An interview with Dr. John Wright

Interview by Alistair Craven

Dr. John Wright is Director of Clinical Governance & Operations Medical Director at Bradford Royal Infirmary in the UK.

Dr. Wright is responsible for developing clinical excellence in secondary care, clinical effectiveness, clinical audit, evidence-based practice, patient safety, and service evaluation. In addition to this, Dr. Wright is visiting Professor of Clinical Epidemiology at Bradford University and Honorary Senior Lecturer in Public Health at York University, North Yorkshire.

Dr. Wright is the founder and Chair of NHS LINKS which promotes international health links with developing countries, Editor-in-Chief for the National Clinical Governance Support Team, and project leader for an international development programme for TB and AIDS in Swaziland, Africa. This project has so far raised over £400,000 in research and project funding.

Between 1990 and 1993 you were a Medical Officer and Medical Superintendent in Swaziland, where you gained wide clinical experience in tropical medicine, surgery, obstetrics and trauma. What first inspired you to work there, and how do you look back on this period in terms of your career overall?

John Wright:

I have always been conscious of the widening chasm between rich and poor countries. After training in hospital medicine as a junior doctor I went out to Swaziland with my wife to a 3 doctor hospital in the Lebombo Mountains. The hospital was on the Mozambique border and there was a civil war going on just over this border. At the same time in South Africa to the south, the last days of apartheid were burning brightly. In Swaziland itself the AIDS epidemic had started to explode and the country suffered one of its worst ever droughts.

Working in this environment provided me with a completely different perspective about health and healthcare and also about my own personal development. It taught me how to look at health systems and the wider public health agenda as well as the individual patient. For example, putting a fence up along the road to stop the cattle wandering onto the road at night was a far more effective way to save lives than operating on patients who have been involved in major road traffic accidents.

Clinical governance has been promoted within the NHS since 1998. What is your preferred definition of the term?

John Wright:

Clinical governance is about putting quality and patient safety at the top of the agenda for hospitals and primary care trusts. It means moving quality improvement from the sidelines of professional interest to the core of the healthcare organization.

How does clinical governance relate to patient safety?

John Wright:

Over the last 10 years we have become increasingly aware about the risks of healthcare. Patient safety is an integral part of clinical governance and there is a large overlap between improving patient safety and improving quality. The common theme behind clinical governance quality improvement and patient safety is that of continuous improvement and the challenge of changing professional practice.

In what ways can clinical governance help to drive quality improvement in the NHS?

John Wright:

Clinical governance will work as it is locally owned by clinicians with good leadership and good support. I am a great believer in good information being at the heart of quality improvement to inform our learning.

It has been said that implementing clinical governance requires the transformation of
culture, ways of working, attitudes and of systems in local NHS organizations. Is this agenda for change perhaps too much for the NHS to handle?

John Wright:

I am a bit sceptical about transformational change. I am more Darwinian. I think we tend to evolve and improve on a more evolutionary or stepwise manner, but I think the impact of this slower evolution can be just as great as the more ambitious transformation.

Ultimately, the pressures on the NHS are that from patients to improve quality and that from the Government to improve cost effectiveness. If we don’t recognize and adapt to these pressures then the NHS will struggle to survive.

With regards to the NHS, some news sites claim that much of the cash from UK taxpayers’ National Insurance contributions is actually being swallowed up by red tape and the creation of hundreds of meaningless jobs with high salaries. What is your opinion on such reports?

John Wright:

Like many people, I get frustrated about the continuous reorganization of the NHS. I would like to see the NHS be given more independence like the Bank of England. While some of the endless reorganization may lead to meaningless jobs because of duplication, I don't see this happening to a great extent. We work in a post-modern health service which has become much more complex and sub-specialized than the halcyon days of a local family doctor and a local hospital. The range and nature of professional support to deliver high quality, effective and safe health care has diversified to meet this new environment.

In an interview with the NHS Clinical Governance Support Team you commented that despite being a National Health Service, we rarely look to find out how others are providing healthcare and what we can learn from them. As well as looking domestically, what do you think we can learn from looking at healthcare systems overseas?

John Wright:

I think we can learn from healthcare systems overseas that the NHS is one of the most equitable and cost effective health services in the world. However I think there is much to learn about how we can improve. Kaiser Permanente in the US are often quoted as an example of good practice. I have been impressed by their models of chronic disease management and think that we should be adopting some of the principles underlying their health service provision.

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However, at the opposite end of the spectrum I think there is also a lot to learn from developing countries about how best to use limited resources and not to get sucked up into the illusion that high tech and expensive health care is the solution to good health.

You are Chair of the ‘Hospital at Home’ group, which is working to develop innovative alternatives to traditional in-patient care. Why is this an important area of study?

John Wright:

Patients do not want to be in hospital unless they really need to. Being at home is more efficient and safer for patients and we should be working to ensure that patients get the care they need in the right setting by the right professional.

What are the main components of a clinical audit policy, and what does such a policy set out to achieve?

John Wright:

Clinical audit started off as a very piecemeal process to quality improvement. Much of the initial work around clinical audit was of dubious effectiveness and limited to one-off pieces of work that would highlight a gap in quality which was rarely dealt with. I think clinical audit can work if it is based around regular feedback of individual performance to clinicians or clinical teams. There is an increasing emphasis on this sort of benchmarking comparison at a national and regional level which can really stimulate better practice.
Finally, what interests you outside of your professional life, and why?

John Wright:

My wife Helen and three daughters are my main interest outside of my professional life and a constant joy to me. I love music both listening and playing the saxophone and guitar. I find music inspiring and uplifting and helps me lose myself. With my experience working in Africa I am also passionate about global health and continue my links with Africa and more recently with Pakistan.