	Procedures to support professional staff in tackling poor performance *(First Class Service paragraph 3.12)*
Uncoordinated CPD unrelated to needs of organisation *(First Class Service paragraph 3.33)*	→	Co-ordination and targeting of CPD activity

Figure 2: Grouping policy aims



This is clearly resource intensive. Although it is promised that national guidance backed by NICE will be authoritative it is local guidelines as part of a multi-faceted local intervention that has the credibility and legitimacy necessary to deliver real changes in practice (Day et al 1998). Clinical and managerial staff at all levels will need to learn about the complex micro-political challenges of change management. This competence will need to be valued and rewarded. NICE aims to produce thirty to fifty sets of clinical guidance a year alongside an annual National Service Framework. The scale of the task cannot be underestimated.

With only a limited capacity to deliver such a large agenda there will be a need to set local priorities for achieving limited change. Establishing national consistency through comprehensive implementation of NICE guidance should be modified to a more realistic local implementation of discrete pieces of NICE guidance from a national menu. This is already being signalled through the latest guidance on clinical governance (Department of Health 1999c). This establishes a local focus and allows for local variation. Each Trust is required to come up with a local plan. This plan will need to be agreed with the Health Authority (HA), and presumably Primary Care Groups (PCGs), who will provide financial resources to support the change. This plan will become part of the local Health Improvement Programme (HImP) for which HAs are accountable.

The scope for national variation will be substantial. Similarly available resources for building Trust capacity will also vary. In some areas HAs and PCGs may put the standard of clinical care within Trusts high up their list of health improvement priorities, in other areas health promotion might, for example, provide an alternative focus for the work. This may well create the circumstances of geographical accident that lead to variations in quality across similar services.

Summary and questions

Achieving national consistency is a laudable aim. However, the need to ensure that limited resources are used to greatest effect means that local organisations will prioritise action rather than deliver changes across a comprehensive national agenda.

- Will the Department of Health hold Trusts to an obligation to implement all national guidelines on clinical quality or allow local choice?
- What sanctions will commissioners, regional offices or the Commission for Health Improvement (CHI) take if change is too slow?
- Is the NHS prepared to take healthcare professionals to task if they refuse to apply national guidelines?

Accountability

The approach taken to quality 'involves the Government taking responsibility for guaranteeing fair access and high quality throughout the health service' (Department of Health 1998a). The Government has laid out its accountability which it will seek to meet predominantly through NICE and CHI. However, it envisages 'the responsibility for delivery being taken locally' through the clinical governance system. A First Class Service lists the main components of clinical governance for NHS Trusts and the first section concerns 'clear lines of responsibility and accountability for the overall quality of clinical care'(Department of Health 1998a).

To be accountable means to be responsible for carrying out a particular task and to be available to give an account. A major policy aim is to design a system for generating authoritative guidance and ensuring that it gets into practice. The key aspect of this approach is the assertion of legitimate central decision-making with accountability for local implementation. Establishing the accountability for ensuring that change happens is at the heart of this approach.

A clear system of accountability is required to ensure that Trusts can be held to account for implementing clinical governance. In the past purchasers, particularly public health professionals, have been given a significant role facilitating work within Trusts on clinical quality. Health Authorities have been responsible for allocating audit money and have been encouraged to use this power to set priorities within Trusts and establish systems of performance management to see that effective audit has been completed.

The new quality agenda places the burden of responsibility more squarely upon the health-providing organisation. The statutory duty for quality, the introduction of clinical governance, and proposed visits by the Commission for Health Improvement (CHI) all reinforce this message. Trusts, local Health Authorities (HAs) and Primary Care Groups (PCGs) need to agree a new division of tasks, labour and resources with the local Health Improvement Programme (HImP). In reality HAs and PCGs will be responsible for allocating any specific resources to clinical governance and managing results. However, Regional Offices (ROs) will take up the official performance management of Trust clinical governance and there will need to be clarity over respective roles and responsibilities (see more in Chapter 3).

Accountability arrangements will also be needed within Trusts to ensure that systematic quality improvement takes place. Establishing accountability within the Trust brings various challenges. General management and performance review techniques are tried and tested ways of devolving responsibility. To be an effective driver of change, accountability needs to come hand in hand with authority and information. Managers need to know that appropriate action is taking place. If it is not, they need to have the authority to act. But management action is not simple within health care organisations. Whatever the power available to managers and chief executives as employers of clinical staff, there are few sanctions that can

be taken against clinical members of the organisation without risking alienation and poor prospects for future collaboration.

Inspection by CHI may strengthen managers' hands in establishing participation in governance arrangements. However, it is unclear what sanctions might be taken against those clinicians who do not participate. The General Medical Council have stated that participation in audit is, for doctors, part of their professional duty (General Medical Council 1998) but it is unclear if clinicians would be held to account by their regulatory bodies or their colleges and professional organisations for not participating in audit or clinical governance arrangements.

Summary and questions

Accountability is seen as a key driver for change but questions of who is accountable to whom and for what, as well as how to make the responsibilities real, remain unanswered.

- Health Authorities and Primary Care Groups have detailed knowledge of local Trusts and will manage the allocation of resources for audit and clinical governance – how will this role fit with Regional Office responsibilities for performance managing implementation of clinical governance in Trusts?
- The Commission for Health Improvement will inspect Trust clinical governance arrangements - will they share the results with Trusts, Health Authorities, Primary Care Groups, Regional Offices and the Public?
- Professional bodies are working on their own systems for clinical governance - how will these dovetail with Trusts' responsibilities for clinical governance?
- Will there be clear, professionally led expectations for participation in clinical governance and should the professional bodies support managers who exercise their authority over non-participating clinicians?

Quality improvement and assurance

Clinical governance stresses the systematic bringing together of many different strands of existing activity. Pushing forward work on audit, clinical effectiveness, complaints, risk management, information and clinical leadership is not new. The wish to co-ordinate and link this work together within an over arching and coherent concept is new. The priority given to quality, the all-embracing nature of the clinical governance task, and the role of systems to bring the work together as a central organisational concern, all represent a new emphasis.

Government guidance identifies the elements of a good clinical governance system but how they should be put together is left an open question to be answered by each Trust.

Unfortunately current discussion about clinical governance pays little attention to what is meant by quality. Instead policy documents focus on the management of quality and present a number of different concepts including processes of quality improvement, systems of quality assurance, the implementation of national standards, and the identification and management of poor performance.

Government policy asserts continuous quality improvement as the overarching aim of clinical governance. But given that quality and the way that we might measure it is undefined this may not be as helpful as it first appears. The preliminary National Performance Framework and the National Patients and Users Survey provide some clues but how much a Trust values the different contributions of effective quality assurance, implemented national standards, or the management of poor performance to an overall improvement of quality will be a matter for local debate.

One well-known elaboration of quality emphasises effectiveness; acceptability; efficiency; access; equity; and relevance (Maxwell 1992). This view of health care quality attaches importance to non-clinical elements, such as those that relate to the views, wishes and sensitivities of patients. 'Clinical' governance implies that clinical factors are to take precedence. But what counts as a clinical factor? Will the 'non-clinical' factors be left behind? Here quality is a contested concept where different aspects of quality might have to be traded off against one another (Baeza 1999 and Klein 1998). The importance given to technical or clinical quality in relation to other factors relating to service delivery will have to be decided on a Trust by Trust basis. These decisions will be subjective and will reflect the view of the world held by those in charge.

Similarly the balance between work on quality assurance, the management of poor performance, and the implementation of national standards will be driven by a subjective and local vision. Is the effective management of poor performance and the consequent lessening of the chances of patients receiving poor quality care the most effective contribution to overall quality? Or would such an emphasis damage participation in the clinical governance initiative? Maybe a focus on the implementation of national standards would do more to improve the quality of the general body of care within the Trust?

There may not be any way of answering such questions. Even if quality could be defined and measured it is still uncertain whether one type of quality improvement could be compared with another or whether it would be right or plausible to take such a utilitarian approach to comparing different benefits. What is clear is that the Department of Health guidance suggests a balance in work to improve quality between activities centred on changing, learning, and monitoring at individual, professional, team and organisational levels. The third dimension to the framework being a focus on local priorities, national obligations and organisational development.

Some analysts have drawn a bell curve to illustrate variation in quality over a number of individuals, services, or organisations (Scally 1998). It is used as an example of how quality might vary. This 'normal quality curve' is a handy and appealing metaphor for professionals with a scientific background. Despite the difficulty in measuring quality, particularly given

potential contradictions between different elements of the concept itself, the curve usefully stresses variability in the competence of individuals, organisations and services. Given the predominant role of local services in defining the right clinical governance system for them this imagined picture of variability might continue to ring true. Indeed, one central challenge posed by clinical governance will be how well the centre manages to sustain levels of quality that do not vary more than is necessary nationally rather than how any single institution manages to 'continuously improve' its services in isolation.

Development of any or all of these strands of work on quality inevitably raise questions about what information will be generated and the degree of openness with which the mechanisms of clinical governance will be applied. If the quality of services is to be assured against national standards, in order to generate renewed public confidence in the NHS, then information will need to be shared with the public. This information will need to be consistent across Trusts - generated using consistent definitions and in a format that is understandable and meaningful.

Summary and questions

The elements of a good clinical governance system are known but how they should be put together is still unclear.

- How will Regional Offices measure successful quality improvement?
- What balance of effort and what links are expected between different quality management tasks?
- How will the Department of Health identify different and effective local models of clinical governance and understand what combinations of context and approach work well?
- Given the emphasis on clinical excellence how can Trusts be helped to admit the true range of clinical quality to their boards and to the public?
- What information from local or national quality improvement audits will be shared with the public?

Managing poor performance

'Bristol' has changed attitudes to poor performance. Its impact on the medical profession and public has been enormous. A reforming government keen to strengthen the case for change has used its emotional intensity to underpin its recommendations. Current policy aims to put in place mechanisms to stop similar tragedies happening again and to rebuild public confidence. A central objective is to identify and respond to poor clinical quality as early as possible and before it is able to affect the patient.

The need to manage poor performance effectively and to assure the clinical quality of healthcare is not new. However, the following specific requirements are new: a statutory duty of quality on chief executives; establishing an independent inspector to visit Trusts; obligating all hospital doctors to take part in appraisal and national comparable audit; and modernising systems of self-regulation. We need to be clear how they will help to identify and to rectify poor performance and to what degree they will provide any additional protection for the public.

In this climate the statutory duty of quality on Trust chief executives has a particular significance. However, the duty (Health Bill, House of Lords and House of Commons 1999) gives chief executives a limited responsibility to "put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals." This establishes responsibility for the process rather than the outcome of clinical governance. Chief Executives only need to show arrangements for quality management.

The wording in the Bill represents a missed opportunity. Of course chief executives will still respond to the spirit of proposed reform, and clinical governance arrangements are likely to promote their greater involvement in the development of effective quality management. But if the tragedy of future poor performance should occur in their Trust a chief executive may now be able to argue that they are not responsible. This undermines a powerful message within clinical governance, that clinical quality is a concern for chief executive, board and the whole organisation, and fractures the organisational cohesion needed to tackle the problem.

What if chief executives had been made responsible for clinical quality and thereby accountable for poor clinical performance? Some might argue that such accountability would only be symbolic because chief executives neither have the clinical knowledge or time to police each and every clinical intervention within their Trust. However, there are many examples of leadership that involve accountability for the professional actions of others. After all chief executives are not accountants and do not check every invoice but they are still financially accountable.

It may be argued that clinicians themselves have to be responsible for the quality of their own work – such responsibility is a defining characteristic of professional ethics. However, the development of multiple accountability to profession, organisation, and public is a common characteristic of modern systems. Clinical staff are responsible to both the NHS and to their professional ethical codes and the real nature of these responsibilities should be reflected by accountability arrangements. The challenge is for Trusts to establish systems of local regulation that weave these lines of multiple accountability into a safety net that protects from poor performance.

Establishing such a personal and public accountability for poor performance would have provided a powerful incentive for action. Chief executives would minimise their risk of being made accountable for poor quality by ensuring that the organisation develops in a way that significantly reduces the chances of poor clinical quality slipping through unnoticed by colleagues, patient complaint, routine audit, or effective performance management.

Unfortunately now chief executives may respond only to the letter of their duty by demonstrating reasonable structures rather than worrying about the content and quality of actual clinical interaction.

There are six specific proposals which relate to the management of poor performance: the statutory duty of quality; inspections from CHI; the national external audit of all hospital doctors; internal appraisal and job review systems within Trusts; new re-validation systems for modern self regulation (General Medical Council 1999); and performance management of clinical governance. Currently the links between these approaches are unclear. To give one example - professional bodies are planning to take a more proactive responsibility for assuring clinical quality. The question is how will such schemes be funded and how might they inter-link with systems within provider organisations and the different approaches taken by different professions often working in the same team.

The policy watchword for the management of poor performance is openness, yet it seems that practice will still be shrouded in secrecy. There is no central information on the level of suspensions within Trusts or resultant decisions. There are no formal links between the employers' procedure for disciplining poorly performing professionals and the new approaches to regulation and national audit. It is helpful to establish the individual bits of the jigsaw but there is still a need to put the pieces together.

Summary and questions

The challenge in systematically managing poor performance will be integrating the local actions and accountabilities of different individuals and professions. It is a shame that the statutory duty of quality fails to emphasise real organisational accountability for clinical quality.

- Will different professional re-validation procedures be realistic systems for actively assuring the quality of individual clinicians?
- Who will co-ordinate and provide funding for the plans of different professional bodies and the obligations of Trusts to ensure that local arrangements for managing poor performance work as an effective whole?
- Will information produced by the external audit of doctors be shared with the NHS and the public?

Collaborative working

New accountabilities have been established at the top of healthcare organisations and at the level of the individual clinical professional but it is the clinical team that usually provides

clinical care. Policy documents emphasise the value of professional partnership and teamwork but do not suggest mechanisms to manage this important element of quality.

Policy initiatives and modern self-regulation still focus exclusively on uni-professional standards and individual responsibilities. A clear example of this is found in the policy assertion that "since healthcare is a team effort, it makes sense for ... information to be on the local unit rather than the individual doctor" (Department of Health 1998c). However, it is proposed to collect national information gained by a uni-professional external audit focused on hospital doctors and organised by specialty and sub-specialty professional bodies.

There is a gap between policy aspiration and detail. While partnership and teamwork is central to the former it is absent from the latter. Little attention is given to positive ways of supporting effective teamwork. Nor has the modernisation of professional accountabilities led to any movement away from a uni-professional approach to regulation, re-validation, and education.

In addition to multi-disciplinary team working, partnership with patients and the public is presented as beneficial to the management of quality. Patient and public participation is seen as a tool to re-build public confidence in the NHS. Government policy suggests that this can be achieved by incorporating the concerns and priorities of service users into the quality framework. Sharing information is proposed as a way to assure the public of the high clinical quality of their local health services. However, it is unclear if information, which indicates the existence of poor, as well as high quality clinical service will be so widely shared.

Being open with data would also mean being open about data quality. There are well-documented concerns about the quality of comparative data on health outcomes and methodological difficulties in casemix adjustment that otherwise might make information meaningful. However, if such information were in the public domain then whatever the caveats about its meaningfulness the public would want to act upon it. When the life of a loved one is at stake people want to ensure that they are treated by the best available. Once information is in the hands of the public, can the NHS adjust to accommodate a clamour for greater public choice?

The next chapter illustrates the store that is placed by chief executives and medical directors on the capacity and competence of multi-professional teams to take up the challenge of clinical governance as it is devolved through the organisation. It is clear that many organisations believe that the real work has to be done by these groups while the chief executive, medical director and clinical governance board focus on effective delegation, priority setting and performance management. So achievements in clinical governance depend mainly on the ability of these teams to respond. Support for this aspect of partnership working is the most crucial contribution that can be made to increasing the capacity of the NHS to deliver the high expectations that clinical governance has engendered.

Summary and questions

Although policy statements assert the value of multi-discplinary teamwork and patient and public involvement there are few practical changes to help the service achieve these goals.

- How will multi-disciplinary teams be accountable when different professions have different professional standards and different mechanisms for assuring the quality?
- Who will have access to information on health outcomes for patients treated by different doctors or different clinical teams?
- How will those who educate clinical professionals enhance the capacity and competence of multi-professional teams to take up the challenge of clinical governance?

2. Clinical governance on the ground

Interviews were held with six chief executives, four medical directors and seven quality leads in nine organisations in London. The nine were a mixture of three hospitals, two community Trusts, two community and mental health Trusts, one community and acute trust, and one community, acute and mental health Trust. They were not chosen to be a representative group.

Clinical governance on the ground is an early snapshot of the opinions and approaches of senior staff across a small number of organisations. Common themes are drawn from interview notes and are presented as a descriptive account of the views of the interviewees without analysis or critical commentary. Quotations are used to highlight important points but individuals and organisations have been kept anonymous. I am grateful to the interviewees who were extremely helpful and generous with their time.

A discussion section at the end of the chapter pulls together an analysis of four major gaps between policy and practice:

1. reconciling local ownership and national demands;
2. clarifying roles and responsibilities
3. funding the funding;
4. living with acceptable variation.

Getting clinical governance clear

Trusts feel that they need to help staff understand 'clinical governance'. They want to help answer questions about what the phrase means and more importantly what the phrase means *here* - in this organisation.

> ***"At the moment staff don't understand the term or what it means"***
>
> *Trust C: Acute and Community*
>
> ***"Clinical governance is seen as a foggy grey mass of additional work"***
>
> *Trust A: Acute*

All nine organisations want to get the message across that clinical governance is not new but builds on existing work. Managers feel strongly that the work "shouldn't be given a new title"[1]. This would risk creating a new clinical governance industry. That is seen as a bad thing. It would make clinical governance a specialist activity - giving everybody a reason not to do it. It would create an incentive for experts to mystify and sell their "special 'knowledge' to the rest of us"[2].

---

[1] *Trust C: Acute and Community*

[2] *Trust A: Acute*

Trusts recognise the importance of ownership if clinical governance is going to go anywhere. Managers are aware of staff cynicism over initiatives such as clinical governance, which are often seen as devices to put pressure on them to do more, with no more resources.

> ***"If participation is to be achieved and cynicism overcome then great care is needed to ensure that clinical governance is not something that is going to be done to them – again".***
>
> *Trust C: Acute and Community*

A number of methods have been used to promote this type of ownership. Some Trusts have held events and 'roadshows' with a cross section of staff to explore the concept[3]. One Trust used a day with an external facilitator to explore clinical governance and learn from previous experience of quality improvement[4]. Others are establishing structures that extend the role of small teams and multi-professional groups to set the agenda for clinical governance and to take responsibility for work on the ground[5].

Successfully sharing responsibility

The overarching theme amongst Trusts has been the search for effective ways of sharing the responsibility for quality. Chief executives recognise the need for clinical teams to act on clinical governance.

> ***"The locus of response to the statutory duty of quality really rests with the directorates. It is my responsibility as chief executive to monitor and satisfy myself that the changes are happening."***
>
> *Trust F: Acute*

Chief executives don't feel they can do clinical governance themselves. They point to the fact that they often do not have the clinical knowledge to ensure appropriate and meaningful performance indicators for clinical work. They do not necessarily feel able to be responsible for clinical care because they themselves do not provide it. But they do accept responsibility for making sure that clinical governance happens[6].

Using the history of clinical audit as an example, many managers have learnt that clinical ownership is crucial and will only come if clinicians are in at the beginning, making it *their* clinical governance[7]. Quality will only become everybody's business if clinical governance is made everybody's business.

> ***"Some Trusts may have decreed that clinical governance is too important to be left to the clinicians but by doing so they have missed the point"***
>
> *Trust A: Acute*

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[3] *eg. Trusts C (Acute and Community) and H (Community)*

[4] *Trust G: Acute, Community and Mental Health*

[5] *eg. Trusts D (Community) and G (Acute, Community and Mental Health)*

[6] *eg. Trusts A (Acute) and F (Acute)*

[7] *eg. Trusts A (Acute) and F (Acute)*

The delegation of the clinical governance task to clinical teams is a common approach but managers raise a serious question about the capacity of the clinical teams to respond to the challenge. The following comment was representative of a number of interviewees who highlighted the variable level of organisational sophistication and leadership within different clinical groups as having a direct impact on their ability to deliver clinical governance.

> ***"Some group are only on the first rung of organisational working while taking on clinical governance may not really be possible until rung ten."***
>
> *Trust A: Acute*

Many executives are thinking about how to provide the incentives and the support to help clinical teams undertake the clinical governance task. Why should staff play ball with this new initiative? First thoughts have focused on getting the message right and emphasising the positive aspects of quality improvement for the service and the patient. One Trust talked about the need to establish a culture where participation in clinical governance is a way of arguing the case for resources and service developments. This approach is based upon their belief that professional aspiration is a key driver for clinical staff and that clinical governance should offer opportunities for personal, professional and organisational development[8].

The most commonly identified barrier to participation in clinical governance was limited time. Time for clinical groups to meet, to understand the task, to consider best practice, to address the difficulties of collecting data and agree changes in practice. The need for time was not seen as the same as the need for money. While money *may* buy time, it may not be possible to identify and access clinical cover to enable core staff to take time out.

Some Trusts identified the need for help to enable clinical teams to undertake what may be a new and difficult task. One Trust is seeking collaboration with local educators to support this[9]. Another is finding ways to enable lead clinicians and clinical teams to access training budgets and audit to support the work[10]. One Trust medical director felt that targeted national resources for this sort of support would be an important resource for effective governance[11]. One chief executive provided an example to illustrate that progress on quality improvement will crucially depend on developing a systematic understanding of service provision.

> ***"The appointment of a new consultant may mean a new casemix - then a change in the level of patient dependency and a knock on risk for nursing staff faced with a different set of tasks and different training and development needs"***
>
> *Trust C: Acute and Community*

Like much else about clinical governance, the need for good and credible support was not seen as something new. One London community Trust has had senior professionals in the field for a number of years providing local professional supervision, research support,

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[8] *Trust C: Acute and Community*

[9] *Trust E: Acute*

[10] *Trust A: Acute*

[11] *Trust A: Acute*

practice development, and knowledge management[12]. The Trust combined these roles with clinical practice in order to ensure that post holders carried sufficient credibility. Similarly, the call from one interviewee for more co-ordinated multi-professional and practice based learning, as part of the national agenda for professional education is not new, even if it is now more urgent[13].

Many Trusts are delegating clinical governance to 'directorates', 'care groups' or 'service' / 'business' units, depending on the language of their organisations. Many of these groups are then delegating the task down to smaller clinical teams or 'natural work groups'. Interviewees felt that developing the capacity and competencies of individuals to take on this new *team* responsibility is a central issue.

> ***"Effective team working will give effective team audit and effective clinical governance but if the team is not working together then there can be no ownership of joint governance arrangements."***
>
> *Trust F: Acute*

Within Community Trusts team working is seen as central to arrangements for clinical governance and even more complex to address. Here there are particular challenges arising from a workforce of many different professionals based in several geographical locations working at the interface between different service providers. Clinical governance will have to work in close partnership with other organisations and other health professionals. Developing this 'shared governance' is seen as key to improving services[14].

One interviewee noted that the development of an effective response to the clinical governance challenge might be more difficult in some clinical teams than others. Some clinical units might find the process of standard setting more difficult because it may not be possible to clearly describe or control their work. In emergency care for example any parameter of quality can be compromised by unlimited demand[15].

This was used as an example of how for the interviewee quality is not a concept that has any meaning in isolation. For him quality is something that has to be balanced against unlimited demand, limited resources and national recruitment crises, a series of trade-offs that raise a whole host of 'wicked questions'.

> ***"If a major incident or a flu epidemic overwhelms the capacity of the A&E department to stick to its standards of quality then what does the duty of quality mean for a chief executive?"***
>
> *Trust C: Acute and Community*

The dominant model for delegating the clinical governance task is to pass responsibility down the line of clinical directorates or groups to clinical teams. But other lines of delegation

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[12] *Trust D: Community*

[13] *Trust A: Acute*

[14] *Trust D: Community*

[15] *Trust C: Acute and Community*

are also in use, often as complementary mechanisms to try and stimulate effective 'bottom up' responsibility for clinical governance. The use of local groups within one community Trust provides one example of trying to ensure a multi-professional input by geographical patch. A central forum of professional representatives from locality level enables corporate devolution while instilling a sense of democratic involvement in the process. This use of localities, which happen to be co-terminus with PCG boundaries, also offers potential for the development of locality based 'shared governance' arrangements with primary care[16].

Within one Trust which faces considerable 're-structuring' and change to its organisational boundaries the development of clinical governance responsibilities within individual professional bodies is seen as one way of ensuring that good governance habits survive whatever happens to the organisation. In this Trust new contracts for clinical leads will include responsibility to represent professional opinion within the organisation on risk management and clinical governance committees. This Trust sees this as important in helping the organisation understand national and professional guidance.

Establishing effective performance management

One chief executive identified the lack of effective performance management as one reason for audit's relative failure. He was keen to ensure that this will not be the case for clinical governance[17]. Effective performance management was identified by many as the key to achieving effective clinical governance. Indicators of quality, clinical performance, and risk are seen as important parts of routine performance management reports from directorates or clinical groups. These interviewees feel that directorate business plans need to include objectives and milestones for this agenda.

> ***"From the perspective of the Trust board the situation to avoid is the one where a clinical governance board of enthusiasts tell us that everything is wonderful. The job of the clinical governance board is to sit on top of the Trust performance management process - it should be their job to notice that its happening better in directorate A than directorate B and to say what we are doing about it".***
>
> *Trust F: Acute*

The value of performance management was endorsed by many chief executives as a way of effectively delegating responsibility for clinical governance. Many also recognised the limitations of this tool.

> ***"There is a need to be realistic about performance management systems – you can't get into detail but can only be assured that change is being achieved through new behaviours and new systems within the directorate".***
>
> *Trust F: Acute*

One of the difficulties of performance management is seen to be the potential for misusing or misinterpreting data that in the initial stages will often be of poor quality.

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[16] *Trust D: Community*

[17] *Trust F: Acute*

> ***"One major challenge to effective clinical governance will be ensuring management sensitivity in the use of often-unreliable data – the real task here is to try and ensure maximum professional participation in the generation of the data in the first place".***
>
> *Trust F: Acute*

This danger is seen to apply to those taking an overview of clinical governance within the organisation and also to those who have a role in the external inspection or performance management of clinical governance. Trusts know they will need to respond to visits from CHI, to performance management frameworks applied by regional offices, and to standard setting as part of local commissioning and local HImPs. There is uncertainty about how these separate systems will be co-ordinated to ensure that clinical governance does not become a paper chase with multiple inspection, performance management and organisational audit outrunning practical support[18].

The management of poor performance

Chief executives, medical directors and quality leads all acknowledge the importance of tackling poor performance as a part of clinical governance. But there is a common view that the organisation needs to focus on more positive aspects of the agenda in order to develop wide clinical participation in the work.

> ***"Recent well-reported cases of poor performance had been overplayed by press and politicians - this had led to a considerable backlash against the good things that we are trying to do".***
>
> *Trust E: Acute*

The predominant tool for approaching the management of poor performance is the development of systems of appraisal for all clinical as well as managerial staff. Many different organisations noted the need to carefully explain and 'sell' the notion of job plan review in a way that illustrates its advantages to clinicians. The process should offer opportunities for staff to demonstrate the quality of their work, to enable them to be protected and developed by the organisation, it should be in their interests to participate. Respondents recognised that clinical governance had provided new emphasis and drive to their existing work on appraisal.

> ***"The new policy agenda has helped provide the right timing for the change. The Trust is highlighting this development as an opportunity for doctors to access help, support and resources over issues such as career development. However, there is also an explicit acknowledgement, for the first time, that there is also a need to ensure that the Trust provides a high standard of clinical care".***
>
> *Trust B: Community and Mental Health*

[18] *Trust I: Community and Mental Health*

The lack of joined up policy

Asked to describe the main barrier to effective clinical governance many different chief executives and medical directors identified policy overload and the lack of joined-up links between policy initiatives. Respondents feel that the danger in this lack of linkage is that it can lead to tribal behaviour within a Trust with the implementation of different policies competing with each other for organisational priority.

> ***"It can not be a question of clinical governance today and then balancing the books tomorrow."***
>
> *Trust C: Acute and Community*

An irony not lost on some is the need to develop organisational identity and commitment in order to take clinical governance forward, at the same time as other policies are threatening major changes in organisational boundaries.

> ***"In terms of clinical governance to get one's house in order would be hard work even if nothing else where changing, but at a time when the whole house is being rebuilt it's a Herculean task".***
>
> *Trust B: Community and Mental Health*

With so many organisations such as HAs and Regional Offices having a stake in clinical governance respondents feel that there is a danger that clinical governance is seen as the answer to too many problems and then workload and expectation will exceed that which can be delivered sensibly. Some Trusts feel that clinical governance needs to give them more clout to set their own audit and quality agenda, and re-establish ownership of this type of work. One Trust felt that in the past audit had been 'hijacked' by public health and contracting departments of Health Authorities[19].

> ***"One major danger to clinical governance is the risk of a consultant backlash against the whole agenda. The only way through is slow steady progress."***
>
> *Trust F: Acute*

The developmental tasks are seen as substantial. Despite a scepticism about the ability of NICE to turn out guidelines and frameworks at the projected speed, the need to build an organisation that has the systems and capacity to handle the number and range of demands flowing from the centre is perceived to be a real problem [20].

Public / patient involvement in clinical governance

Guidance on clinical governance emphasises work across different professional groups, across different health organisations, and with both patients and public. The Trusts interviewed are starting to develop strategies for public and patient involvement but they feel the real involvement of patients or public in clinical governance is 'down the track'.

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[19] *Trust B: Community and Mental Health*

[20] *Trust F: Acute*

> ***"The Trust is developing ways of involving patients and public in decision making about the operational delivery of its services. It hopes to integrate these initiatives with clinical governance within the next 18 months".***
>
> *Trust B: Community and Mental Health*

Many anticipated that links with PCGs, Community Health Councils (CHCs), public and appropriate patient groups or representatives would be made at the level of the clinical team or 'directorate'/'care group'[21].

Success criteria

Informants indicated a number of different success criteria which might apply over the next 18 months:

- some Trust chief executives identified clinician participation in clinical governance as a key indicator[22];
- another suggested process measures related to the development of guidelines[23];
- one Trust wanted demonstrable evidence of effective linkage between existing parts of the clinical governance system such as complaints, adverse events and training and education[24];
- one Community Trust emphasised the importance of wider work across agencies and professionals and set the development of inter-agency integrated care pathways as a key measure of success[25].

> ***"If clinical service units were articulating key indicators for their own services concerning volume, cost, and quality of service delivery that would constitute success".***
>
> *Trust C: Acute and Community*
>
> ***"If quality reports to the board start to contain clinically useful information that clinicians see as valuable that would be a sign that we were on the right track".***
>
> *Trust B: Community and Mental Health*

Discussion:
Four gaps between practice and policy

1. Reconciling local ownership and national demands

As a policy clinical governance is primarily concerned with setting up means to achieve ends. One important 'end' is the delivery of national health care standards. Clinical governance is a system to ensure national standards can be promulgated and implemented across the country

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[21] *Trust A: Acute*

[22] *eg. Trusts F (Acute) & C (Acute and Community)*

[23] *Trust E: Acute*

[24] *Trust B: Community and Mental Health*

[25] *Trust D: Community*

through an effective chain of accountability and authority. On the ground the practice of clinical governance is different. Chief Executives, Medical Directors and audit leads are not primarily concerned about responding to top-down standards.

Their first task is getting clinical professionals on board. Identifying incentives for getting clinicians engaged in the process and finding ways to achieve effective delegation. The focus is not on assembling a system for the implementation of national standards because such a top down approach does not appeal. Staff are already cynical about top-down initiatives that have sought to make them do more with less. Trusts are working to engage the whole clinical organisation in their *own* thinking about standard setting, performance monitoring and management. In practice the clinical governance system has to be owned by the organisation and serve local and organisational wishes first and national purposes second.

For these reasons the gap between the desired implementation of national standards and the development of systems working to a local agenda on quality improvement will remain for sometime. Clinical governance has to be nourished and it may not be appropriate to overload it with national expectations. The concept of achieving consistent clinical excellence through the national implementation of between 30-50 sets of NICE guidance a year is unrealistic and does not fit alongside the need for local ownership.

In a visionary future the clinical governance rainbow might be broad enough to encompass a range of activity on separate local, national and professional priorities. Local clinical governance may develop into a conduit through which properly financed national change on clinical issues can be agreed and implemented. But in the meantime we might be forced to return to a menu of national guidance from which topics are chosen locally for implementation.

2. Clarifying roles and responsibilities

Policy confers the responsibility for clinical governance on Trust chief executives. On the ground the practice of clinical governance is delegated to clinical teams. Clinical teams will have the responsibility for making clinical governance real and implementing clinical change. In much the same way that those caught up in traumatic events are routinely offered counselling chief executives and medical directors are routinely offered conferences and learning sets to help them come to terms with the aftermath of new policy. But it is the accountability and capacity of the clinical team which is key and many chief executives are thinking about incentives and support to enable them to undertake the task.

The chief executive committed to achieving the implementation of clinical governance might question what powers she has to ensure that policy gets translated into practice. The deputy director of the Institute of Health Services Management has pointed out that clinical governance "is making managers responsible for something without giving them the power to achieve it" (Moore 1999). Chief executives do have power but chief executives also need the confidence and co-operation of clinical staff to manage the organisation effectively. If the statuary duty of quality had made chief executives responsible for clinical quality rather than

arrangements for clinical governance this would have legitimising their role in assuring the quality of clinical work.

Chief executives are asked, although not statutorily required, to ensure full participation by all hospital doctors in audit programmes including external audit endorsed by CHI, participation in confidential enquiries, and implementation of NICE recommendations. If chief executives are accountable for these arrangements they need to delegate effectively. However, in the health service delegation is more an exercise in persuasion than power. Professional and academic bodies are an important part of that process if they are able to reinforce the requirements to participate the position of the chief executive will be strengthened.

Establishing appropriate roles and responsibilities is hindered by the fact that existing systems of accountability put the emphasis on individuals. The chief executive's new duty, the audit of hospital doctors, and the modernisation of self-regulation for single professions, are all examples of individual rather than inter-professional or corporate responsibilities. Policy makers, healthcare organisations and professional bodies need to find ways out of uni-professional thinking in order to target support and place responsibility on the real and complex teams of people who actually make up the public experience of health care.

So what can the centre do? First, the biggest barrier to engaging people in the project is time: not money but time. A national way of enabling organisations to draw upon clinical cover may need to be found. Such a rethink would require a radical questioning of the current patterns of service delivery in order to allow clinical staff time out to learn and engage in new thinking about defining best practice, setting and monitoring standards, and changing work patterns as a team.

Second, educational systems have to be focused on helping staff understand and deliver effective and accountable clinical governance. This means focusing national educational resource on co-ordinated learning for clinical teams. This may be targeted at individual professions learning on their own or at multi-professional teams learning together. Co-ordinating this learning through the use of national bodies with resources and professional credibility will reinforce the importance and the nature of this work in a way that the local system is not able to do.

3. Finding the funding

Policy states that clinical governance should be cost neutral. On the ground everyone knows that it will cost money. Clinical quality is an organisational issue. Developing the capacity of the organisation to undertake clinical governance will involve: finding time for clinical teams to understand effective clinical governance, time to set meaningful standards; making skills available to help with effective data management; and dedicating staff to the effective management of change. These activities will cost money or use limited resources.

But it isn't just the development of clinical governance that requires investment. Once up and running effective clinical governance will generate its own agenda of education, clinical

change and service development all with their own financial implications. The call for money to improve service quality will compete against the need for money to increase the quantity of services. Both the development of clinical governance *and* the response to clinical governance activity will involve costs.

So far much of the discussion of clinical governance has been conducted in a vacuum without thinking about how it might fit into other real world considerations such as financial limitations, increasing demand, emergency admissions, waiting time initiatives and NHS recruitment crises. But if we take the leap of faith and imagine that the required commitment and funding necessary to deliver effective clinical governance, how might the NHS respond to the sort of information that it is likely to deliver? When clinical governance uncovers the cost of developing and sustaining clinical excellence the Department of Health will have to make choices between quality and service accessibility and availability.

New plans for the NHS acknowledge that we need more explicit consideration of the way in which we spend NHS money. When it comes to new healthcare innovations the role of NICE allows for the weighing of evidence and the opinion of public and professionals on relative priorities for spending NHS money in relation to new technologies. Clinical governance will raise similar dilemmas. If the NHS spends money on assuring the quality of key services then that money is not available for the provision of other services. At both local and national levels we will need transparent processes to identify and weigh up the real opportunity costs of quality and manage the implementation of standards. Integral to this are explicit statements about where money will be taken from or how priorities will be adjusted to accommodate change.

4. Living with acceptable variation

The avowed purpose of government policy is to bring an end to unacceptable variations in the quality of clinical care and unacceptable variation in the application of tools for quality improvement. Trusts acknowledge that developing clinical governance means starting with the capacity of their own organisations. Some will be more or less developed in terms of the competence and capacity of clinical teams to respond to the challenge. There will continue to be variation in the application of tools for quality improvement and variation in the effectiveness of arrangements for clinical governance to actually deliver on any one dimension of the governance task.

Some clear expectations would help. Trusts should have targets for process and outcome and it needs to be acknowledged that the aim is not to avoid variation but ensure that basic high standards of clinical care are in place.

3. Mapping accountabilities and testing their strength

Introduction

NHS policy has been criticised for failing to have impact on the practice of healthcare on the ground. So how will clinical governance ensure that effective mechanisms are in place to translate the fine words into action?

Clinical governance is a local system for delivering clinical standards within a national framework for quality health care. So success will depend not only on the approach taken to local implementation but also on action throughout the health care system.

A First Class Service proposes action and accountability for all the organisations commissioning and providing health, as well as those that set the professional and political framework for health services. Clinical governance is not a private issue for doctors, nurses, therapists, chief executives, commissioners, or NICE and CHI, but a challenge to all parts of the service.

'Successful clinical governance will rely on proper arrangements for accountability'
A First Class Service

The aim of this chapter is to map out the shape of this complex system, establish who is accountable to whom for doing what, and test out the strength of these new accountabilities and thereby assess the chances of success.

Defining terms

This is not an attempt to be definitive about the meaning of terms such as accountability, power, and authority, but to be clear about our use of these terms. For this purpose brief definitions are given below in Box A.

Clinical governance seeks to establish and clarify accountabilities. To make someone accountable requires 'power'. There are at least two dimensions to power; one dimension is 'explicit' power, which enables actions that can further or harm an individual's career, remuneration or professional status. The other dimension is 'implicit' power such as the ability to use profession, status or personality to resist or complement explicit power. Power is usually drawn from a mixture of explicit and implicit factors. 'Authority' is a good term for the power underlying accountability. Authority will determine the legitimacy of a new accountability; the capacity of those held accountable to deliver the task; and their ability to share the accountability with others.

It is not necessary to have direct control over something to be accountable for it. But authority is needed over those people who do control the part of the system to which the accountability refers. This authority can then be used to make people accountable for different parts of a task. They may continue to share and often divide up the task, making others accountable or responsible for its achievement.

Box A

Accountability - to be held to account for the delivery of a specified objective or to give an account of one's actions.

'Explicit' power - the ability to further or harm a person's job, remuneration or status

'Implicit' power – the ability to use profession, status or personality either to resist or complement explicit power

Authority – the mixture of explicit and implicit power underlying the process of making someone accountability or delivering the task for which one is accountable

Responsibility - suggests an immediate relationship within your organisation. *Accountability* - suggests a wider relationship with the organisation, the wider system or the public

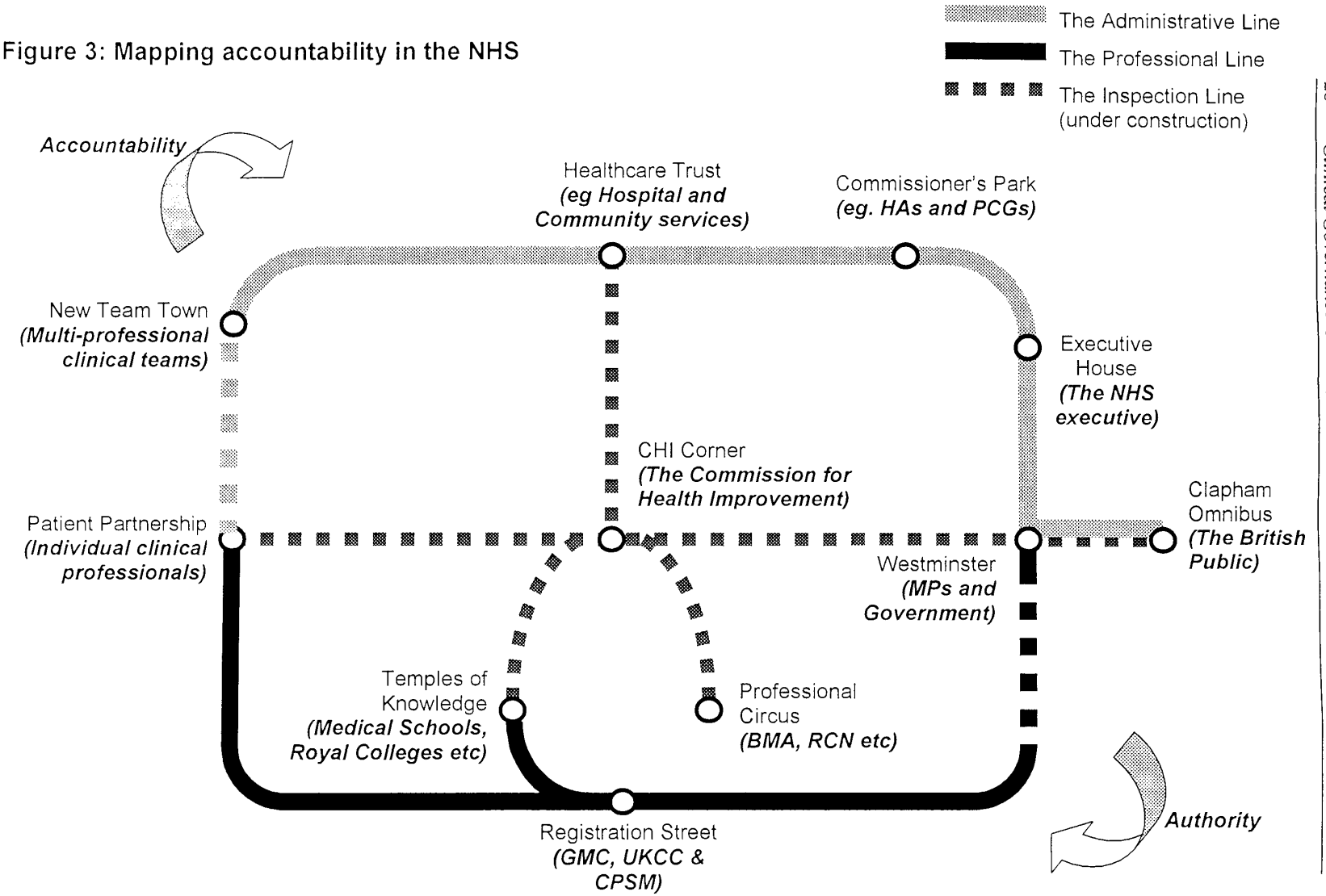
Mapping lines of accountability

In the NHS, organisations are held accountable through a chain of managerial accountability that goes back to government, who are themselves accountable to the public through the ballot box. Clinicians are accountable to the organisations who regulate their profession under the delegated authority of parliament. These professional regulators set standards of behaviour and may act to remove professional title and privileges from individuals on the grounds of misconduct, poor health or, in the case of the GMC, poor performance.

A 'map' of accountability is useful to clarify responsibilities for health care quality. Figure 3 illustrates the different lines of accountability. Three lines are shown; first, the administrative line of accountability from government to NHS executive, Health Authority, commissioner (PCG), and on to the healthcare organisation and to the teams and individuals who provide care. Second, the professional line of accountability where devolved authority from government allows professional and regulatory bodies to take control of their own arrangements for professional registration, specialist recognition and education. Lastly, there is a new line of inspection running from government to an 'independent' inspector in the form of CHI.

In figure 3 authority runs from right to left and accountability from left to right. These forces of authority and accountability enable the movement of policy around the track. No

Figure 3: Mapping accountability in the NHS



organisation gets a station unless they have explicit power over the next station down the line. NHS organisations, for example, may suspend or sack clinical teams or individuals, or the executive may sack or suspend the chief executive of a commissioning body. No accountability to patients or local populations has been included because although some organisations have developed systems to enable such accountability these arrangements do not usually involve public power over professionals or NHS organisations as a whole.

The administrative line

The authority of explicit political power is used to legitimise aims for the service. These aims are achieved through establishing accountabilities for specific actions at increasingly local tiers of management. The executive works to convert political values and ideas into policy and translate policy into accountabilities expressed as statutory duties, executive letters and guidance for regional managers and district or PCG level commissioners. At that point we cross the divide into health care providing organisations and accountabilities need to be established from chief executive down to the level of clinical teams and clinical individuals.

The professional line

This line of accountability runs from government through the various professional regulatory bodies to individual healthcare professionals in their consulting rooms, on the ward or in the community. Branching off from the authority of the regulatory bodies are the numerous professional bodies and royal colleges representing different professional specialities and a network of educational providers. Different regulatory bodies may have devolved varying amounts of authority to these bodies to establish curricula and provide education. These bodies do not have any substantive role in the professional line of accountability for the trained and registered professional.

Following the line of professional accountability back to government there is no link to the public. Although the public have an authority over government no real accountability for professional self-regulation is directly exercised this way. Few people know that government controls the scope of professional self-regulation by statute. Indeed, the link between Westminster and the professional regulators has until recently been an unused line of authority. Only now as the government pushes for the modernisation of self-regulation has the threat of enforced changes to the rules of regulation been considered, and changes made to ensure that legislation could have a speedy passage through parliament.

The line between regulatory body and professional has always existed but the service between these two stations has lacked consistency. The system of accountability has been reactive and each professional body has different thresholds to justify suspension or de-registration. The mechanisms and rules of investigation are varied and operate slowly. Proposals for a more proactive role in monitoring the competence of professionals are now being developed for doctors. But as a whole the regulatory system does not work proactively

to protect the public. Instead it operates as backstop, enabling action to be taken after damage has been done.

The line of inspection

Figure 3 shows the central position of this new proposed line of accountability connecting health care organisations, individual clinical professionals and the powerful professional bodies for self-regulation and education. CHI will call chief executives and Trusts to account while co-ordinating standards with the professional bodies. In endorsing external national and comparative audits of hospital doctor performance it will ensure that both professional bodies and government are sharing common expectations.

The need to generate policy coherence amidst a complex pattern of accountabilities may have been seen as a problem and CHI as part of the solution. The Commission provides a short cut between Secretary of State and Trust chief executive, hospital doctor and professional opinion leader. The long line of administrative accountability has been effectively bypassed. CHI is well positioned to co-ordinate policy between the line of administrative accountability and professional accountability. For every policy aspiration, a policy pincer movement can now be applied with direct monitoring of Trusts and clinicians to a co-ordinated set of standards agreed by profession and politician. The Commission is potentially a key tool of government for driving and co-ordinating change.

Testing accountability and authority

As we travel down the administrative line of accountability, the use of explicit power changes from the wielding of political power, to that of performance management and line management. Tables showing the impact of new policy on accountability at all the levels of the administrative line are provided in figures 4 and 5.

Effective clinical governance will depend on the strength of this network of accountabilities. To be strong, an accountability needs to be legitimate. In other words it must be established upon a person, or an organisation, by someone with sufficient authority. To be effectively discharged the accountability must be accepted by the accountable person; who must have sufficient authority to deliver the necessary change.

Accountability at the levels of Government and NHS Executive have been legitimately established and current policy strengthens the explicit powers and mechanisms available to deliver change. However, as we progress down the 'ladder' of accountability there are four areas where different problems emerge:

1. for commissioning bodies current policy weakens accountability for clinical quality;
2. within Trusts all groups of staff need to build a stronger authority to ensure implementation; and
3. accountability to patients and the public is paid lip service but not truly thought through.

Figure 4: Impact of policy on administrative accountability

Accountability and explicit power	Policy impact
Public Democratic process ↑	Policy strengthens the public's ability to judge the service by generating the following information: • the national patients and users survey; • the performance framework; • CHI reports; and • routine comparative audit. It is unclear how much information and in what form will be shared with the public or how the service might accommodate any desire for public choice on the basis of this information.
Government Political power ↑	Policy strengthens the government's ability to centrally manage quality improvement, by: • legitimising a central role for NICE; • placing a statutory duty on chief executives; and • establishing control over direct health care inspection (via CHI).
Executive Performance Managment ↑	Policy strengthens the executive's ability to manage quality in the service, by: • legitimising a central role in service guidance through NICE; and • establishing the regional office role in direct performance management of Trust quality. It is unclear what access the executive will have to CHI results and what role they might have in response to CHI visits.
Commissioners	Policy *weakens* the position of the commissioning body: • structural transition during PCG/T development means uncertainty about the commissioner role; • the move to direct provider responsibility for quality could undermine commissioner role in management of Trust quality; and • establishing regional offices as direct performance managers of Trust quality could dilute the formal role of commissioners in standard setting and monitoring of clinical quality.

Figure 5: Impact of policy on accountability within Trusts

Accountability and explicit power	Policy impact
Health care providers Line management	Policy strengthens accountability through the statutory duty and the role of CHI but fails to increase explicit power to help with implementation. Success will depend on local and national moves to strengthen the implicit power and overall authority of chief executives and boards including: • establishing a local 'accountability culture'; • the role of CHI in strengthening the hand of Trust boards; and • the outcome of new arrangements for self regulation that might align professional accountability with management objectives on the assurance of clinical quality.
Clinical teams Professional duty	Policy emphasises the importance of teamwork as the common unit of care and stresses professional responsibility to work across disciplines and organisations. However, there are no new proposals that will help establish accountability at this level of care.
Heath care professionals	Policy strengthens the hand of the organisation by legitimising systems of appraisal and input into resources used on education. The modernisation of self regulation and development of CHI might lead to alignment of professional and managerial accountability for the new quality agenda.
Patients	The policy strengthens the hand of patients by emphasising elements of public/patient partnership but crucially fails to provide any mechanisms for power or sanction to sit alongside accountability. Public perception of failing professionals and/or the media portrayal of such a perception may be important in strengthening the implicit power of managers and politicians to introduce change. Alternatively, such bad press might damage the collaborative work required for effective clinical governance.

Each of these problem areas is considered in turn.

Accountability arrangements between Trusts and commissioners

Commissioners were one main source of pressure on Trusts to deliver quality health care. Contracts, service reviews, and detailed specifications were all mechanisms for promoting, with a varied degree of success, the development of clinical quality. Health Authorities and particularly public health departments often took a role in the development of quality. The move to place the responsibility for clinical quality more squarely on the Trust within a more explicit framework of accountabilities to a host of local and national bodies diminishes the role of the local commissioner in directly promoting change. The new accountability framework surrounding a trust is illustrated in figure 6.

HAs used to set the quality agenda through audit contracts and monitor progress through their own mechanisms of performance management. Now the agenda is a national one and performance management is a regional task. Local commissioners will still influence quality through HImPs and a more clinically orientated perspective on commissioning from PCGs. But in some districts the Director of Public Health or the audit manager from the authority had been an effective voice in putting quality on the agenda. New policy weakens their position.

The main push for change will now come from Trust chief executives and the work of the new national bodies NICE and CHI. These bodies will translate government policy into Trust directives. However, with regional offices busy with the transition of HAs and fledgling PCGs and neither NICE or CHI up and running there is a danger that rather than being centrally controlled the development of clinical quality may slip. A chain of accountability is only as powerful as its weakest link and if the national and regional bodies become too distant to effect change then the success of this venture will rest with a local management system with diluted power and distracted by their own organisational transformation.

Accountability within Trusts

The central objective of the policy superstructure is to assure the quality of clinical care. Ultimately this has to be done by individual clinicians and clinical teams. The rest of the framework only has one purpose, which is to support and enable these individuals to reflect on their practice. But the closer we get to the sharing of accountability between clinicians and managers within a Trust, the less specific policy becomes.

Trusts consist of a board and chief executive, directorates or service groupings, clinical teams and individual clinical professionals. Chief executives and boards need to share their accountability with directorates or service groupings and, through them, with clinical teams and individual clinicians. Individual clinicians have professional accountability that requires them to reflect on the quality of their own work and to find ways of managing clinical quality within teams.

It is up to each Trust to find a way of establishing lines of accountability between these groups. However, testing the strength of these accountabilities produces a mixed picture. Explicit power to establish and deliver accountability is far from clear and the role of implicit power is a strong determinant of overall authority. An analysis of the balance of power and authority within Trusts is provided in figure 7.

Health care organisations rely upon collaboration, with professionals agreeing common objectives within a basic contract of co-operation. This is a culture where power wielded too fiercely or formally may lead to clinical staff withdrawing the co-operation upon which the service is run. The analysis provided in figure 7 illustrates how the authority of the different groups required to deliver effective clinical governance is often diluted. To strengthen accountabilities for clinical governance ways have to be found to support the authority of all groups to take on the challenge. Chief executives, clinical teams and individual clinicians need to be able to raise issues of quality and to make themselves and others accountable. Outside the organisation, a strong statutory duty, clear guidance from NICE, and constructive action planning as a result of CHI inspection could all help reinforce this power.

Support is required for the implicit power needed to boost the authority of each group to deliver effective clinical governance. The role of public and professional opinion is crucial here. Constant reinforcement of the priority given to this work by the public, the professionals and the politicians will enhance the authority to act. The rest will, to a large degree, depend on the sensitivity and organisational culture of the Trust. Effective participation and appropriate organisational and personal development are required to sustain change.

The challenge is a cultural one. Trusts have to change the joint expectations of the organisation and its common objectives to reflect an agreed focus on clinical quality for the sake of the patient. Many Trusts are treading carefully to maximise the chances for ownership and culture change. Actions that reinforce this message would help provide Trusts with the necessary authority to deliver change.

The problem of accountability to the public

There are a host of policy initiatives that in different ways attempt to develop the involvement of patients and public in the new NHS. These include the development of a new approach to the NHS charter, a further review of the NHS complaints procedures and an anticipated re-launch of the Patient Partnership Strategy. While patient and public involvement is recommended at all stages of the new framework for quality little attention is given to the numerous difficulties of integrating such work with other more clearly specified objectives. The problem of aligning accountability with real public involvement has not been addressed.

One of the central thrusts of the government's policy is to strengthen accountability for the delivery of an extensive, centrally determined, top-down agenda. Meaningful involvement of

Figure 6: The accountability framework for Trust clinical governance

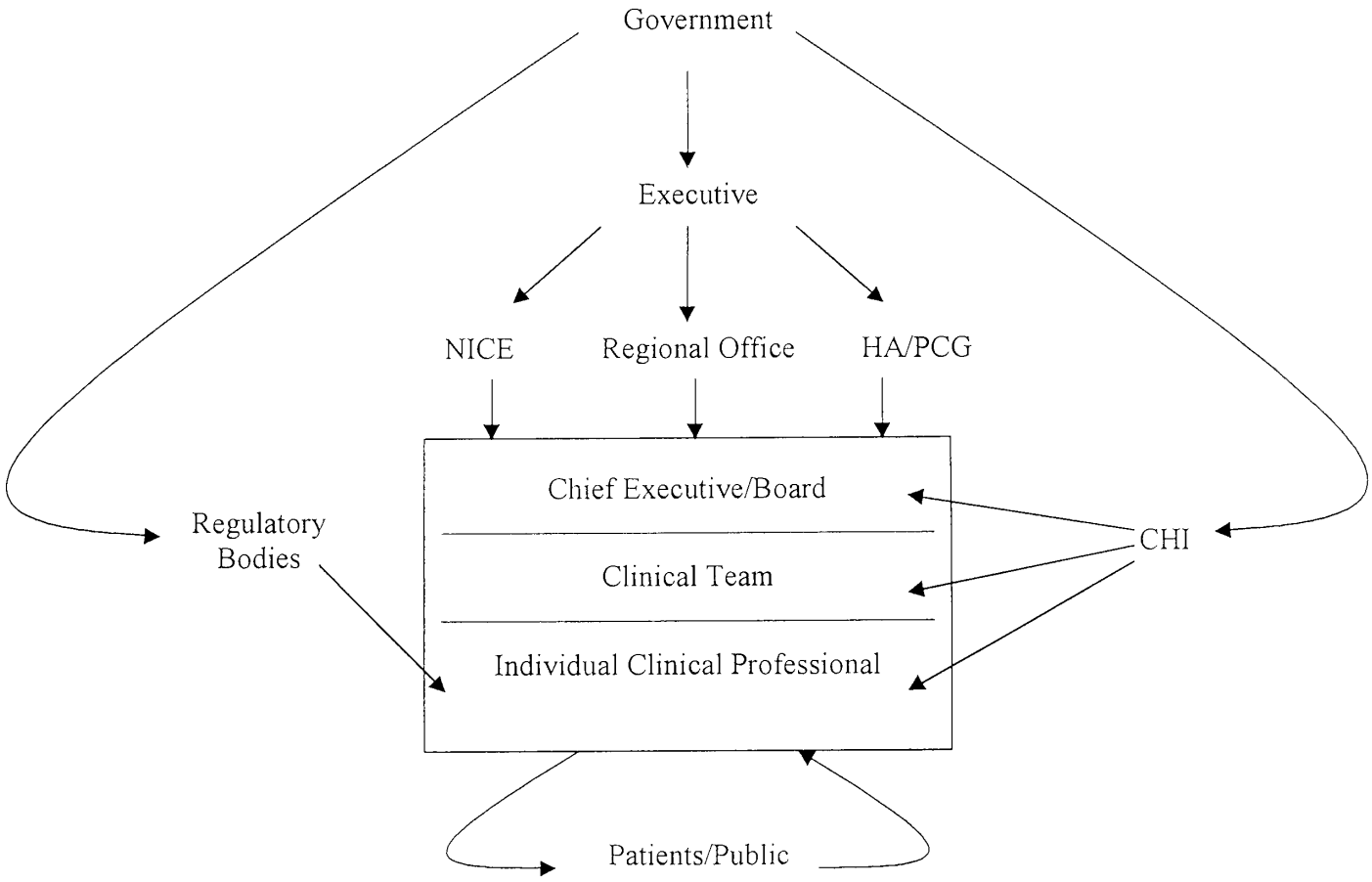


Figure 7: The authority underlying new accountabilities within Trusts

The three levels of clinical governance within a Trust	*Accountabilities*	*Task*	*Explicit power*	*Implicit power*	*Authority*
Chief Executive devolving responsibility to clinicians/clinical teams	Given accountability for clinical governance– statutory duty for quality	To establish shared accountabilities for clinical governance particularly with clinical teams	STRONG (see 1)	INCREASING (see 2)	MIXED (see 3)
Clinical teams taking joint accountability for quality with individual clinicians	*Lack of formal accountabilities on clinical teams despite their key role in clinical quality*	To establish arrangements for clinical governance at heart of everyday work	DEVELOPING (see 4)	DEVELOPING (see 4)	MIXED (see 4)
Individual clinical professionals building responsibilities within clinical teams	Given accountability for standards of professional practice	To be accountable for quality of own work and to find ways of managing clinical quality within clinical teams	WEAK (see 1)	STRONG (see 1)	MIXED (see 5)

1. Managers have explicit power as employer over clinical professionals as employees (Department of Health 1990, 1994). But professional groups have implicit power arising from strong representation and their central role in the organisation.
2. Strong professional groups hold substantial implicit power. However, the degree to which the government currently have public and professional opinion on side with the thrust of new policy is helping to strengthen the implicit power of chief executives.
3. Trusts have sought to increase authority by working on organisational ownership of clinical governance but the authority to share and deliver on these new accountabilities will vary according to the organisational culture.
4. The clinical governance task is often devolved even within directorates to clinical teams. Their authority to respond to the challenge varies. The explicit power of the clinical team to set and manage standards of care will need to develop if clinical governance is to be effective. This is the area where work on developing the capacity of the organisation should be focused.
5. The authority of clinicians to take on and deliver accountability for quality depends partly on the differing status of the different professions but also on the degree to which organisations will delegate power to change services alongside accountability for quality.

the public in quality management means the local NHS ceding the power to set local priorities and action. The rationale for this raft of policy development is that it is being done for the public on the public's behalf. However, the development of more effective systems of local involvement raises the prospect of a clash between priorities driven from the top-downwards and priorities that emerge from the 'bottom-up'. Such a clash would raise questions about the degree of real participation and power that it is intended to give to the public.

How are the conflicting priorities that may arise from meaningful public participation to be balanced with national directives? As the number of tasks increase the less likely it is that the different objectives arising from internal governance systems, national standard setting, and local priorities can all be accommodated. Something will have to give and the relative strengths of accountability to government, to the outputs of systematic clinical governance, and to genuine local involvement will be tested.

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