The development of clinical governance in the UK: its implications for rehabilitation medicine*

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ABSTRACT – Clinical governance has been introduced in the UK as a mechanism to improve the quality of health services, and the professional performance of clinicians. Specialist societies have a pivotal role to play in developing systems to support its implementation in clinical practice. Rehabilitation medicine is a specialty characterised by closely integrated interdisciplinary teamwork. The particular issues that this poses for clinical governance may also be relevant to other specialities. This paper presents an overview of the development of audit and clinical governance procedures in the UK and their specific implications for rehabilitation medicine. It also summarises the work undertaken to date by the British Society for Rehabilitation Medicine towards implementation of clinical governance, to improve the quality of care offered to patients.

KEY WORDS: clinical audit, clinical governance, clinical standards, rehabilitation medicine

Clinical governance in the UK

Throughout the 1990s, clinical audit was the hallmark of quality assurance in the UK. Essential features of clinical audit were the systematic assessment of clinical practice, against agreed standards, to ensure the best quality of care. Implementation of change was then followed by re-audit to complete the audit cycle.

However, audit had no real teeth. There was no statutory duty applicable to NHS hospital trusts with respect to quality of care. In a competitive open-market health system, the only statutory requirement for hospital managers was to maintain financial balance. In 1998, the UK Government introduced reforms for 'modernisation'.¹ Clinical governance was the framework through which NHS organisations would be 'accountable for continuously improving the quality of their services'. The audit cycle became the audit *spiral* (Fig 1),² and hospital trust boards now had statutory responsibility for the *quality* of services, as well as financial management.³

Nationally agreed standards and guidelines

A central tenet of clinical governance is the elimination of unnecessary variation in practice. 'Benchmarking' is now required against nationally agreed standards which are based on research evidence or consensus of widely gathered expert opinion.

The terms 'standards' and 'guidelines' are sometimes used interchangeably, but this is incorrect. *Standards* define the quality of service delivery, while *guidelines* provide guidance to the clinician for individual patient care. A 'standard' is therefore interpreted at the level of a population, while a 'guideline' is interpreted at the level of the individual. Nevertheless there is a close relationship between the two, illustrated in Box 1.⁴

If guidelines are to become 'compulsory' practice, the advice must be correct and up to date. Guideline developers carry a major responsibility and the process must be meticulous. In the UK, the Scottish Intercollegiate Guidelines Network (SIGN) pioneered guideline development with a rigorous system of gathering and evaluating evidence, achieving consensus through consultation of stakeholders, and regular updating of the published

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Key Points

Audit and clinical governance have evolved in the UK over the last decade, with increasing emphasis on national standards and guidelines

Assessment of personal performance poses particular problems for rehabilitation doctors who work as an integral part of an interdisciplinary team – their role is likened to that of the conductor of an orchestra, as opposed to an instrumental soloist

Multiprofessional 360° appraisal is being explored as a mechanism for confirming fitness to practise, but is not universally embraced

The BSRM has been active in the development of standards and guidelines for specialist rehabilitation services, both in hospital and community settings

Common language outcome measures are required, but should not detract from the identification and pursuit of individual goals determined by patients and their family/carers

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guideline. More recently, the National Institute of Clinical Excellence (NICE) together with its six National Collaborating Centres (NCCs) has adopted a similar brief in England. An instrument for assessing the quality of guidelines, the Appraisal of Guidelines Research and Evaluation (AGREE) tool, has been developed and validated.⁵ Scores are given to items in six domains (see Table 1).

Implementation of guidelines – pathways and protocols

Evidence-based practice is a laudable aim, but poses a major challenge for implementation at the bedside. A plethora of guidelines, some of them contradictory, besieges the clinician, leaving little room for sensible and considered clinical judgement. In the heat of the moment, it may be hard to recall even that the guideline exists, let alone what it recommends. Wherever possible, therefore, guidelines should be supported by tools for implementation.

Integrated care pathways (ICPs) with proforma documentation offer a means not only of prompting the clinician in the application of guidelines, but also of providing an audit trail for assessing whether the guidelines were followed, and recording variance and the reasons for it. Systematically recorded, they also supply a means to determine whether the 'evidence' gathered from the somewhat rarified confines of the clinical trial is borne out when translated into the messy realities of everyday NHS life, with its unselected populations and non-standardised conditions.

Professional performance

Clinical governance also challenges poor performance through regular appraisal and assessment. Clinical risk systems will monitor complaints and adverse incidents, but it is not enough

simply to keep out of trouble. A system of appraisal and assessment has now been introduced for all doctors in the UK.⁶ The General Medical Council (GMC) has laid down plans for the process of revalidation in three stages:

- 1 **A personal folder** will be kept up to date and reviewed in the **annual appraisal**.
- 2 **Periodic revalidation** will take place at five-yearly intervals; the accumulated folder will be reviewed by a group of lay and medical people, who recommend either that the doctor remains fit to practise, or that his/her registration should be reviewed by the GMC.
- 3 **Action by the GMC** will either be revalidation of the doctor's entry on the GMC register, or detailed investigation which may lead to restrictions on practice, suspension or erasure.

The Medical Colleges, which oversee training and continued medical education, define those criteria on which assessment of the doctor is based. The specialist societies advise on the particular skills and knowledge required to practise effectively in the field.

Clinical governance in rehabilitation medicine

In the USA, payer-driven care has been a fact of life for much longer than in the UK, and most purchasers require that a rehabilitation facility is accredited before contracting for its services. The Commission on Accreditation of Rehabilitation Facilities (CARF) increasingly focuses on outcome-orientated standards, rather than on the quality of process alone.⁷ In Australia, the Australian Council of Healthcare Standards has set standards for brain injury rehabilitation services,⁸ and in Europe, a task-force of the European Federation of Neurological Societies (EFNS) has developed minimum standards for neurological rehabilitation.⁹ Within the UK, the development of monitored systems for

Fig 1 The audit spiral.
The audit spiral denotes a process by which repeated cycles of assessment, implementation of change, re-audit and further change produce continuous improvement in the quality of care.

Box I. Example of a guideline and its respective standard in relation to thrombolysis for stroke.

Guideline	'Aspirin should be given as soon as possible after the onset of stroke symptoms, if a diagnosis of heamorrhage is unlikely.'
Standard	'All cases of ischaemic stroke should be treated with aspirin within five days of stroke or the reasons for variance recorded.'

Source: Royal College of Physicians' *National Guidelines for Stroke*.⁴

audit and clinical governance has slowly gathered momentum. Clinical standards have been defined, but as yet there is no central system for accreditation of rehabilitation services.

Work to date in the UK

A summary of the work undertaken by the British Society of Rehabilitation Medicine (BSRM) towards implementation of clinical governance in rehabilitation medicine has been published recently.¹⁰ This includes:

- 1 development of nationally agreed standards and guidelines
- 2 outcome evaluation – establishment of a 'basket' of recommended outcome measures
- 3 a system of peer review for rehabilitation services
- 4 recommendations for professional appraisal systems.

Some of the issues may have relevance for other fields of medical practice.

Table 1. The six domains of the AGREE instrument.

Domain	Description of criteria
1 Scope and purpose	Objectives, clinical questions and patients to whom the guidelines apply are specifically described
2 Stakeholder involvement	Development group includes professionals from all the relevant groups and patients' views are sought
3 Rigour of development	The guidelines are based on systematic literature review with explicit links between the recommendations and supporting evidence, and are methodologically sound
4 Clarity and presentation	The recommendations are clear, specific and unambiguous
5 Applicability	Supported by tools for application (eg protocols) The target users are clearly defined and organisational barriers to implementation have been discussed
6 Editorial independence	The guidelines are editorially independent from the funding body. Conflicts of interest of guideline have been recorded.

For a more detailed description of the criteria for assessment under each domain, see the AGREE Collaboration website: www.agreecollaboration.org

Standards for rehabilitation services

Nationally agreed standards have been published by the BSRM for specialist inpatient,¹¹ and outpatient and community rehabilitation services.¹² They address the following areas:

- service provision and organisation
- staffing (numbers and experience) and staff training/development
- the process and coordination of assessment, rehabilitation and discharge planning
- liaison and integration with other services
- documentation and outcome assessment.

Standard development was preceded by a critical evaluation of the literature to gather the evidence for effectiveness of rehabilitation and its various components.¹³ In most areas, there was little hard research evidence to guide individual standards. Instead, they rested heavily on expert opinion and consensus. The standards were modelled on those developed initially by a process of very wide consultation.¹⁴ Consensus was then achieved through a three-round Delphi survey, and finally a national survey was conducted among the BSRM membership to assess the extent to which each standard was currently met.

There was considerable debate within the BSRM as to whether standards should be 'minimum' or 'desirable' standards. 'Minimum' standards could engender a false sense of security. 'Desirable' standards may be harder to achieve, but may provide a strong argument for the allocation of adequate resources. In the interest of maintaining the best possible quality of service for patients, a set of desirable standards was developed, but with recognition that not all of them will be appropriate to every service and setting. Instead, each service will identify:

- 1 standards to which they expect to conform at the current time
- 2 standards to which they aspire, given appropriate staff and resources
- 3 standards which they believe to be irrelevant or unachievable by their service.

National surveys may help to guide this choice by providing information on how many other services meet each standard.

Guidelines for clinical practice

Development of specific guidelines for clinical practice poses a significant challenge in rehabilitation medicine because of the heterogeneity of condition, approach and goals, which vary enormously from patient to patient. Nevertheless, clinical guidelines have been developed for the use of botulinum toxin in the management of spasticity in adults.¹⁵ The summary guidelines have since been approved by the Royal College of Physicians as a National Collaborating Centre for NICE, and became the first of a series of short guidelines, to be published through that mechanism.¹⁶ Further guidelines are now in gestation, and the BSRM has drawn up procedures for guideline development which are closely modelled on the AGREE criteria.

Outcome evaluation

One of the major challenges remaining to rehabilitation medicine is how to measure outcome. In order to define and compare different programmes, practices and populations, we need standardised outcome measures. Unfortunately, there is no single measure which is simple enough for use in routine clinical practice and which will adequately describe all the different aspects of rehabilitation.

In the USA and Australia, routine collection and central collation of outcome data has become an essential requisite of purchasers, before the service will be paid for. In the UK, that approach has been resisted to date. There is anxiety about basing clinical decisions on 'quasi numbers' and population statistics, and planning rehabilitation around items on measurement tools. Instead, emphasis is placed on individually defined goal sets, determined wherever possible by patients and their families, and based on their own particular clinical needs and priorities.

Nevertheless, there is increasing pressure to demonstrate not only effectiveness but also cost effectiveness of rehabilitation. A common core set of information may be helpful for comparison, even if only to describe the population differences that present to different services. No single outcome measure can suit all situations but the BSRM has drawn up a 'basket' of preferred measures, published on its website (www.bsrm.org.uk). Criteria for inclusion in the basket are:

- published evidence of validity and/or reliability
- current use in routine clinical practice in at least ten units in the UK.

In reality, we may be closer to having a common language than we realise. A survey in 1997 demonstrated that 95% of

units which used at least one measure in the course of routine practice, used either the Barthel Index (BI), the Functional Independence Measure (FIM) or the Functional Assessment Measure (FIM+FAM).¹⁷ These measures cover a common core set of information. The FIM+FAM contains the FIM items, and a Barthel Index can be derived from a FIM score.¹⁸ Therefore, without any imposition at all, a potential common language already exists at the level of the Barthel Index for 95% of the units in the UK. Moreover, for those units that want a slightly more detailed dataset, there is opportunity for expanding it in a standardised manner.

The UK FIM+FAM user group was set up in 1995 to provide consistent training and use of the FIM+FAM as an outcome measure for brain injury rehabilitation in the UK.¹⁹ A computerised database offers data collation at the level of the FIM+FAM, FIM or the Barthel Index. Graphic representation is automatically generated in the form of a 'FAM-splat' (Fig 2), and the system includes an agreed minimum dataset of demographic details, diagnosis and deficits. Therefore the opportunity for centralised data collection is also already in existence in the UK, should we choose to use it.

Appraisal and assessment for rehabilitation doctors

Coordinated interdisciplinary teamwork is the very heart and soul of rehabilitation practice. The rehabilitation doctor functions, not as an individual, but as an integral member of the team. This may pose particular challenges for assessment of individual performance, which may also be relevant to other areas of medical practice involving closely integrated teamwork.

For surgeons and physicians in areas of medicine where the success of procedures relies on the skill of the individual

Fig 2 FAM splat. The Functional Assessment Measure (FAM) is a 30-item scale of functional independence in activities of daily living. It includes motor items (self-care, mobility, transfers etc) and cognitive/psychosocial items (communication, social interaction, problem solving etc). Each item is scored from 1 (totally dependent) to 7 (fully independent). The 'FAM splat' is a radar chart where each item is arranged like the spokes of a wheel and change in score from admission to discharge (shaded area) is recorded for each item along each 'spoke'. The splat provides a view 'at a glance' of those areas in which change occurred, without the need to summate ordinal data.

clinician, the demonstration of fitness to practise may rest simply on analysis of outcomes and complication rates. In the context of practice in a coordinated interdisciplinary team, the individual contribution of a particular clinician may be hard to define or assess.

To give a musical analogy, the role of a surgeon may be likened to that of a soloist in a concerto. S/he relies on the backing of the

Fig 3 *Paganini and the Royal Philharmonic Orchestra*. This pencil drawing by Daniel Maclise shows Il Maestro Paganini set in clear relief. Although the shadowy form of the Philharmonic Orchestra can be seen in the background, there is no mistaking the brilliance and virtuosity of the Master, on whom the success of the performance ultimately depends. (Reproduced with permission from the Victoria and Albert Museum.)

orchestra for a rounded performance, but his/her own personal contribution can be easily identified and appraised (Fig 3). By contrast, the role of a rehabilitation physician may be likened to that of a conductor (Fig 4). Conductors do not play an instrument themselves – their skill is in directing and coordinating the orchestra (team) to produce a cohesive performance. In auditing a rehabilitation service, it is easy to define standards which reflect the activity of the whole team, but much harder to identify the individual's performance. Is it reasonable, then, to judge the effectiveness of the individual consultant on the performance of their whole team? This will depend on the role of that consultant within the team.

The role of the consultant in rehabilitation medicine

The consultant in rehabilitation medicine may function in a number of different models:¹⁰

- In an inpatient rehabilitation ward, the consultant may have medico-legal responsibility for treatment decisions regarding a patient under his/her care. However, s/he has no responsibility for the practice and training of other disciplines within the team, who are accountable to other managers within the trust (usually through therapy service managers).
- In some settings, however, the consultant is also the 'director' or 'lead' for a service, and holds managerial responsibility for the multidisciplinary team members who are directly accountable to him/her. In this case s/he may have responsibility for their clinical conduct and training.
- In other models, the consultant provides sessional input to support and advise a rehabilitation team (for example, in the community), but does not have either a leadership role, or actual clinical responsibility for the patient, who remains under the medical care of the general practitioner.

Irrespective of managerial arrangements, consultants will always be held responsible for the decisions they make, the advice they give and the consequent action taken. However, the

Fig 4 *Die Philharmoniker*. By contrast to Figure 3, in Max Oppenheimer's rendition, the conductor is surrounded completely by his *Philharmoniker*, and is almost indistinguishable in the flurry of orchestral activity. Nor can it be quite certain exactly who is in charge! (Reproduced with permission from the Österreichische Galerie Belvedere Vienna, Austria.)

extent to which consultants carry responsibility for decisions made by the multidisciplinary team depends upon their role within the team. In setting up systems for clinical governance, therefore, it will be necessary to define carefully the level of managerial responsibility for each individual.²⁰

In rehabilitation medicine, as in other areas of medical practice where teamwork is central to clinical practice, clinical governance procedures will be needed at two levels:

- service level – reflecting the activities of the unit and multidisciplinary team
- individual level – reflecting the activities of the individual doctor/consultant in rehabilitation medicine.

The quality of service may be appropriately assessed by routine monitoring process or outcome parameters against a set of standards – ideally agreed at national level. Individual assessment is likely to be made at appraisal.

Appraisal for consultants in rehabilitation medicine

In the absence of specific procedures and tasks on which to provide objective demonstration of their skills, rehabilitation doctors must necessarily rely on the more subjective views of their colleagues as an assessment of performance to be recorded in their personal folder. 'Three hundred and sixty degree' appraisal systems are already in place some rehabilitation units in the UK (eg in North-West Thames), where consultant appraisals are undertaken by representatives of the multiprofessional team. Experience in those units suggests that a further advantage of multidisciplinary appraisal is that it gives other team members insight into their colleagues' other roles and responsibilities. It helps to generate mutual respect and to prevent staff from making inappropriate demands on each other's time.

By no means all of the BSRM membership were ready to embrace this principle, however, and the British Medical Association has rejected this approach as a blanket policy, and even as a recommended one. Nevertheless, in rehabilitation medicine, effective interdisciplinary working is so crucial to good practice that it is recommended that the appraisal should at least include some formal mechanism for feedback from the team, especially on issues such as:

- communication and interpersonal skills,
- courtesy and behaviour towards other staff, patients, relatives etc.

Where to now?

In the UK, the planned development of services is now focused on priorities identified in National Service Frameworks (NSFs). Planning of these frameworks is undertaken over several years, which in theory gives time to assemble evidence-based guidelines and standards. One might reasonably suppose that commissioning of guidelines would be coordinated with framework development, but sadly this is not always the case. Governments are increasingly aware of the importance of health

issues to their electorates, but decisions regarding healthcare developments are often based more on political expedience than on any logical planning process. Specialist societies need to be ready to participate and the Colleges need to support them in the development of guidelines in the less 'headline-grabbing' areas of practice.

A National Service Framework for Long-term Conditions is due for publication in 2004/5, and will include rehabilitation for acquired brain injury and spinal cord injury, as well as progressive neurological conditions. At last rehabilitation features as a priority on the UK NHS agenda. NICE has embarked on development guidelines for head injury²¹ although, somewhat incongruously, these are restricted to management during the first 48 hours. Therefore, the BSRM has commissioned a parallel and complementary set of guidelines addressing the rehabilitation of people with traumatic brain injury. In order for these to be as strongly based as the NICE guidelines, they will follow a strict development process. The guidelines will be based on rigorous review of the literature in the form of a Cochrane review. They will draw heavily on existing published consensus-based documents, and will be scrutinised and evaluated by a multi-professional working party with user and carer representation. In stark contrast, however, to the substantial funds commanded by NICE for its guidelines development, there is no central funding for this initiative whatsoever.

A final word of caution...

Standards and guidelines may go a considerable way towards improving the quality of care, but there is also a downside. We may become so preoccupied with measurement and with following guidelines that we forget to see patients as the individuals they are. While working to meet the various national standards, we must endeavour to ensure that our patients' individual hopes and aspirations will always command higher priority than standard datasets as the primary goals towards which we strive.

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