

REVIEW

Clinical governance and pathology

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This article looks at clinical governance and pathology. Clinical governance should be an important tool in seeking quality improvement within the National Health Service. But how as pathologists should we go about it?

also be two external bodies CHI(MP) and NICE, which will have responsibilities to reinforce and facilitate this pursuit of quality.

NICE (NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE)

This body is involved in the setting of healthcare standards, although some critics might argue it stands for "National Institute of Cost Effectiveness". Briefly, it aims to do the following:

- (1) Appraise various individual clinical interventions.
- (2) Compile certain evidence based treatment guidelines.
- (3) Highlight which new clinical developments are most likely to benefit patient care.
- (4) Facilitate the introduction of good value treatments throughout the NHS.
- (5) Look at any unacceptable variations in clinical practice.

CHIMP (COMMISSION FOR HEALTH IMPROVEMENT)

CHIMP, or as now seems to be the preferred acronym CHI, is responsible for the monitoring of the clinical standards proposed by NICE and also the National Service Frameworks. In addition, it should be responsible for the following:

- (1) Giving support where necessary to enhance quality standards.
- (2) Overseeing the NHS in improving quality.
- (3) Performing site visits every three to four years.
- (4) Investigating and, if necessary, intervening where quality appears to be compromised.

As pathologists where does this leave us and what should we do about clinical governance? The first question is easy to answer because we surely cannot be complacent regarding these new processes, particularly as they put quality of patient care on a central podium. In any case, clinical governance is mandatory, and if we do not participate the task will simply be done for us by others. After all, the high profiles given to Alder Hey, the Bristol Royal Infirmary paediatric cardiothoracic unit, and the Kent and Canterbury cancer screening services emphasise the public support for change in the provision of quality health care. The second part of the question is more tricky to answer because how does one get

We have recently witnessed an important change within the new National Health Service (NHS). There has been a shift from focusing upon activity, financial targets, and competition to seeking quality improvement within a framework of collaboration.¹⁻³ This change will come about mainly by clinical governance, which is a statutory duty throughout the NHS.

Although it is difficult to establish a definition of quality this could be taken as "doing the right things, for the right people, at the right time and doing them right first time".⁴ Clinical governance, in turn, can be defined as "a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".⁵ This can also be reworded as "a new initiative to ensure and improve clinical standards at local level throughout the NHS", and includes action to ensure that risks are avoided, adverse events are rapidly detected and investigated openly, and lessons are learned. Good practice should be readily disseminated and systems put in place to ensure continuous improvements in clinical care.⁶

The concept of clinical governance has been set up in the government's white paper entitled "The NHS: Modern and Dependable". Here, it is outlined how NHS organisations will be accountable for improving the quality of patient care.

There are varying facets of clinical governance, which broadly include quality improvement activities, identification and management of risk, personal accountability, and continuing professional development. The World Health Organisation's report of clinical governance usefully divides these quality issues into four major areas.⁷

- (1) Efficiency or resource use in the provision of health care.
- (2) Management of risk; that is, resulting from the service provided.
- (3) Patient satisfaction of the service provided.
- (4) Professional performance review.

National service frameworks have been set up to define the quality of care for various health conditions. One will be set up each year, with the initial ones being Heart Disease 1999, Elderly Care 2000, and Diabetes Mellitus 2001. There will

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Abbreviations: CHI(MP), Commission For Health Improvement; NHS, National Health Service; NICE, National Institute For Clinical Excellence

involved in clinical governance and make it work? In one sense, as pathologists we are probably one step ahead of many of our clinical colleagues because we have been monitoring the quality of our laboratory results by internal and external quality control (EQA) schemes for many years. Indeed, regional EQA schemes may feature strongly in clinical governance in pathology by potentially allowing laboratory result comparison.

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Furthermore, many of us work in accredited laboratories and eventually we may see accreditation of hospitals, primary care groups, and community providers. In this context, CPA accreditation may also have a large role in clinical governance of pathology laboratories. Let us explore further what we could do about clinical governance as pathologists.

Clinical governance requires an organisation wide transformation, with clinical leadership and a positive supportive organisational culture. Local self regulation by healthcare professionals is central to reducing poor performance. New approaches will be necessary to decide upon best clinical practice and how to utilise this to improve health care. We will need to learn not only from failures but also from the exemplars, thus shifting the mean of healthcare service provision by spreading good practice and sifting out the bad.⁸

The so called building blocks of clinical governance consist of:

- (1) Clinical audit.
- (2) Clinical risk management.
- (3) Quality assurance.
- (4) Clinical effectiveness.
- (5) Staff and organisational development.

Haslock has suggested that the introduction of clinical governance should be centred on the following: a structured analysis of present strengths and weaknesses, targeting this to everyday management and clinical structures. In this system, everyone involved should be supported in an atmosphere in which excellence can flourish, rather than simply developing mechanisms.⁹

As stated above, the reign of competition within the NHS has passed and instead has been superseded by an era of collaboration. Partnerships will become more relevant, such as those with patient groups, voluntary organisations, universities, and local authorities. We should anticipate an ethos of teamwork, which is open and participative, with excellent communication links and aligned goals. Clear lines of responsibility and accountability are central in providing a quality service. The trust chief executive will hold ultimate responsibility and a designated doctor, nurse, or other clinical professional will be appointed to ensure that the infrastructure is in place for clinical governance and its monitoring. There should also be regular reports to trust boards on the quality of care provided and reports to the NHS executive.¹⁰⁻¹³

A comprehensive programme to assess quality methods will also be essential. Clinical audit processes should be in place to ensure good practice and the evaluation of innovations and ideas. However, audit can fail if it is without proper participation, funding, or focus. In addition, is audit itself audited and what is the right amount of audit for pathologists to perform? If we take the definition of clinical governance above as basically “doing the right thing at the right time”, does that mean that as pathologists we should offer a round the clock, every day of the year service, supplying a full repertoire of tests?

There will be setting of standards in clinical care. In keeping with this there should be effective monitoring of clinical care,

with collection of information and excellent clinical record keeping. There will also be a shift towards evidence based medicine decisions in health policy and away from opinions alone. In view of this, one might expect greater importance attached to NHS research and development looking at service delivery and organisation. On a provocative note, would this lead to greater subspecialisation in pathology? For example should all tumour diagnoses be confirmed by a subspecialist? Alternatively, should all hospital chemical pathology laboratories have a medically qualified consultant member of staff to provide clinical advice?

Access by information technology to specialist databases, such as the Cochrane library, should be readily available to ensure the momentum of evidence based medicine.¹⁴⁻¹⁷ One challenge to us as pathologists may be that we should be leaders in producing an evidence base for attaining correct diagnoses because at present there is far more evidence base for the management of patients than for diagnostics.

Another challenge will be thorough and appropriate analysis of healthcare information that could allow clinical governance to be assessed. In conjunction with this will be the need for clear policies aimed at managing risks consisting of programmes to identify and reduce pitfalls. Amazingly, iatrogenic patient injury may be between 4% and 17%. Formal risk management protocols should be in place where analysis of such clinical incidents should centre more on organisational factors and less on individuals. Such analysis of incidents may be an efficient method of learning about healthcare organisational structure and may result in enhanced patient safety.¹⁸⁻¹⁹ This will need well trained staff and a conducive environment to work within. Appropriate guidelines and protocols for clinical performance will also increase and should not exist in a ghost written vacuum but be implemented.²⁰⁻²¹ The use of benchmarking will almost certainly increase. Here, comparison between different laboratories would occur regarding aspects of their work, including requesting patterns of clinicians using pathology services.²²

One of the most controversial, or at least most personal, changes will be that procedures should be in place aimed at identifying and remedying poor performance. Transparent complaints procedures, which are accessible to patients and their families, are needed. Lessons learnt from these will be important to reduce reoccurrence promptly.

There should also be fair disciplinary procedures that swiftly ensure that patients are not harmed and which also allow individuals to improve their performance if possible.

“Transparent complaints procedures, which are accessible to patients and their families, are needed”

Professional self regulation will be an essential element, according to the new NHS white paper, in the delivery of quality patient services and these should be open, responsive, publicly accountable, and provide feedback to participants. The medical school and postgraduate deans, Academy of Medical Royal Colleges, and the British Medical Association will all have roles in maintaining standards, with reporting to the relevant statutory bodies such as the General Medical Council.

The staff of a healthcare organisation will be crucial to the delivery of a quality healthcare service, and the following are important for this to be optimised: good staff recruitment, retention, training and development, and a valued workforce. We will be expected to participate in continuing professional development (CPD) programmes, such as that of the Royal College of Pathologists, be appraised, and be lifelong learners. High quality education and training are essential and various forms of clinical revalidation will be seen.²³⁻²⁶ Interactive learning programmes such as “Pathology Interactive” may be useful for pathologists with its core articles, multiple choice questions, and “Best Practice” series.²⁷

Not all are so optimistic, however, about the virtues of clinical governance.^{28,29} How committed will trusts, purchasers, and the government remain towards clinical governance? Scapegoats could be made when quality problems arise. Will sufficient funding be available and appropriate time allowed to execute governance requirements adequately? (It has been claimed that doctors implicating all the various systems necessary for clinical governance may have 10% less clinical work.) Tensions may also develop between clinicians and healthcare managers, and could innovation be stifled in a culture of clinical risk management? Furthermore, will clinical governance lack a clearly defined *modus operandi*?

Over the past 20 years, we have seen a gradual progression in the history of clinical governance. In the 1980s we saw resource management, soon followed in the 1990s by clinical audit, the patient's charter, and then clinical guidelines and effectiveness. I believe that almost without exception pathologists work hard to achieve the best results for their patients through clinical excellence. Clinical governance may itself metamorphose into something better, but its basic goal to increase patient care must be good and worth seeking. One commentator has written eloquently that clinical governance is in principle simple, and that it essentially relies on fruitful relationships between human beings in conjunction with common courtesies between patients and working colleagues.³⁰ That to me seems a good starting point.

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REFERENCES

- 1 **NHS Executive.** *The new NHS modern, dependable.* London: HMSO, 1997.
- 2 **NHS Executive.** *A first class service.* London: HMSO, 1998.
- 3 **NHS Executive.** *Clinical governance; quality in the new NHS.* London: HMSO, 1999.
- 4 **Donaldson LJ.** Clinical governance. *Health Care* 1998;**7**(suppl):S37-44.
- 5 **Scally G, Donaldson LJ.** Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998;**317**:61-5.
- 6 **Cook R.** Picture in profile. *Health Service Journal* 1998, 9 July:26-7.
- 7 **World Health Organisation.** *The principles of quality assurance.* Copenhagen: WHO, 1983.
- 8 **Donaldson Li.** Clinical governance: a statutory duty for quality improvement. *J Epidemiol Community Health* 1998;**52**:73-4.
- 9 **Haslock I.** Introducing clinical governance in an acute trust. *Hospital Medicine* 1999;**60**:744-7.
- 10 **Koek C.** Time for organisational development in healthcare organisations. *BMJ* 1998;**317**:1267-8.
- 11 **Baker R, Lakhani M, Fraser R, et al.** A model for clinical governance in primary care groups. *BMJ* 1999;**318**:779-83.
- 12 **Campbell J, Proctor S.** *What clinical governance will mean for GPs.* 1999 Guidelines in Practice. 2.1.
- 13 **Goodman NW.** Clinical governance. *BMJ* 1999;**317**:1725-7.
- 14 **Bloor K, Maynard A.** *Clinical governance: clinician, heal thyself. Management policy in the new NHS.* 1998. The Institute of Health Services Management.
- 15 **Ayres P.** Clinical governance: setting the scene. *Hospital Medicine* 1999;**60**:505-8.
- 16 **Sackett DL, Haynes RB.** On the need for evidence based medicine. *Evidence Based Medicine* 1995;**1**:5-6.
- 17 **Evidence Based Medicine Working Group.** Evidence based medicine: a new approach to teaching the practice of medicine. *JAMA* 1992;**268**:2420-5.
- 18 **Vincent C, Taylor-Adams S, Stanhope N.** Framework for analysing risk and safety in clinical medicine. *BMJ* 1998;**316**:1154-7.
- 19 **Vincent C, Taylor-Adams S, Chapman E, et al.** How to investigate and analyse clinical incidents: clinical risk unit and association of litigation and risk management protocol. *BMJ* 2000;**320**:777-81.
- 20 **Hill P.** Clinical governance: an educational perspective. *Hospital Medicine* 1999;**60**:596-8.
- 21 **Davies DA, Thomas MA, Oxman AD, et al.** Evidence for the effectiveness of CME: a review of 50 randomised controlled trials. *JAMA* 1992;**268**:1111-17.
- 22 **Smellie WSA, Galloway MJ, Chinn D.** Benchmarking general practice use of pathology services: a model for monitoring change. *J Clin Pathol* 2000;**53**:476-80.
- 23 **Lakhani M.** Ten questions about clinical governance. *Audit Trends* 1999;**7**:2-5.
- 24 **Kleijnen J, Bosel G.** Guidelines and quality of clinical services in the new NHS. *BMJ* 1998;**316**:299-300.
- 25 **Ayres P, Wright J, Donaldson LJ.** Achieving clinical effectiveness: the new world of clinical governance. *Clinician in Management* 1996;**7**:106-11.
- 26 **Du Boulay C.** From CME to CPD: getting better at getting better. *BMJ* 2000;**320**:393-4.
- 27 **Holzel H, Van Diest P, Heard S.** Continuing professional development; is the future Pathology Interactive? *J Clin Pathol* 1999;**52**:401-2.
- 28 **Black N.** Clinical governance: fine words or action? *BMJ* 1998;**316**:297-98.
- 29 **Sandeman DR.** Will clinical governance make a difference? *BMJ* 1999;**318**:1085.
- 30 **Watkins P.** Clinical governance. *J R Coll Physicians Lond* 1999;**33**:201.



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