Quality improvement and assurance in the NHS – confidence levels of NHS Trust Boards.

by Andrew Corbett-Nolan and Angus Malcolm

1.0 The background

Over the past two years there has been an enormous growth in both activity around and interest relating to the subject of quality in healthcare. Building on the seminal work of early champions and gurus, the Blair administration is giving greater profile to quality in healthcare with the result that, slowly but surely, quality is taking its place alongside finance and throughput on the agendas of those who run the NHS.

Of the various steps taken by the Department of Health, potentially the most significant is that of clinical governance, the explicit responsibility held by Boards of NHS Trusts for the quality of care their organisations provide. Although this new responsibility was announced nearly two years ago, it is only in the last few months that it has begun to bite, in the run up to 1 April 1999, when the new policy comes into effect. This potentially very significant milestone in the history of the NHS has to some extent been obscured by lack of clarity (the guidance promised in the autumn has only just been published), initiative mania from the centre and a genuine and hardly surprising ostrich reaction from those running the NHS locally.

There is more to come. Over the coming two years two new national organisations are being set up. Firstly the National Institute for Clinical Excellence (NICE), which has a range of responsibilities surrounding defining service expectations. This will operate from April as well. Secondly, the Commission for Health Improvement (CHImp), a "health Ofsted", will systematically inspect the clinical governance arrangements of NHS Trusts and investigate failures in the quality of care delivered to patients.

Since the 1980s, all NHS Trusts have been starting work to evaluate systematically the care they deliver against explicit standards, and using this process to identify items for improvement – in other words, clinical audit, an important dimension of the reforms of the last Government. Gradually, over the past decade, nearly all NHS Trusts have started to look at the quality of care, setting up quality departments and teams, and developing quality strategies. Increasingly and inevitably, NHS Trusts have involved themselves in various external quality systems, such as benchmarking and peer review exercises. The most significant of these has been accreditation, a concept pioneered in the United States of America and other New World countries but more and more being imported into Europe.

Accreditation is the whole system which drives interest in many other individual quality initiatives, standards development, for example. What use is it to have developed an expectation of performance (a standard) without implementation and assurance mechanisms? Accreditation opens the door for benchmarking, the assurance of national standards, systematic and high quality peer review and the independent scrutiny of public service provision.

Quality work has largely been driven through occasional bribery (ringfenced funding) and individual interest. There has been little in the way of reward or incentive for

taking up the quality mantle, other than the feeling of a job well done. Many chief executives have been moved on for not meeting their budgets – none for having a poor clinical audit programme. Recently, however, a few high profile disasters have started to focus attention on the value of quality assurance systems, and the prospect of clinical governance has accelerated this process.

Since it was founded as King's Fund Organisational Audit in 1989, The Health Quality Service (HQS), the principal independent healthcare quality accreditation organisation in the United Kingdom, has gradually been introducing change. Other national programmes, such as the Hospital Accreditation Programme (HAP) and Health Services Accreditation (HSA), have also contributed significantly to the mission, though the former is somewhat in limbo at present and the latter is being closed down. Many smaller systems work with particular professions or services. Whilst all these schemes have helped to put the NHS ahead of other European countries in terms of an understanding and use of accreditation, it has long been our view that there remains a huge educational need within the NHS regarding the different theories of quality improvement and assurance, and in particular of the unique and fundamental role of accreditation.

As 1998 drew to a close, it became apparent to us that interest in quality in the NHS was both changing and increasing, and that there had been a sea change in the way our programme was being received. Typically, it takes about a year to sign an NHS Trust up to the HQS programme, from first contact through to signed contract. That was similar to the experience at Health Services Accreditation, HAP and BSI. We can track interest in our programme quite simply through the number of NHS Trusts requesting information, attending our various marketing events and asking for presentations. From November onwards, these requests started to grow in intensity, and in character they started to change. Anecdotally, we were hearing real concern, even a degree of fear, about the quality systems NHS Trusts had in place and this was being accelerated by thoughts of clinical governance. That the promised central guidance from the Department of Health was not in evidence only increased anxiety.

2.0 The need for quantitative research

We therefore decided that some kind of market research survey would be helpful, and started to think how we could gather more accurate information on attitudes to quality in NHS Trust management. At that stage we also approached the Health Service Journal, to see if they would be interested in supporting this initiative. We would like to record our thanks to Peter Davies and his team at the HSJ for actively supporting the project, and particularly Mark Crail, who has been our principal contact point.

3.0 Research methodology

We decided to conduct a postal survey targeting four key decision makers in all UK NHS Trusts: the chair, chief executive, medical director and chief nurse. The survey would gather a mixture of information that would be useful to HQS in our marketing of the programme, and information to help gauge confidence in quality assurance, particularly as we approached the start of clinical governance.

The survey was sent to named individuals holding the above posts in all UK NHS Trusts, using Binley's database. Each form was accompanied by a covering letter

from Peter Davies, and guidance from both him and Andrew Corbett-Nolan, the Director of Development at the Health Quality Service.

These covering instructions explained the purpose of the survey, that it was intended that the recipient was to complete the survey in person and without researching the answers in any way. The idea was to collect perceptions and beliefs rather than facts. The guidance also explained that each survey form was coded to help in the analysis of the survey and for follow up. The survey questionnaires were distributed in January 1999 with two weeks given for response. At the end of that period a further survey form was sent out to all those who had not responded with a follow-up letter and another deadline for completion two weeks later. Freepost envelopes were included.

4.0 Response rate

The response rate was high. Of 1,860 survey forms distributed, 499 were returned properly filled in, giving a highly commendable response rate of 27%. Because of sample sizes individual statistically safe conclusions can only be made for England or for the UK as a whole. As it happened, there was little variation in any case from the replies in any of the four UK countries.

The total number of responses by post for the survey was as follows:

Post	No. of respondents	% of total	*% of national total*
Chair	102	20.44%	*20.82%*
Chief executive	158	31.66%	*32.24%*
Medical director	125	25.05%	*25.51%*
Chief nurse	114	22.85%	*23.27%*
Total	499	100.00%	

Fig. 1: Composition of respondents by post held

All 490 NHS Trusts were sent the questionnaire, and replies were received from 126 different organisations. Interestingly, there was no relationship between the client base of HQS and respondents to the survey.

We were not satisfied that in every case the addressee had actually filled in the form themselves, despite the crystal clear instructions that this was what we were asking them to do. In a few cases it was obvious that the form had been passed for the quality officer in the NHS Trust to fill in. However, the form did clearly ask that the returned form should represent the views of the addressee, and so we have had to give the addressees the benefit of the doubt. We have therefore accepted that where a form was filled in by someone else, it nevertheless represents the view of the person to whom it was sent.

5.0 Arrangements for corporate and clinical governance and controls assurance

Starting with the systems that Trusts had put in place regarding governance, we asked about how the respondents felt about the corporate governance, clinical governance and controls assurance arrangements of the Trust. These matters are the direct responsibility of the Board of the NHS Trust. Respondents had four choices: 'confident', 'not sure', 'not really confident' and 'not confident at all'.

Taking the latter two possibilities together, the results show a real level of concern in respect of all these macro control systems. Not surprisingly, clinical governance provoked the most concern, but controls assurance scored highly too.

Fig 2: Percentage of respondents who lack confidence in arrangements for corporate and clinical governance and controls assurance

Post	Corporate governance	Clinical governance	Controls assurance
Chair	8.82%	45.10%	32.00%
Chief executive	13.29%	48.73%	31.01%
Medical director	16.00%	43.20%	36.00%
Chief nurse	10.53%	45.61%	35.96%

Fig 3: Percentage of respondents who have confidence in arrangements for corporate and clinical governance and controls assurance

Post	Corporate governance	Clinical governance	Controls assurance
Chair	89.22%	50.00%	61.76%
Chief executive	80.38%	46.2%	57.59%
Medical director	80.00%	55.2%	49.70%
Chief nurse	80.70%	48.25%	57.02%

These figures, to us, make disturbing reading. They demonstrate a fundamental lack of confidence in the arrangements many Trusts have in place to cover the main responsibilities of the Board. Later in the survey we dig into other, more detailed matters that help to confirm this picture of a substantial lack of confidence in the systems that Trusts have put in place to inform and reassure themselves about their governance responsibilities.

6.0 What information do Trust Boards see?

We next asked about the kind of information that NHS Trust Boards regularly see, and that which they find useful or would find useful were they to see it.

This fits in with the view of the Health Quality Service that NHS Trusts do not consider the full range of results areas which one could reasonably expect of healthcare organisations. With this in mind, HQS has developed a set of indicators covering the five outputs or success criteria one would expect a healthcare organisation to be measuring itself against. These are:

- clinical effectiveness
- patient satisfaction
- service efficiency
- service access
- staff motivation

Our supposition was that NHS Trust Boards currently receive a lot of information on fiscal issues and waiting lists, but little systematically on the rest of the above output areas. This was confirmed, but not as dramatically as we thought it might have been. In the last few years, it appears, NHS Trust Boards have been broadening the information that is regularly given to them, though there is still progress to be made. Certainly, if you look at information respondents were not getting but would find useful to get, particularly in the area of managing the human resource, there is considerable scope for improvement.

6.1 Information regularly received by Trust Boards

Looking first at information that is regularly reported to the Boards of NHS Trusts, the following results were reported. The differences in perceptions, or perhaps powers of recollection, between the various job titles are interesting.

Fig 4: Percentage who believe information on the following is sent to the Board

Type of information	Chair	Chief executive	Medical director	Chief nurse
Finances	100.00%	96.84%	98.04%	98.25%
Activity	97.06%	93.04%	95.20%	96.49%
Waiting lists	82.35%	72.15%	78.40%	85.96%
Patient satisfaction	53.92%	46.84%	39.20%	54.39%
Staff satisfaction	18.63%	17.09%	12.00%	21.05%
Clinical effectiveness	30.39%	40.51%	33.60%	44.74%
Complaints	98.04%	93.04%	92.00%	97.37%
Absenteeism	69.61%	70.89%	64.80%	72.81%
Near misses	44.12%	41.77%	33.60%	43.86%
Risk management	78.43%	67.72%	62.40%	70.18%
Litigation and claims	86.27%	72.78%	73.60%	83.33%
Staff turnover	63.73%	65.19%	56.00%	58.77%
Use of locums	24.51%	15.82%	20.80%	15.79%
Disciplinary actions in progress	42.16%	26.58%	41.60%	37.72%
Failed discharge	17.65%	12.66%	12.80%	12.28%
Incompleteness of clinical notes	7.84%	6.33%	4.00%	4.39%

Looking at where the respondents reported that they did not get information of certain sorts, but nevertheless would find it useful, a fuller picture starts to emerge, one which certainly encourages the HQS views about where the gaps are. It would appear that survey and indicator information has some way to go before NHS Trust Boards are regularly receiving this kind of information.

Fig 5: Of those who believe information in the following areas is not sent to the Board, percentage who think it would be useful to do so

Type of information	Chair	Chief executive	Medical director	Chief nurse
Patient satisfaction	63.83%	60.94%	46.05%	44.23%
Staff satisfaction	50.60%	48.85%	47.27%	47.78%
Clinical effectiveness	50.70%	54.26%	45.78%	44.44%
Near misses	36.84%	34.78%	38.55%	48.44%
Failed discharge	4.76%	13.77%	12.84%	5.00%
Incompleteness of Clinical Notes	26.60%	16.22%	24.17%	23.85%

6.2 Clinical records

Comparing the two tables above, some puzzling facts emerge. For example, not many NHS Trust Boards look at the completeness of the clinical record, and only between a fifth and a quarter would feel it useful to have a handle on this important matter at the Trust Board. For nearly a decade NCEPOD have been reporting problems with the clinical record, as have various reports from the Audit Commission. Poor record keeping is a potent cause of failures in the defence of litigation. It causes a haemorrhage of NHS resources and leads to a poor standard of patient care. The policy message is clearly that good medical records are not just an administrative chore, but are a vital part of patient care. However, the information from the survey suggests that nine tenths of Trust Boards do not systematically receive information on this matter, and less than a quarter feel that it would be useful to do so.

6.3 Failed discharges

A similar pattern emerges for failed discharge, again in the wake of perhaps twenty years' policy attention across all care areas. The costs of failed discharge for patient and NHS Trust alike are huge, and yet this does not seem a matter on which most NHS Trust Boards receive information, nor one on which they feel that it would be helpful to do so.

6.4 Patient and staff satisfaction

More obvious gaps emerge around patient and, more significantly, staff satisfaction. We feel it will be worthwhile to track these as the long-awaited national patient satisfaction and the recently-published NHS human resources strategy come into play. One would suspect that the figures in the survey would reflect, to a degree, not only the interest of the individuals on NHS Trust Boards but also the performance management mechanisms in place on these matters. Certainly the figures should encourage those policy makers who are keen for a stronger emphasis on staff motivation.

6.5 Clinical governance arrangements

We then wanted to probe the question of clinical governance a little more deeply. There are two levels at which a Trust Board could look at clinical governance. It could develop a system of development and review and delegate this to others - in other words, it could be satisfied that arrangements were in place to police the Trust's performance of its clinical duties and that the Board did not therefore need to know the details. However, and particularly at the start of this process, it could look at certain specific functions to be assured that they were occurring. In either case, NHS Trust Boards should at the least be confident that good care is being provided to patients, or failing that, know that it is not and that remedial action is being taken. Whilst recent descriptions of the responsibilities of Boards, as opposed to the responsibilities of doctors, emphasise that Boards are responsible for clinical governance arrangements rather than the delivery of clinical care, we would suggest that in the event this distinction would be merely academic. We take the view that should there be a serious failure in clinical quality, Boards would in reality not be able to absolve themselves of responsibility. There would be heads on spikes, and Boards know this.

The information from the survey indicated that Trust Boards are not presently reviewing much of the information that they would need to assure themselves in this respect. Most surprisingly, this lack of concern was again apparent in some areas where there have been some very public failures in systems. The overall impression is that a sizeable number of members of Boards just do not know whether or not their Trust has a problem.

7.0 Clinically related activities

We produced three separate tables, for providers of acute services, community services and, finally, mental health services. Obviously, some respondents filled in more than one table. Respondents had three choices for confidence in a range of clinically-related activities happening . They were asked whether, without specially checking, they could be confident that these tasks were being performed. The possible answers were 'happens', 'does not happen' or 'in all honesty, not sure'. The results are as follows.

7.1 For providers of acute services

Fig 6: Do the events in these statements happen in your Trust?

Question	Chairs	CEOs	Medical directors	Chief nurses
At least 80% of patients arriving at A and E with chest pains had a care plan initiated within 30 minutes of their arrival	59.72% *0%* 18.06%	47.00% *5.00%* 25.00%	57.00% *8.00%* 19.00%	69.88% *8.43%* 7.23%
An audit of operation notes would be able to identify in at least 98% of cases both the operating surgeon and the anaesthetist	48.61% *4.17%* 31.94%	55.00% *4.00%* 43.00%	67.00% *3.00%* 52.00%	62.65% *7.23%* 22.89%
The hospital's discharge policy has been reviewed within the last 12 months	84.72% *5.56%* 4.17%	86.00% *5.00%* 5.00%	77.00% *9.00%* 13.00%	91.57% *4.82%* 1.20%
At least 95% of patients are discharged in accordance with the discharge policy	48.61% *12.50%* 31.94%	39.00% *13.00%* 43.00%	28.00% *19.00%* 52.00%	43.37% *31.33%* 22.89%
All cervical cytopathological samples are processed in this hospital in line with national guidelines	52.78% *1.39%* 16.67%	58.00% *5.00%* 11.00%	68.00% *2.00%* 15.00%	62.65% *0%* 15.66%
References are taken up and qualifications checked on all permanently employed doctors and registered nurses	90.28% *2.78%* 4.17%	90.00% *1.00%* 5.00%	88.00% *2.00%* 9.00%	92.77% *2.41%* 3.61%
n=	72	100	100	83

n% = happens
n%=does not happen
n%=in all honesty, not sure

Percentages are given as a proportion of all those in a particular post who answered any questions for a care area (ie, acute, community or mental health). Some wrote N/A to some individual sections of each table, or just missed some sections out. For example, only 74 of the 100 chief executives who filled in the section for providers of acute services responded to the section on cervical cytology screening services. This could reflect that their hospital did not process cervical cytology samples, or it could mean that the chief executive concerned just did not want to answer the question – it is impossible to say. However, the percentages are given as a portion of all those who answered for the care area concerned.

7.2 For community services providers

Fig 7: Do the events in these statements happen in your Trust?

Questions	Chairs	Chief executives	Medical directors	Chief nurses
References are taken up and checked on all permanently employed doctors and registered nurses	83.67% *2.04%* 10.20%	91.46% *0%* 3.66%	84.75% *0%* 10.17%	93.44% *0%* 4.92%
The discharge policy of the local acute hospital was reviewed within the last 12 months	51.02% *8.16%* 26.53%	51.22% *3.66%* 26.83%	38.98% *10.17%* 42.37%	70.49% *4.92%* 16.39%
Our formulary has been agreed with the local hospital and has been reviewed within the last 12 months	32.65% *10.20%* 38.78%	36.59% *13.41%* 28.05%	61.02% *15.25%* 15.25%	49.18% *4.92%* 32.79%
We have an agreed policy for at risk children, agreed with the local authority, which has been reviewed within the last 12 months	73.47% *0%* 12.24%	79.27% *0%* 8.54%	76.27% *1.69%* 15.25%	83.61% *0%* 6.56%
We have a protocol for use by community nurses of opiate derivative painkillers, and an audit of case notes would reveal compliance with this policy	24.49% *6.12%* 55.10%	18.29% *9.76%* 58.54%	22.03% *10.17%* 54.24%	27.87% *18.03%* 37.70%
Patients prescribed continence aids for longer than 6 months are reviewed by a specialist continence advisor	40.82% *6.12%* 38.78%	62.20% *9.76%* 14.63%	49.15% *0%* 44.07%	62.30% *8.20%* 16.39%
n=	49	82	59	61

7.3 For providers of mental health services

Fig 8: Do the events in these statements happen in your Trust?

Questions	Chairs	Chief executives	Medical directors	Chief nurses
All psychiatric patients discharged are signed off by a consultant psychiatrist and an audit of the case notes would confirm this	60.00% *2.22%* 37.78%	56.16% *4.11%* 35.62%	48.28% *10.34%* 34.48%	58.18% *5.45%* 29.09%
All patients prescribed ECT have a medical examination prior to treatment by a medical practitioner and an audit of case notes would confirm this	64.44% *3.51%* 28.89%	61.64% *0%* 34.25%	51.72% *0%* 34.48%	63.64% *1.82%* 25.45%
We have an agreed formulary which has been reviewed within the last 12 months	62.22% *1.75%* 33.33%	49.32% *15.07%* 27.40%	63.79% *8.62%* 15.52%	49.09% *9.09%* 32.73%
References are taken up and qualifications checked on all permanently employed doctors and registered nurses	77.78% *1.75%* 13.33%	91.78% *1.37%* 4.11%	82.76% *0%* 10.34%	83.64% *0%* 9.09%
The discharge policy has been reviewed within the last 12 months	71.11% *3.51%* 13.33%	67.12% *2.74%* 24.66%	53.45% *10.34%* 31.03%	72.73% *7.27%* 9.09%
At least 95% of all patients are discharged in accordance with the discharge policy	55.56% *5.26%* 33.33%	41.10% *9.59%* 46.58%	36.21% *6.90%* 51.72%	54.55% *10.91%* 27.27%
n=	45	73	58	55

The statements or hypotheses we selected were in areas where, we thought, a quality failure would result in a Trust Board being hung out to dry by public opinion; in most of the above there have been well-publicised problems. The questions on continence aids were included because of the benefits to both patient dignity and value for money of the regular review of patients being prescribed such aids. The formulary was included because, again, there has been considerable effort at the policy and professional level in terms of cost effectiveness, patient safety and continuity of care.

7.4 Cervical cytology screening

After the Kent and Canterbury Hospitals NHS Trust problems in the cervical cytology screening programme, following on from other disasters such as at the James Paget Hospital, it is hard to believe that a single chief executive in the country would not insist on knowing for certain that samples were being processed in line with national guidelines. However, the survey found that 15% of medical directors and 11% of chief executives could not be sure. Furthermore, 2% of Medical Directors and 5% of Chief Executives were certain that guidelines were not being followed. Though these numbers seem low, it is barely credible that we were able to find a single Trust where the chief executive remained in ignorance of what was going on in the cytology screening laboratory.

7.5 Discharge of psychiatric patients

Likewise, after the many headlines regarding the discharge of psychiatric patients, it beggars belief that the principal recommendations of the Clunis Report are not in place, yet looking at the discharge arrangements from mental health providers, 24.66% of chief executives were not sure if they had up to date discharge arrangements (reviewed with the last 12 months), and 35.62% were not sure if all psychiatric patients were being discharged on the authority of a consultant and whether case notes would bear this out. In regard to this latter point, one wonders whether the disparity between the 10.34% of medical directors who believed that this did not happen should be in contact with their Trust chairs, as only 2.22% of chairs were likewise sure that the standard was not being met!

Variation between the different post holders may be an indication of a separation of intention and reality. Taking the differences in respect of discharge arrangements, higher numbers of chief nurses were confident in the policy having been looked at over in the last 12 months, yet much higher numbers of medical directors were not sure whether patients were being discharged in accordance with the policy. It should be remembered that most medical directors are part-time and retain day-to-day responsibility for the care of patients, while chief nurses do not. One could suggest that the doctors were more aware of what was actually happening on the wards, while the chief nurses were more likely to be the principal officer responsible for drawing up and agreeing the policy itself.

Perhaps the other side of the higher number of medical directors uncertain whether the policy had been reviewed in the previous 12 months indicates that they were not involved in drawing up the policy. There is a similar suggestion in the question for community services providers on at risk children. Here chief nurses are most confident that there is a policy and medical directors the least. What is certain is that practice follows on from policy only in the dictionary.

7.6 A&E national standards

With all the professional and policy efforts to promote better door to needle time for patients with possible cardiac problems, it is hard to credit that a quarter of all chief executives could not be certain that their accident and emergency service was able to deliver the national standard. Chief nurses were more confident of their knowledge, and tended to believe that their Trust could deliver the standard. Chief executives were the most sceptical that their organisation could deliver the national standard.

7.7 Opiate derivative painkillers

Very disturbing is that about half the respondents from community Trusts could not be sure that nurses working in the community were guided by a policy regarding the use of opiate derivative painkillers that would translate through to records being kept of their use. Only a quarter of chief nurses, in charge of the troops actually doing the business, were confident that there was guidance and that an audit would reveal compliance with the guidance. Significantly fewer chief executives enjoyed the same level of confidence.

7.8 Clinical records

It is disappointing that despite all the work of NCEPOD and many others in promoting the importance of the clinical record, that only two thirds of medical directors were confident that in 98% of cases both the surgeon and the anaesthetist could be traced using operation records. Less that half chairs were so confident. A small portion of all postholders were sure that their Trust could not meet this standard, and a disturbing fifth of all medical directors and nearly a third of all chief executives could not be certain.

8.0 Lifetime learning, peer review and continuous professional development

Finally, the survey looked at another plank of the changes proposed by the Department of Health – lifetime learning, peer review and continuous professional development. The medical Royal Colleges have been leaders in promoting the benefits of taking time out to spend with one's colleagues in other Trusts on peer review visits. Both the visitor and the visited accrue benefits. At the Health Quality Service we use peer review as a fundamental part of the accreditation process, and our 450 surveyors report how useful they find the experience of time spent in another Trust. Likewise, our clients value the input from their peers when they come and visit.

We wanted to look at both those who would like to engage in this kind of activity, but have been unable to. Also, we felt that it would be interesting to see how many did not, and felt that there would be no benefit in doing so. Again, the responses make depressing reading. They are as follows.

Fig 9: Peer review and professional development

Details	Chair	Chief Exec	Medical director	Chief nurse
Respondents who felt it would be useful to spend at least a week a year in another Trust	72.55%	86.08%	82.40%	82.46%
Respondents who felt it would be useful to spend at least a week a year in another Trust, but have been able to do so in the last 5 years	36.27%	35.44%	52.80%	33.33%
Respondents who felt it would be of no value to spend at least a week each year in another Trust	27.45%	13.92%	17.60%	17.54%

Doctors were least able to engage in peer review and most strongly in favour. More than half had not had the opportunity but felt that it would be useful – an open door for reformers to push on. This squares with the strong lead given by the medical Royal Colleges. However, that one in six felt there would be little value leaves more work for the Colleges on the propaganda front with their members.

Overall, these last results confirm our belief in the value of the peer review opportunities we give executive members of Boards through our accreditation programmes. We are currently engaged in an active recruiting drive to broaden the benefits to NHS colleagues.

9.0 Conclusions

As a whole, the survey is an interesting starter for speculation and discussion. For some of the responses, that we found any Trust Boards members to respond in the way that many have, is a concern. It paints a picture of a service lacking in good quality information and Boards bereft of confidence in the business they are supposed to be running. It seems that even in areas where the media have taken to task their colleagues, some Trust Boards just have not taken the hint. Overall, it is a very articulate polemic of the need for a strong national system of clinical governance. Media activity may have been a catalyst for change is some instances, yet with so much progress still to be made national systems to monitor arrangements are vital to patients using NHS services.

We agree, feeling that if ever their was an argument for the current emphasis on quality, this survey provides it. As accreditors, it is a challenge to us to be able to give Trust Boards, who use our services, the confidence they need to be able to assure themselves that, where there are problems in the organisation of and systems relating to patient care, at the least they know of them.

For those involved in clinical governance arrangements, the challenge is to translate this picture to one of greater confidence over time.

We feel that this survey further demonstrates the need to take the concept of clinical governance further. When asked about confidence in particular activities, many Trust Board members could not answer with any degree of confidence. We would suggest this provides an argument for the broadening of the concept of clinical governance from just a system in itself. It also supports the utility of indicators and other quantitative data to test suppositions and anecdote.

It would be interesting to run a similar survey once clinical governance had had the opportunity to bed in. If clinical governance is going to help to broaden the responsibilities of Trust Boards to include a better handle on patient care, then they will need to know the answers to the kinds of questions posed in this survey.

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