

## CURRENT TOPIC

## Clinical standards in the reformed NHS

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Unfettered by such restraining influences as a clear view of the end results, in 1991 the government of the UK made a fundamental change to the administration of its 43 year old NHS. Previous reorganisations had merely tinkered with the machinery for cascading funds from the chancellor of the exchequer to the NHS foot soldiers. This time there was a revolutionary idea at the core. Right down to a local level those deciding how and where to spend NHS money were to be separated from those running NHS hospitals.

The result of this is that medical service providers now have to haggle over contracts with numerous public sector health purchasers in a nationwide clinical bazaar. An unsurprising consequence is that, desperate to cut costs and increase revenue, many hospitals have developed business management systems where words like 'restructure', 'contracting out', and 'down sizing' are in everyday use.

Pressures of this type pose a potential threat to standards of clinical practice. Not, perhaps, to the extent that some doctors imply (hell hath no fury like a vested interest when paraded as a moral principle), but nevertheless there is a real risk. For example, pathology laboratories are the first clinical services that hospital managers will be encouraged to subject to 'market testing'. In plain English this means the work will be put out to tender, almost certainly resulting in some acute hospitals losing their on-site departments. That may or may not be a sensible decision, but it raises questions about the service to patients. Similar problems are bound to arise in other departments, so the protection of clinical standards is presently an important consideration.

Aware of all this, NHS purchasers try to ensure that the issue of quality is addressed (as they usually put it) when negotiating contracts. They stipulate standards, define specifications and look for hallmarks, but are still rather clumsy and insecure in the process. To help them, a number of initiatives have been developed.

**The patient's charter**

Published by the Government in 1991 this catalogues patients' rights under the NHS and defines nine national standards relating to such matters as respect for privacy, information for relatives, waiting time in emergency

departments, the cancellation of operations, and arrangements for discharge from hospital.<sup>1</sup>

The charter is laudably designed to improve areas in which the NHS, like many large public services, has traditionally failed to shine. But simply smartening up customer relations falls a long way short of maintaining or improving professional standards of clinical practice. For that, other measures are needed.

**The Clinical Standards Advisory Group (CSAG)**

Under pressure from the medical royal colleges and others, the government set up a statutory body as part of the NHS reforms to provide an independent source of expert advice to the UK health ministers on NHS standards of clinical care. The CSAG includes members nominated by the medical, nursing, and dental royal colleges and their faculties. Its investigations are carried out by its own members and co-opted experts.

Its first report, on access to and availability of selected specialist services, was published in March 1993.<sup>2</sup> This included three areas relevant to paediatrics: neonatal intensive care, childhood leukaemia, and cystic fibrosis.

The report was fearful of the effect of the new NHS market on specialist services where patients with rare and expensive diseases needed treatment based on tertiary referral centres. As far as childhood leukaemia was concerned, the CSAG concluded that the resources needed for such centres and their levels of performance should be defined by a national profession-led group set up specifically for the purpose.

With the support of the Medical Research Council Leukaemia Steering Committee and the Department of Health, such a group has now been established. Its core members include a general paediatrician, a general haematologist, a hospital chief executive, and a public health consultant together with four specialists and a senior nurse. Its ambition is to define acceptable standards of care for children with leukaemia and to audit compliance with those standards in different centres by site visits. It will advise those paying for leukaemia care where approved centres are. Effectively the idea amounts to a surrogate accreditation scheme (see below). If it is successful and avoids the pitfall of veering towards restrictive practice, other specialist services may follow suit.

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### Audit

As part of the reforms, NHS hospital paediatricians have been obliged to indulge in regular and formal critical review of their clinical activities since 1991. Much has been written about medical audit and the topic was reviewed in this journal some time ago.<sup>3</sup> Most UK physicians are now familiar with the principles involved, and audit is a major source of consensus guidelines (see below).

### Accreditation

Accreditation is a specially differentiated and formalised form of audit. It requires some authoritative body to define standards of practice, and for departments seeking approval to comply with those standards. Compliance is then checked by regular on-site inspection, and if confirmed, some certification of the fact is issued. Departments may then display their award as a hallmark of having achieved the required standards.

There is presently only one accreditation scheme specifically for clinical services in the UK, and that is for diagnostic pathology.<sup>4</sup> It is jointly owned by the Royal College of Pathologists, the Association of Clinical Pathologists, the Association of Clinical Biochemists, the Institute of Biomedical Sciences, the Institute of Health Services Management, and the Independent Healthcare Association. In its first two years the scheme attracted applications from most of the laboratories in the country.

Formal accreditation schemes have their advantages and disadvantages, but it is likely that the basic idea of national standard setting and on-site audit will develop further for specialist clinical services – as indeed it has already in haemophilia and childhood leukaemia.

### Consensus guidelines

Endorsed by the government in its drive for 'clinical effectiveness', consensus clinical guidelines from various peer groups now abound. They are based on clinical research or the result of medical audit. They stretch from discursive documents to brief algorithms presented as flowcharts. A useful background to their strengths and weaknesses has been produced by the Clinical Resource and Audit Group in Scotland.<sup>5</sup>

Their pros include the potential to achieve a homogeneity of approach to a clinical problem or service where presently there is none, to eradicate outdated practice, and also to provide a basis for a fair contract between buyers and sellers in the NHS market. Their cons include the potential to suppress innova-

tive excellence and to expose those who fail to follow them to the risk of litigation.

Opponents of guidelines fear loss of clinical freedom. That is a moot point. The Scottish document argues that clinical freedom 'implies the obligation to do what is best for the patient at all times, not the right to do whatever one pleases'. Others would argue that clinical freedom 'like other sorts of freedom cannot be limited without being lost'.<sup>6</sup>

Whether guidelines are likely to be followed depends on the motivation to adopt them. If contracts depend on them, they probably will. Whether they actually improve clinical practice is not yet certain, though there is evidence that they can, at least in some instances.<sup>7</sup>

### Continuing medical education (CME)

Under pressure from the government the medical royal colleges are, at variable pace but in collusion, all introducing schemes of formal CME whereby their members or fellows will be obliged to amass a certain number of educational points over a defined period of time. Points will be awarded for several activities such as attending approved meetings, writing papers, or demonstrably participating in self assessment exercises. In the belief that it will improve standards of professional practice, CME is likely to become a contractual requirement for NHS consultants in due course, and NHS purchasers will expect it.

### Conclusion

CME, internal audit, consensus guidelines, and, for some services, external audit and accreditation will develop further. The new NHS market will greatly accelerate these processes by which doctors are called more to account. In truth, though, the reforms are not the root cause. That lies in the fact that the NHS can no longer afford any treatment in any hospital at the whim of any clinician. Long before 1991 it was plain that potential NHS expenditure could easily exceed any income any government might feel able to give it. And that will strike a chord in many countries throughout the world.

1 *The patient's charter*. London: HMSO, 1991.

2 Clinical Standards Advisory Group. *Access to and availability of specialist services*. London: HMSO, 1993.

3 Primavesi R, MacFaul R. Paediatric medical audit. *Arch Dis Child* 1990; 65: 1170-3.

4 Advisory task force on standards to the audit steering committee of the Royal College of Pathologists. Pathology department accreditation in the United Kingdom: a synopsis. *J Clin Pathol* 1991; 44: 798-802.

5 Clinical Resource and Audit Group. *Clinical guidelines*. Edinburgh: Scottish Office, 1993.

6 Delamothe T. Wanted: guidelines that doctors will follow. *BMJ* 1993; 307: 218.

7 Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. *Lancet* 1993; 342: 1317-22.