Quality in Primary Care (2003) 11: 147–54 © 2003 Radcliffe Medical Press

Debate

The impact of CHI: evidence from Wales

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ABSTRACT

The Commission for Health Improvement (CHI) recently published an overview of 175 clinical governance reviews that suggests that it is having little impact on the NHS. This paper overviews the content and context of CHI's message to trusts in an attempt to shed some light on why this may be so.

Content is examined through an overview of policy documents. We deduce that CHI's message is strong on the individual elements of clinical governance but lacks a framework to integrate these elements where it matters most, the individual clinical unit.

Context is examined using survey and focus group data from six Welsh trusts in 2000. The data indicate that the various professional groups in Welsh trusts have very different experience with, understandings of, and evaluations of, clinical governance. Further, each professional group's evaluation is influenced by its professional culture and stances on key issues of the modernisation agenda.

The paper argues that, to be more effective, CHI needs to increase its awareness of how staff perceive and evaluate clinical governance and be clearer about the specific changes in practices and cultures it is seeking to promote.

Keywords: clinical governance, Commission for Health Improvement, evaluation, Wales

Introduction

The Commission for Health Improvement (CHI) recently published an overview of 175 clinical governance reviews that suggests that it is having little impact on the NHS.[1] It described trusts as 'reactive', lacking organisationally coherent policies, with particular shortcomings in risk management, staff management, patient involvement and the use of information. Taking six Welsh trusts as an exemplar, this paper explores how both CHI's message and differences in staff perceptions of clinical governance may be contributing to these shortcomings.

Study sites and methods

This paper is informed by the results of three studies conducted in six trusts in Wales in 2000.[2] The first study comprised content analysis of trusts' clinical governance development plans, baseline assessments, annual reports and implementation reports. A study of professional cultures used a closed-ended questionnaire to map the stances of 695 randomly selected doctors, nurses and managerial professionals about:

- key healthcare issues
- strategies for dealing with resource issues

- interconnections between the clinical and resource dimensions of care
- the causes of clinical practice variation
- the formation of clinical standards
- clinical unit management
- clinical accountability and autonomy.

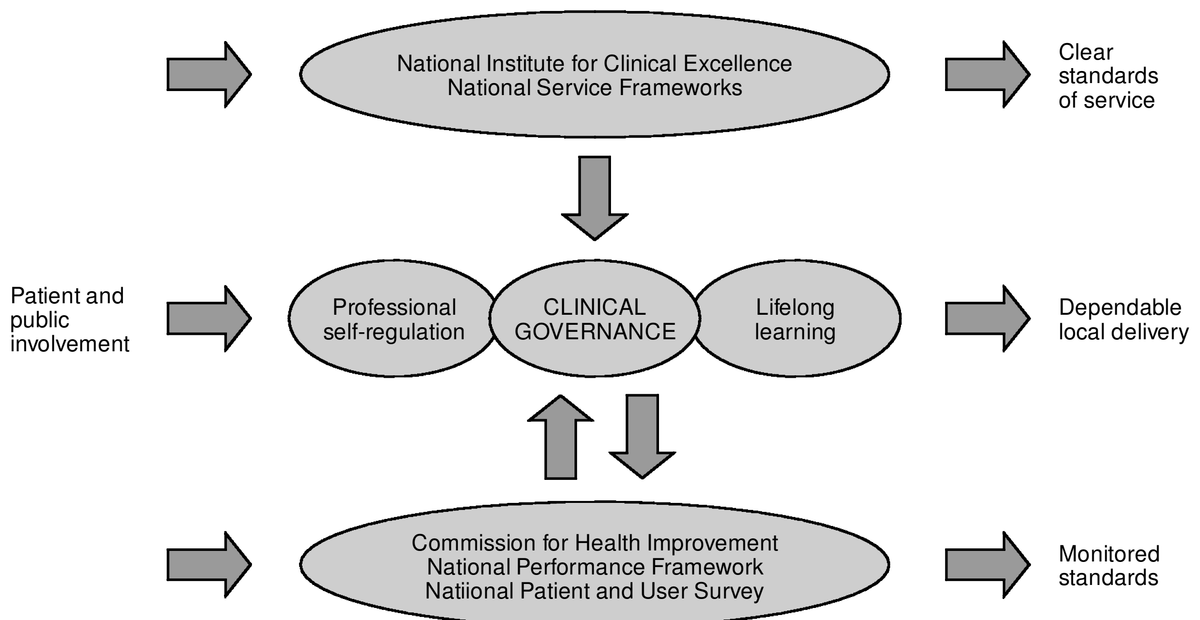
The third study used a convenience sample of 163 medical, nursing and managerial personnel to ascertain, by means of focus groups and a closed-ended questionnaire, their:

- perceptions of the objectives of clinical governance
- understanding of the components of clinical governance (clinical risk management, clinical audit, care pathways, patient involvement, etc)
- self-assessments of their knowledge and experience with those components of clinical governance
- perceptions of internal and external barriers to clinical governance
- assessments of how clinical governance initiatives would affect the clinical and organisational dimensions of care at the level of individual clinical units (e.g. an orthopaedics unit)
- perceptions of the likely outcomes of clinical governance.

CHI's message

Assessing CHI's impact on the NHS requires analysis of both the content of key messages sent by CHI and the context in which these messages occur. An understanding of content is provided by an analysis of CHI documents. An understanding of the context in which these messages are sent is derived from a study of the cultural predispositions of healthcare staff.

Policy documents depict CHI (see Figure 1) as performing both advisory and inspectorial functions in its role as regulator of trusts' efforts in implementing clinical governance, National Service Frameworks (NSFs) and National Institute for Clinical Excellence (NICE) guidance.[3,4] CHI defines clinical governance as a 'system of steps and procedures . . . to ensure that patients receive the highest possible quality of care' and seeks to provide 'national leadership on principles of clinical governance and to support those organisations having trouble setting up clinical governance principles locally'.[5–8] CHI provides very detailed advice on individual aspects of clinical governance such as risk management, clinical audit, clinical effectiveness, quality assurance and staff development, and on its formal arrangement at board level.



Source: Secretary of State for Health (1998) A First Class Service: quality in the new NHS. NHS Executive: London.
Reproduced in: Swage T (2000) Clinical Governance in Health Care Practice. Butterworth Heinemann: Oxford.

Figure 1 CHI's role in the health system

The same level of detail however is absent from its advice on how the components of clinical governance can be effectively integrated at the level where it matters most, i.e. within individual clinical settings such as an orthopaedics unit or obstetrics unit. This lack of detail is not surprising given that CHI's website summarises the integrative mechanisms of clinical governance by means of a question mark (see Figure 2).[9] It would appear that CHI itself does not know how this integration should occur. Though it may be argued that the current government provides guidance 'in principle' and devolves the outworking of those principles to those closer to the provision of care,[10] CHI's statutory obligations surely make the persistence of this absence unacceptable.

The effect of this and the emphasis on the individual components of clinical governance is seen in our study of the structures for clinical governance set up in the Welsh trusts. All trusts had a 'silo' structure such as that shown in Figure 3. These silo structures meet the formal arrangements required by government, but, by failing to integrate the components of clinical governance at the level at which clinical work is actually carried out, clinical governance becomes a managerial exercise with little direct clinical relevance. For example, it does not assist a urological team to monitor the efficiency, effectiveness and safety of care for patients undergoing transurethral prostatectomy. Nor does it help clinicians to identify and minimise the 59% of adverse events attributed to system errors in other western healthcare systems.[11–13]

Given this gap in its advisory and 'developmental' function, it is not surprising that responses in the focus groups showed that staff in the Welsh trusts saw CHI as having an exclusively inspectorial role. They saw it as an addition to other external inspection bodies such as the Audit Commission, Health Service Ombudsman and professional regulatory bodies. Paradoxically, they also expressed a great deal of confusion and uncertainty about the details of CHI's inspectorial processes and about the basis of findings contained in inspection reports.

Though anecdotal, these findings show how CHI's message is being interpreted by the very staff that should be central to effective clinical governance. Taken together, the above findings suggest the 'form' overtaking 'substance' in the future development of clinical governance – that managerial structures have been set up without real changes at the level at which clinical work is done.

The context

This does not imply that CHI's message is merely a product of what it does or does not do. The meaning of the message is also significantly affected by the cultural predispositions of the audience. This is illustrated by our findings in the study of professional cultures in Welsh trusts. In summary, these showed significant differences between professional groups in their willingness to accept four key themes (see Table 1) namely:

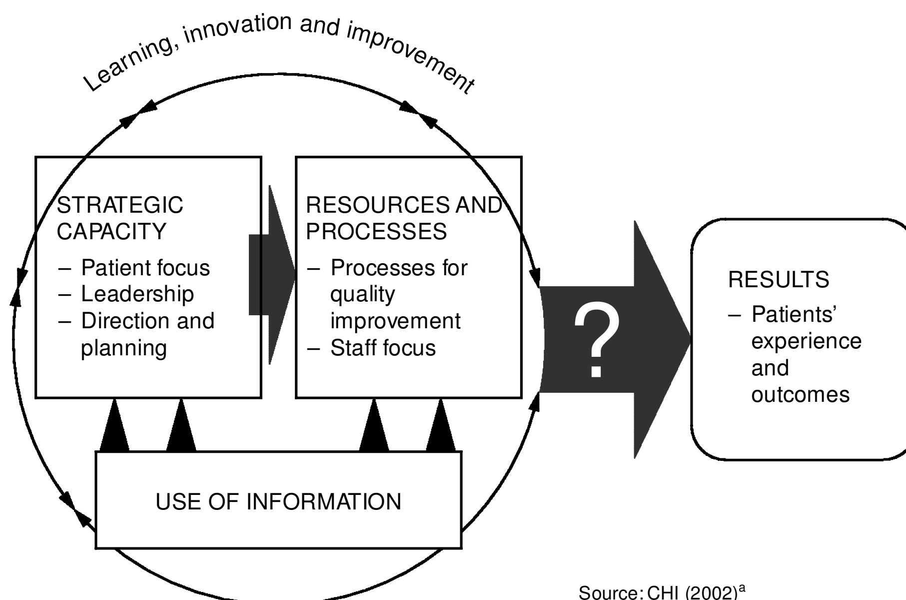


Figure 2 CHI's model for clinical governance

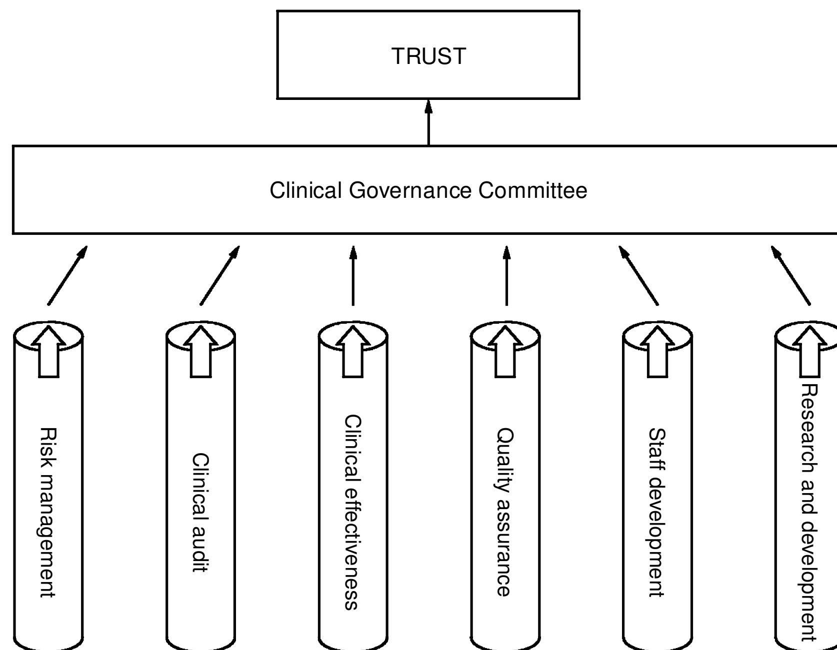


Figure 3 'Silo' organisational structure for clinical governance in Wales

- the recognition of interconnections between the clinical and resource dimensions of care
- a balance between autonomy and transparent accountability
- their participation in systematising clinical work (e.g. using clinical guidelines and care pathways)
- an acceptance that multidisciplinary and team-based approaches to service provision may lead to redistribution of power.

Discriminant analysis shows that the statistically significant differences ($P < 0.001$) in stances between the Welsh professional groups occur across two dimensions that together account for 93% of the variation in the data. These dimensions reflect differences between individualistic and systematised concepts of clinical work and differences between clinically divorced and work practice-centred approaches to reform. Each professional group's stance on these two dimensions is presented graphically in Figure 4.

These statistically significant and clinically relevant differences highlight issues that are likely to prove crucial to implementing both modernisation and clinical governance initiatives. For example, our focus group responses suggested that medical managers' support for individualistic concepts of clinical work ('clinical freedom') may lead them to ignore the thorny issues arising from medical individualism and question the use of more systematised approaches to clinical work (clinical guidelines, protocols, care pathways, etc).

Nurse managers, in contrast, are critical of medical individualism and strongly support more systematised approaches to clinical work. Their capacity to promote systematised care however seems to be compromised by:

- the dominance of doctors in clinical teams
- the fact that doctors and general managers generally marginalise nurses in the modernisation agenda
- their own (tentative) support for a medically ascendant model of clinical unit management.

Taken together with nurses' relative lack of status, this implies that nurse managers' strengths in promoting and implementing alternative models of clinical governance mostly go under-recognised and under-used.

This, in part, explains general management's support for clinically divorced and externally driven approaches to reform. Put simply, in the absence of clinical leadership from either doctors or nurses, and in the face of the top-down reporting requirements imposed on them by government, general managers limit themselves to 'blunt instruments' such as the imposition of budgetary constraints and/or performance management systems to encourage clinical practice change. This means that medical managers avoid addressing issues that transgress traditional medical culture, for example, models of clinical unit management that focus on systematising clinical work.

This situation is not without cost. The focus group

Table 1 How acute and community care professional groups in Wales evaluate issues central to modernisation and clinical governance

Reform agenda items	Medical clinicians	Medical managers	General managers	Nurse managers	Nurse clinicians
Recognise interconnections between the clinical and resource dimensions of care	Deny	**Strongly recognise**	**Strongly recognise**	Deny	Strongly deny
Balance autonomy with transparent accountability	Strongly reject	**Agree**	**Strongly agree**	**Agree**	Reject
Systematise clinical work	Reject	Strongly reject	**Agree**	**Agree**	**Agree**
Accept the power redistribution effects of multidisciplinary teams	Strongly reject	Strongly reject	**Weakly agree**	**Agree**	**Agree**

Responses in bold are in accordance with the direction of reform

results indicate that some frontline medical and nurse clinicians (in particular) are interpreting the reluctance of general and medical managers to support the systematisation of care as signifying a lack of commitment to 'follow through' on important quality issues. This, when combined with the very obvious work fatigue and change overload among study participants, seems to be fuelling a widespread disenchantment about the capacity and/or concern of managers for real change. Importantly, the data suggest that CHI and its clinical governance initiatives are not immune from this disaffection.

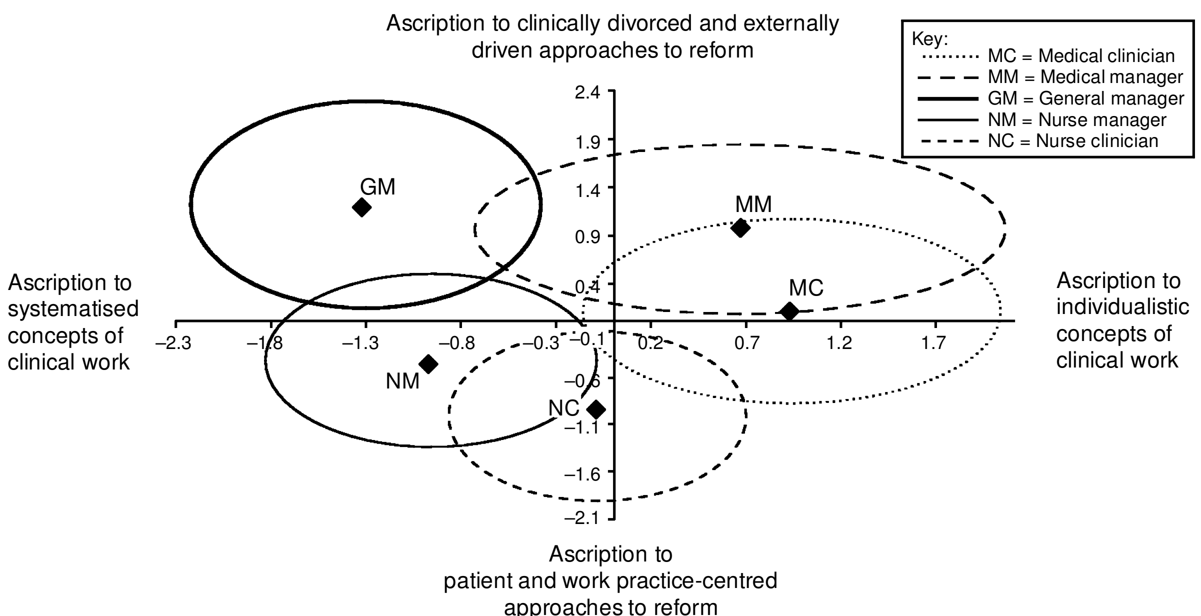


Figure 4 Profiles of professional subcultures in Wales

Perceptions and evaluations of clinical governance

Content analysis of focus group discussions showed that, of all staff, nurse managers are most familiar with, and experienced in, the components of clinical governance. This is reflected in professional groups' responses in the questionnaire on clinical governance. Discriminant analysis showed that the responses differ on four dimensions, two of which account for 78% of the variance. These two dimensions, evaluations of clinical governance and its actual realisability, are illustrated in Figure 5.

The figure shows that in Wales:

- medical clinicians regard clinical governance as a baleful management intrusion and are indifferent about its capacity for enhancing clinicians' capacity for quality improvement-oriented change
- medical managers also see clinical governance as a baleful management intrusion and do not believe that it would enhance clinicians' capacity for quality improvement-oriented change
- general managers regard clinical governance as a positive clinical improvement strategy but do not believe that would enhance clinicians' capacity for quality improvement-oriented change
- nurse managers strongly believe that clinical governance is a positive clinical improvement strategy and also believe that it will enhance clinicians' capacity for quality improvement-oriented change
- nurse clinicians are indifferent to clinical governance's status as either a positive clinical improvement strategy or a baleful management intrusion but to some degree believe it would enhance clinicians' capacity for quality improvement-oriented change.

Interactions between professional subcultures and evaluations of clinical governance

Interconnections between profession-based cultural attitudes and respondents' perceptions and evaluations of clinical governance are suggested in Figure 6.

In particular, the figure suggests interconnections in the Welsh trusts between:

- general managers' and medical managers' support for clinically divorced and externally driven approaches to reform, and their evaluation of clinical governance as an unrealisable strategy for enhancing clinicians' capacity for quality improvement-oriented change
- nurse managers' support for patient- and work practice-centred approaches to reform and their evaluation of clinical governance as a realisable strategy for enhancing clinicians' capacity for quality improvement-oriented change; their commitment to systematised concepts of clinical work and their tendency to view clinical governance as a positive clinical improvement strategy
- medical clinicians' and medical managers' individualistic concepts of clinical work and their

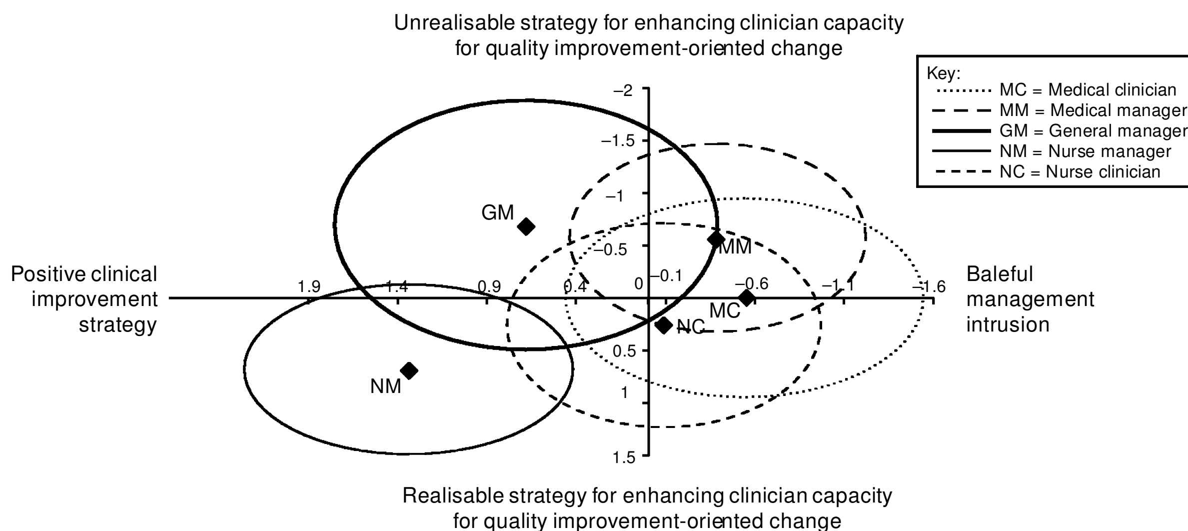


Figure 5 Evaluations of clinical governance by professional groups in Wales

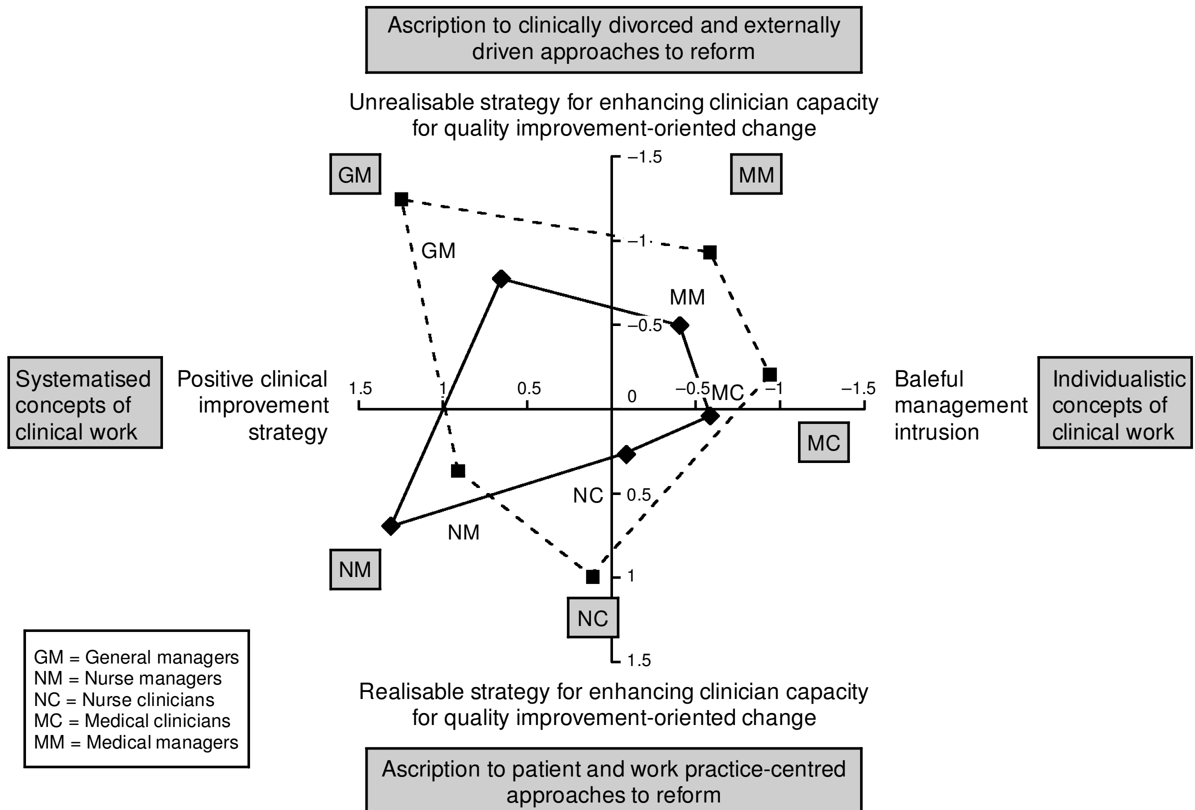


Figure 6 Comparison of similarities between profession-based cultural stances and assessments of clinical governance

tendency to view clinical governance as a baleful management intrusion
- nurse clinicians' commitment to patient- and work practice-centred approaches to reform and their tendency to view clinical governance as a realisable quality improvement strategy.

In summary:

- general and medical managers seem to believe that top-down managerial change works but are sceptical that clinical governance will make a real difference
- nurse managers seem to believe that clinical governance is a good thing and will actually work
- medical managers and clinicians see clinical governance as a real threat to their professional freedom.

The findings suggest that clinical governance is being enacted largely in a managerial world and in ways that alienate clinicians. The existing model of clinical governance ignores the culture changes that clinical governance is meant to address. These cultural attitudes, when combined with the distrust and cynicism generated by previous centrally sponsored reform initiatives (such as drives on budget efficiency and waiting lists), mean that those with responsibility for clinical governance tend to resort to a top-down managerial approach. The result is, as we have seen, an exercise in form rather than substance (Figure 7).

Conclusion

Given the known difficulty of culture change, these results suggest that a more proactive approach to clinical governance will depend on the extent to which change agents, including CHI, are clear about:

- structures and practices that are consistent at the clinical level with the goals of clinical governance
- specific changes in culture that they are seeking to promote.

More specifically, change agents and policy authorities need to recognise and understand the ingrained profession-based subcultures that affect relationships within clinical settings. Against this background they need to promote organisational models of clinical governance that are both clinical product-focused and that provide structures for realising 'responsible autonomy' as an organising principle in clinical work management.

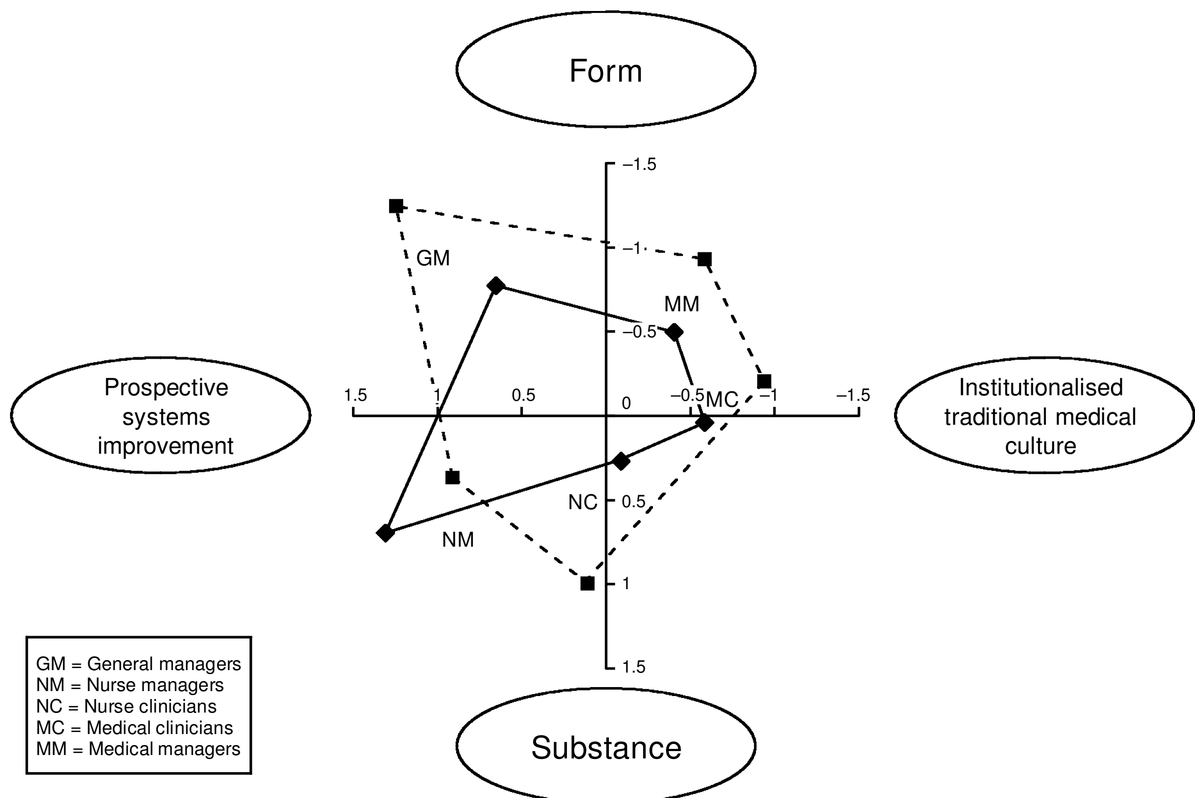


Figure 7 The stalemate in clinical governance implementation

ACKNOWLEDGEMENTS

The study of six NHS trusts in Wales was supported by a grant from the Welsh Office of Research and Development.

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Accepted April 2003