Government directives and changes: the potential impact on clinical practice

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ABSTRACT – Since publication of The new NHS: modern, dependable1 we have had more guidance and circulars from central government than have ever before been received in such a short space of time: 242 in 1998 and already well over 100 in 1999. Furthermore, 'joined-up government' may not have been achieved yet, but it certainly means that all agencies are being changed or modernised simultaneously, and so are all in the same position. This paper examines the impact that some of these directives and changes may have on clinicians and clinical practice. The paper does not deal with the issue of setting up primary care groups (PCGs), which could form the basis of an article on its own.

The past

From the beginning of the 1990s until the present government was elected in 1997, the NHS operated as an internal market2, designed to create incentives within the public sector to raise quality and efficiency. Different models of GP commissioning, including GP fundholding and total fundholding, were used to encourage GPs to achieve changes which health authorities had failed to achieve. While separating the commissioning function from that of health care provision was in many ways successful, by the late 1990s evidence began to emerge that the system had also engendered rivalry between hospitals, encouraging duplication and overcapacity; and had slowed rationalisation of services. There was variation in what was available on the NHS geographically (postcode prescribing) and there were differences between the services provided by GP fundholders and non-fundholders. Also, trusts had different 'prices' for the same procedures for different customers. Board agenda and management meetings of trusts and health authorities were dominated by financial issues and activity targets3.

The present

To a large extent the NHS White Paper was designed to deal with these problems. There was to be one NHS (an end to postcode health care/prescribing) with local responsibility for delivering national standards; partnership was expected and measures were put in place to foster it, efficiency measures (maximising benefit of resources) were introduced, and quality (excellence) was of paramount importance: through these measures public confidence would be rebuilt. Planning would be both local and central, with the focus on health as well as health care. The objectives and targets of the underlying public health framework were clearly set out in Our healthier nation4.

Implementing the changes

A range of initiatives has been introduced to set clear national standards, tighten up funding arrangements and make changes in local organisational arrangements and priorities. The changes, their intentions and probable implications for clinicians are laid out in Table 1. The most significant change for clinicians is that the policies include national standards, local arrangements for clinical governance5 supported by professional self-regulation and lifelong learning, and responsibilities placed on trusts, PCGs and health authorities. There are also to be clear quality standards in long-term service agreements. For the first time all health organisations have a statutory duty to seek quality improvement through clinical governance6.

Assuring and monitoring progress

The whole programme is underpinned by an ambitious National Information Strategy 'Information for Health'7 and monitored through the National Performance Framework for the NHS8, whilst the Commission for Health Improvement's task is to ensure local compliance. Table 2 lists key initiatives, intentions and implications.

Other changes

Other changes, listed in Table 3, include the promised White Paper on public health4.

How is it shaping up?

The vision is hard to fault, but the framework and timescales for implementation are posing problems. There is a widening gap between rhetoric and reality and a growing view that while government policies are strong on what they wish to achieve, they are less clear on how to achieve it. The main problems are gaining local commitment, including that of clinicians, finding the time and resources to do it all, the unrealistic pace of change for some initiatives, and burnout – we are all weary.
For example, implementation of the cancer National Service Framework (Calman/Hine) is proving effective, but time consuming and costly. Can the NHS afford the time and resources simultaneously to implement the next two: coronary heart disease and mental health? Whilst we recognise that a commitment to deliver high quality care should be at the heart of everyday clinical practice, the constant pressure to increase and maintain activity (waiting lists, times, etc), at a time when we are supposed to increase quality with no new resources, is a strain.

The Performance Management Framework will depend on good information and relies on the Information for Health strategy working. Both rely on the involvement and motivation of clinicians, but these aspects of both initiatives have been less thoroughly developed than the technological ones. Though clinicians are increasingly called on to work in partnership with other professionals, other trusts and across sectors, many of these organisations are currently reforming and reconfiguring, so alliance is difficult and will take time to mature. Many clinicians were selected and trained at a time when doctors called the shots and were expected to know best. At a high level there is increasing alignment of national clinical bodies (eg Royal Colleges, National Centre for Clinical Audit) with the National Institute for Clinical Excellence (NICE) and a culture shift in the medical profession towards revalidation and more meaningful definition of pursuit of professional development.

Locally, there is ongoing evolution of a consultant-based and -led service, and growing acceptance that senior management have key responsibility for leading clinical governance.

The Future

These changes illustrate the government's single-mindedness in aiming for a high quality, integrated service which delivers what patients want, how they need and want it. They also illustrate that:

- clinical governance cannot be avoided; evidence-based practice must be the norm and audit is obligatory
- the patients' or carers' views have a major part to play in health care
- team work, multi-professional decision making, collaboration with other trusts and sectors will be expected
- clinicians will need to accept responsibility for their use of resources and recognise their specific management responsibilities
- clinicians will need to accept some responsibility for the effectiveness of Information for Health
- clinicians will need to understand the part they play in overall health improvement goals (H1mPs)
- job flexibility will be required, with a workforce aligned to local needs.

Table 1. Implementing the changes.

| Initiatives                                               | Intentions                                                                                                               | Implications                                                                                     |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| National Service Framework                               | National service standards to:                                                                                             | • Local responsibility for delivering the standards                                             |
|                                                          | - avoid postcode services                                                                                                  |                                                                                  |
|                                                          | - practice 'joined-up' evidence-based services                                                                            |                                                                                  |
|                                                          | - improve outcomes                                                                                                         |                                                                                  |
| National Institute for Clinical Excellence (NICE) (from 1 April 1999) | To produce national evidence-based guidelines for (initially) drugs and technologies                                    | • NICE guidelines are expected to be followed locally unless there is good reason not to         |
| Clinical governance system                               | To create a culture which ensures uniformly good quality care in the NHS and addresses poor quality effectively           | • Audit is no longer optional                                                                   |
| Primary Care Groups                                       | Primary care should have responsibility for:                                                                           | • A culture of learning (from mistakes)                                                         |
|                                                         | - health improvement                                                                                                       | • Managers now have an interest                                                                 |
|                                                         | - developing primary care                                                                                                  | • Professional self-regulation (validation)                                                     |
|                                                         | - commissioning                                                                                                            | • Lifelong learning                                                                            |
| Increased funds from Treasury controlled by reference costs | Clear clinical and financial responsibility alignment                                                                  | • Self-sufficiency/autonomy is not the norm                                                      |
| Management costs capped                                  |                                                                                                                          | • GPs, nurses and primary care managers will increasingly commission secondary care            |
| 'Modernisation funds'                                    |                                                                                                                          |                                                                                                  |
| Bidding procedures                                       |                                                                                                                          |                                                                                                  |
| Health Improvement Programmes (local three year plans in partnership) | To draw up in partnership plans to meet national and local priorities and to improve health, including clinical governance, resource and workforce planning | • Clinicians will have to account for and bid for funds for specific purposes                   |
|                                                          |                                                                                                                          | • Clinicians will be expected to contribute to drawing up local plans in partnership and then work to achieve them |
Opportunities for clinicians

Clinicians should welcome clinical governance and make sure it is interpreted locally to create the right culture in which they can practise good medicine (quality agenda). Better and more authoritative assessments of the evidence from NICE will be helpful as part of the National Service Framework. Adequate provision for training and lifelong learning will be essential.

Clinicians will need to understand what patients want from their health care, so that their desired outcomes can be incorporated into clinicians' own goals and research, and they should involve primary care teams as they have a more rounded understanding of their patients. Good communication with patients, teams and others is essential. As clinicians have had to accept responsibility for resources, they will want to understand resource issues better (a lifelong learning need?) and involve themselves in ensuring that the right information is pursued locally in carrying out Information for Health5.

Potential pitfalls for clinicians

Going backwards or resisting change is not an option; nor is insisting on clinical freedom (to do what? – ignore an evidence-based guideline and deliver non-evidence-based care?), which in any case has never been an absolute freedom11. In a specialty covered by a National Service Framework (eg cancer, and coronary heart disease shortly) there will be prescriptive guidance, but if a patient differs from the average or the study group on which the evidence/guidance is based, a clinician will still have the freedom to take a different, clinically defensible decision. But taking decisions alone, not involving one's colleagues

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**Table 2. Assuring and monitoring progress.**

| Initiatives | Intention | Implications |
|-------------|-----------|--------------|
| Information for Health | To have a modern health information system with electronic records for every patient, capable of measuring clinical indicators and even outcomes | • Doctors will no longer have to face a large proportion of patients with missing records, but will also have to enter relevant, timely and accurate data for clinical governance. |
| National Performance Framework for the NHS | To routinely measure those six aspects of health care most relevant to patients (and others) ie health improvement, fair access, effective delivery of appropriate health care, efficiency, patient/carer expertise, health outcomes of NHS care | • Clinicians will have to take account of all six aspects including patient experience and service. • Better understanding of patient requirements and outcomes is essential. |
| Clinical indicators for trusts | To be able to compare performance of trusts including in admittance and discharge of patients | • Not intended for use as league tables, but likely to be so in the media. |
| Performance Assessment Framework for Social Services | To review whether trusts, health authorities and PCGs are putting quality first and implementing First Class Service policies | • Social Services will take greater note of admittance and discharge issues. • All organisations' performance to be reviewed every three or four years. • Clinicians cannot avoid clinical governance, clinical audit and cannot afford to be outliers in indicators. |

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**Table 3. Other changes**

| Initiatives | Intention |
|-------------|-----------|
| Targeted health and improvement initiatives eg Health Action Zones, Health Living Centres | Targeting resources and partnership action to need |
| NHS Direct, walk-in centres etc | To make primary care more responsive to the requirements of the population |
| Priority given to cancer – two week wait for 'suspected cancer' patients | To improve the outcomes achieved for cancer so that they compare more favourably with those achieved in other countries |
| Public Health White Paper: Saving lives: our healthier nation12 | To set a clear National action plan for health, with targets, settings and clearly understood responsibilities in key areas |
and not taking patients’ views into consideration, will no longer be acceptable. Competition between trusts or clinicians is outmoded and specialising in superspecialties, or specialties where there is no guarantee that consultant posts will be funded locally, is risky. Specialising in an area requiring manual and mental dexterity is also high risk if a clinician’s skills deteriorate in any way.

Potential pitfalls for the government

Telling clinicians how to do everything in detail is not the best way to involve and win the commitment of the profession. The government needs to recognise that most clinicians support its aims, but it is up to clinicians themselves to work out how to achieve them locally; the government can tackle issues of the overall capacity and resource availability for the NHS on a national level. The government needs to recognise that some of these changes will take time and it must have faith in its workforce. The real danger is that the government will force the pace too much, take too little interest in what motivates and energises its workforce and will burn us out.

Acknowledgements

I would like to thank Yvonne Doyle, Jamie Ferguson, Parameswaran Kishore, Eileen Rubery Ruth Wallis and Merryl Wallace for their helpful comments, and Ann Neagle for her patience.

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