

Editorial

Setting objectives for clinical governance

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Editor

Every time I or another patient asked for help the answer was always the same, 'somebody else is responsible for you'. I'm sure that if staff had given the service asked for instead of looking for the 'right person', both the patients and the hospital would have saved time and frustration.¹

After a recent holiday, I returned to the rigours of general practice with eager anticipation. Amongst the many patients that I saw that day, I observed a pattern. I felt a dissonance between the rhetoric and reality of quality. The quotation above aptly captures the essence of the stories I heard – about patients' experience of healthcare. There are too many examples but here are a few that made me reflect on quality of healthcare.

My first patient was someone whom I had admitted with a suspected severe adverse drug reaction. He had been discharged and I had a sketchy discharge summary; the patient had numerous questions, as did I, the information available did not allow me to do a proper management plan. It ended with the almost gratuitous comment 'they didn't tell me anything in hospital doctor . . . should I go back on my medication?'

The next patient I had to deal with was to assume responsibility for the management of warfarin, which had not yet stabilised. This posed many questions about effective clinical management of warfarin, including the monitoring, at the interface between primary and secondary care – a question of patient safety which is an important and emerging science in quality.² Studies identified that medical error occurs between five and 80 times per 100 000 consultations, mainly related to the processes involved in diagnosis and treatment. Prescribing and prescription errors have been identified to occur in up to 11% of all prescriptions, mainly related to errors in dose. This was an issue of sufficient importance to be front-page news in *The Times* newspaper in the UK.³

I then had to see a family in which there had been a sudden and unexpected death of a patient with epilepsy – a well-recognised problem. I felt the urge to conduct a significant event audit – a good method for learning and changing practice. By coincidence I saw a family of another patient, following an admission for status epilepticus. I was struck by the

only comment made by the patient's representative which was to do with the number of times they had had to repeat their story in hospital.

In primary care itself, the big issue for today is co-morbidity. I saw a patient with advanced, chronic and complex rheumatoid arthritis. I noted a rise in her high blood pressure, also diagnosed osteoporosis and undertook therapeutic drug monitoring. I read a news item that suggested that hypertension is often under-diagnosed in people with rheumatoid arthritis. I predict that one key issue for quality in the future is dealing with the complexity of co-morbidity.

In the UK, vertical integration of care is virtually unknown – that is specialists and generalists working in the same teams. Almost all patients come to their primary healthcare team after discharge from hospital, for support and explanation.

What is the importance of these observations? How much do they matter? And to whom do they matter?

I very much doubt whether clinical governance currently captures the essence of any of these, and it made me think about the correct objectives for clinical governance. Are we measuring the right things? What is the focus for measurement, in clinical governance? The person at the receiving end was undoubtedly the patient, sometimes experiencing discontinuity of care and anxiety. It therefore seems to me that to be serious about quality we have to capture these patient experiences.

The issues of concern to patients do not feature strongly in operational clinical governance – this is ironic as patient involvement in the health service is a central plank of NHS policy. This is disappointing given the very powerful contribution and resources that patients can bring to healthcare.⁴ Someone suggested to me recently that maybe we should give clinical guidelines to patients to effect change from their clinicians! A major deficit has been the lack of any meaningful measurements of quality in commissioning and provision of services.

Who and how are objectives set for clinical governance? Will the tide turn also against centralised targets as it has done in education where we have witnessed an about turn in the policy on the 'three Ts'

– tests, targets and tables?⁵ The emphasis now is on standard setting in local educational communities. This new policy, of local standard setting, has the alluring title: ‘Excellence and Enjoyment’!

I have reached the following conclusions in reflecting on my experience: There are limits to clinical governance. Patient issues and concerns are often not captured in routine measurement that is undertaken in clinical governance. The target philosophy may be distorting the development of culture that enables excellence. A key area for refinement is to address the quality of patient experience across the multiple interfaces and integrate this into the commissioning of clinical services.

Almost all clinicians will identify an aspiration to even higher clinical standards. Most will agree that there is much more we can do, yet how do we engage clinicians, particularly doctors, in motivational and inspirational quality improvement? As doctors are to be given more say in the direction of the NHS, perhaps it is time to borrow from other public sectors the philosophy of ‘excellence and enjoyment’.³ We need to move away from something that is cold and bureaucratic to something that is creative and inspirational. Devolving quality to local health

communities centred on clinical networks would be a promising approach to try, particularly with strong collaboration between professionals and the NHS. With this we can start to tackle personal and system discontinuity, an issue that should be a strategic priority in clinical governance.

REFERENCES

- 1 Krogstad U, Hofoss D and Hjortdahl P (2002) Continuity of hospital care: beyond the question of personal contact. *British Medical Journal* **324**: 36–8.
- 2 Sandars J and Esmail A (2003) The frequency and nature of medical error in primary care: understanding the diversity across studies. *Family Practice* **20**: 231–6.
- 3 GPs get it wrong 2.8m times per year. *The Times*. Wednesday 21 May 2003: www.timesonline.co.uk (accessed 21 May 2003).
- 4 Muir Gray J (2002) *The Resourceful Patient*. eRosetta Press: Oxford. www.resourcefulpatient.org/ (accessed 21 May 2003).
- 5 Department for Education and Skills (2003) *Excellence and Enjoyment: a strategy for primary schools*. DFES: London. www.dfes.gov.uk/pns/DisplayPN.cgi?pn_id=2003_0095 (accessed 20 May 2003).