

Implementing Clinical Governance in Gastroenterology

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'Convince an allergic'? (8, 10) anag.

Introduction

The modernisation of the NHS seems to be proceeding at what some might call an alarming pace. The rapid pace of change may account for some clinicians' 'allergy' to the concept of 'clinical governance', but, allergic or not, there is no doubt that it is here to stay. Accountability for quality has now been given equal status to financial accountability¹. The local leaders for clinical governance in both primary and secondary care have the responsibility to make clinical governance acceptable and indeed part of the culture of the New NHS, as well as to manage effectively those resources available for the quality improvement initiatives.

National standards

National standards are being set by the National Institute for Clinical Excellence (NICE) and via the National Service Frameworks (NSFs), and the 'inspection' body, the Commission for Health Improvement (CHI) will ensure that these standards are being met². But local implementation at the level of the health care community still requires an immense amount of enthusiasm, work and resource.

In secondary care, an organisational structure already in place, and in many ways this makes the implementation of any guidance less difficult. In primary care, organisational development of the Primary Care Group (PCG) or Trust (PCT) has to some extent preoccupied local leaders over the last year or so. Recently however, with the publication of several NICE guidelines (Technology Appraisal Guidance), and the NSFs for Coronary Heart Disease (CHD) and Mental Health (and more soon to follow), clinical considerations are rightly regaining centre stage. These frameworks are important because their implementation necessitates a local dialogue about service provision. If nothing else, an NSF or a NICE guideline should get clinicians and managers, from both primary and secondary care, together with lay people and users, around the same table to discuss the local implication of the national clinical directive. It should encourage discussion about a clinical problem and service provision, engender a feeling of local collaboration and ideally facilitate communication and co-operation. Whether this happens or not will be up to local clinical leadership, but it will be key to making the implementation of clinical governance a success.

Gastroenterology

In gastroenterology there is no NSF as yet, but there are important clinical areas which do merit local debate, and are important the local delivery of gastrointestinal services. After all, 10% of consultations in primary care are for gastrointestinal problems, 'dyspepsia' (or indigestion) affects up to 40% of the population in any one year, 1-2% of the adult population are investigated by endoscopy every year, and GI cancers account for about 40,000 deaths in the UK each year^{3,4}. One important NICE guideline on Proton Pump Inhibitor (PPI) prescribing has been published⁵, as well as one on pancreatic disease, and further guidance on other areas of gastroenterological practice are expected.

The Patient

The appreciation of central role of the patient in the NHS is long overdue. We have perhaps recently moved from a 'primary care - led NHS' to a 'patient-led but 'primary care-focussed' NHS. The patient's role in implementing clinical governance is also important, and their view is essential in the quality improvement and accountability process. The user's voice needs to be heard and many patients' support groups are available for various disease areas : e.g.

www.patient.co.uk and www.digestivedisorders.org.uk

Access to care (and in gastroenterology this usually means either some sort of endoscopy or a GI specialist) is of prime importance. The National Patients Access Team (NPAT) has been looking at access to endoscopic services on behalf of the patients during the last 18 months. There has been wide consultation with both professionals and public, and a consensus conference held. A report has been compiled and forwarded to ministers and a response currently awaited⁶.

Primary Care

The implementation of clinical governance in gastroenterology in primary care has been facilitated by a recent publication from the Primary Care Society for Gastroenterology (PCSG)⁴. This is aimed at Primary Care Organisations, Health Authorities and secondary care specialists to help understand and respond to the burden of illness and requirements of care of patients with gastroenterological illness. 17 key clinical topics are identified and systematically examined, providing a template for clinical governance. The clinical point of view, is balanced with information to aid management at the public health and commissioning at the population level.

Each topic is defined, and its significance explained in terms of the numbers of patients or procedures likely to be encountered within a notional PCG with a population of 100,000. Key clinical and therapeutic points are listed, and there are links to national or regional guidelines where these exist, as well as information for patients. There are also sections on access to services, risk management / audit, and health economics for each disease area, and finally guidance on data management, since standardised ways of methods of recording information are now essential for both clinical audit purposes and proper patient care.

The book is available from Radcliffe Medical Press Ltd., 18, Marcham Road, Abingdon Oxon OX14 1AA Tel 01235 528820 or email : orders@radcliffemed.com

Links to other GI sites and more information are available via : www.pcsq.org.uk

Two examples :

- **Endoscopy**

The British Society of Gastroenterology (BSG) has set standards for endoscopy units in secondary care⁷ and also made some early recommendations about standards for primary care⁸. There are also joint guidelines on training for endoscopists⁹. More recently the PCSG has collected data from all primary and intermediate care endoscopists in the country and will soon be publishing results which show a very low morbidity and mortality from procedures performed in these settings. The committee has gone on to compile new recommendations for standards in this field of endoscopy¹⁰. This is of particular importance as the NHS Plan recommends the expansion of GP (and nurse) 'specialists' in endoscopy¹¹. Thus national standards are already being set by a professional groups to influence the implementation of clinical governance at a local level in every primary care organisation (PCO) in the UK. Future interests will revolve around valid outcomes measures from the endoscopic procedure, but research in this important area is still in its infancy^{12,13}.

- **PPI prescribing**

This is important because acid suppression therapy costs the NHS in England and Wales over 521 million a year (1998 figures), and PPIs accounted for 60% of this amount (314m)⁵. Many people may be taking inappropriate doses of these powerful acid suppressing drugs, and it has been estimated that full implementation of the NICE guidance could save the NHS between 40-50m annually in drug costs - although there is a concession that costs of investigation and long term treatment monitoring might counteract these savings.

Many PCOs will have prescribing incentive schemes to try to encourage cheaper prescribing, but it is important that appropriate quality criteria are included. Unfortunately current arrangements do not reward expensive (but good) primary care prescribing which results in savings in the hospital sector (e.g. reduced hospitalisation from GI bleeding by appropriate use of acid suppression therapy). A change in the mechanism is required for recognising cost-benefit of primary care prescribing across the primary-secondary care

interface. Perhaps this could start at the level of the local dyspepsia management guideline? For instance significant event auditing of admissions for GI bleeding could be implemented, with case analysis of prescribed drugs in primary care compared to local recommended guidelines. No doubt this is an issue to be handled tactfully, but surely a powerful tool in improving patient care, learning from significant events, and developing quality as well as cost incentives for primary care prescribing.

The guidance on follow up and the use of the 'least expensive appropriate PPI' should be incorporated into local dyspepsia management guidelines. Again these need many local stakeholders to come together to agree a format, content and implementation strategy.

Conclusion

Standard setting in gastroenterology is already happening, but the process has so far been piecemeal. Professional bodies such as the BSG and PCSG have attempted to set quality standards in their own fields, and there is guidance available to help PCOs and hospital trusts in the gastroenterological field. The patients' and users' voices are beginning to be heard and many patient groups have much to offer. Clinical governance is about accountability and quality improvement: local discussion with involvement of all stakeholders is required to deliver these objectives. Recently published NICE guidance has sparked off local discussions in specific areas. If NSFs do indeed bring about more local discussion about service provision, and do get local professionals and users around the table talking more about what is important in a local service, then the NSF for gastroenterology is eagerly awaited.

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