Refereed papers

Identification of the critical success factors involved in the implementation of clinical governance arrangements within primary care

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ABSTRACT

The study explores the theoretical grounding for clinical governance development as a quality improvement activity and an understanding and awareness of interactions between culture, power and leadership within primary care. The deepest and most difficult elements of culture to change are basic assumptions – 'the way we do things round here'. The study also explores the government commendation to adopt the EFQM Excellence Model as a framework for clinical governance. This research is based on a longitudinal study across two primary care groups, exploring the nature and origin of people's viewpoints, the reasons for them and subsequent consequences in respect to implementing clinical governance arrangements within primary care.

Keywords: clinical governance, quality improvement

Introduction

Many of the changes introduced within the NHS in the past two decades have been connected with the introduction of the principles of quality improvement, ensuring that quality is at the heart of all decision making.

Virtually all work concerned with quality or improvement recognises the work of Donabedian as the foundation for all subsequent work on quality in health care.[1]

> Donabedian's framework is still acknowledged, certainly by clinicians in the UK, as providing the best foundation for considering the assessment of quality in health care.[2]

The literature suggests that the management of quality within primary care requires changes in the way people behave and is rooted in theories of learning, so that behavioural change is driven by internalised 'quality' attitudes and values held by all members of an organisation. Zuboff suggests that with the development of technology the workplace will depend on workers' ability to understand, respond to, manage and create value from information.[3] The implication is that, to be an efficient, 'informated workplace', knowledge and authority will have to be distributed more equitably than in the past, with more people knowing more and more. Nigel Crisp, NHS Chief Executive, states:

> The whole purpose of these changes is to deliver improvements for patients, clients and the public by changing the way the whole system works. We want to deliver changes in behaviour, culture and processes . . . to achieve this we will decentralise authority, 'shift the balance of power', and manage a major programme of individual and organisational change.[4]

Definition of clinical governance

Clinical governance is part of a new approach to assuring quality health care.[5] It is defined as a 'framework through which National Health Service (NHS) organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.[6]

A First Class Service makes it clear that clinical governance needs to be seen in the context of the entire White Paper, national service frameworks (NSFs), the National Institute of Clinical Excellence (NICE), which will set standards for the NHS, and the Commission for Health Improvement (CHI), which will focus on clinical effectiveness expressed in health outcomes, equity (access to services) and humanity (patients' and carers' views).[7]

Culture

To transform culture, it has been identified that there are three outside influences which substantially influence the networks of groups within and outside an organisation, and which shape culture over a period of time.[8] These are: customer requirements, the competitive environment and societal expectations.

After a number of reported incidents in the NHS (in which questionable clinical practices continued unchecked), raising doubts about not just isolated lapses of care but also the possibility of more systematic failings, diminished trust and reduced public confidence were recurrent themes, powerfully expressed.[9,10] There has followed a continuing search of management and business strategies to ensure NHS organisational systems reflect up-to-date management principles based on the principles of self-assessment, continuous improvement, learning and innovation, teamwork and a culture focused on the customer.[11]

The NHS management inquiry, the 'Griffiths Report', recommended that users' values should be placed at the centre of planning and delivery of services, thus democratising health services and making the medical profession and managers more accountable to the general populace.[12] Growing demand for health care led to the publication of the White Paper, *Working for Patients*.[13] Against this backdrop, technological developments opened up the possibility of moves in two directions: decentralisation (known as empowerment), involving delegating decision making to the lowest possible level by allowing the organisation to be viewed as if it had one hierarchical level, providing them with the training to fulfil their responsibilities; and patients' access to clinical information via the advancement of written and telecommunications. E-health will impose a new clinical culture.

> Multiple constituencies and multiple environments require multiple measures. Constituency interests play a role in definitions of effectiveness . . . actions in and around an organisation may require different kinds of effectiveness measures.[14]

This approach goes back at least as far as the Greeks and is based on each individual's subjective interpretation of the world in which they find themselves.
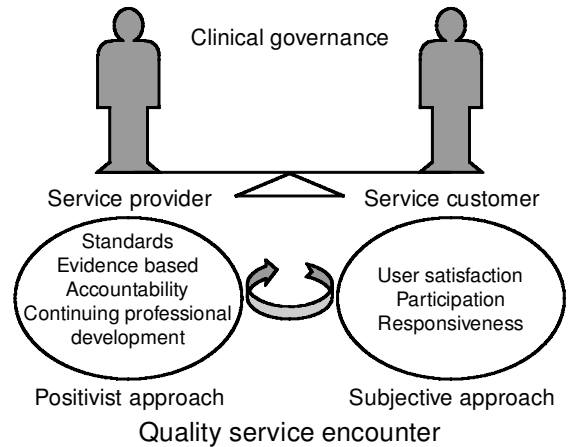

Figure 1 Balance of power

Galbraith explained how individuals within organisations use informal means, which he termed mutual adjustment, to co-ordinate their work.[15] Work by Mintzberg, and others, has laid particular emphasis on the subjective element which draws on individual experiences, intuition and judgement usually identified as tacit knowledge.[16] Psychologists make three basic assumptions when interpreting human behaviour.

1 All human behaviour has a cause, which itself is the consequence of the combined effects of heredity and environment.
2 At the root of human behaviour are needs, wants or motives.
3 Human behaviour is goal seeking; people try to achieve objectives or goals which, when reached, will satisfy their needs.

Considering the first of these assumptions in the context of the research suggests that the combined effect of heredity and environment may impact on a person's perception. Since every individual is different, it is possible for one set of sensations to be perceived in different ways by different people, because they all interpret sensations through their own experiences, motives and attitudes. In the management of people, differences in perception can be the source of many difficulties and conflicts. Therefore good communication is essential to the delivery of local clinical governance arrangements, to ensure understanding by all participants.

The current vision for quality represents an important reaction against the perception of public sector immobility, drift and even ungovernability.[17] It was only in 1994 that the patient was seen as being fundamental to the quality process. In a prospective document looking to the future development of clinical audit in the NHS, the government stated that:

> Clinical audit should be developed by ensuring that it is focused on the patient.[18]

This same document also stated that clinical audit should be undertaken by multiprofessional health teams within a culture of constant evaluation of clinical effectiveness and focusing on patient outcomes, thus laying the foundations for clinical governance.

Methodologies

This section is not intended as a definitive statement on either philosophy or social research, but simply an aid to understanding the relationship between disciplines. It is intended to give some flavour of the philosophical implications of this research and the origins of medical culture, knowledge and power, embedded over centuries. It will take time to implement clinical governance arrangements and to bring about a change in the balance of power.

Until the introduction of formal standards for training and apprenticeships and set medical curricula in the 12th century, little was really known about day-to-day practice:[19]

> What little was known of the healers who worked in the courts, monasteries and villages points to an inclusive system of medicine, where a variety of practitioners – clerical and lay, male and female, literate and illiterate – and a variety of approaches to healing co-existed in loose relationships of co-operation and competition.[20]

The 15th century saw the introduction of systematic dissection of the human body and the production of anatomical atlases, such as those created by Vesalius (*Di Humani Corporis Fabrica*, 1543). This allowed the body to be represented three-dimensionally, allowing the differentiation of internal and external body structures, so that an observer was able to 'view' internal organs from the outside without dissection.[21]

The French philosopher, René Descartes, established a direct connection between the body and the soul which carried profound implications for our developing perceptions of 'self'.

> From this position Descartes proceeded to argue for the existence of two classes of substance that together constitute the human organism: the palpable body, a product of nature, and the intangible mind, which Descartes claimed God had given to humans so they could examine and understand nature.[21]

This formulation gradually opened the door to the reductionist approach characteristic of modern science, including medicine and modern medical practice. Reductionism describes the technique whereby large problems are analysed into successively smaller ones that can be solved individually.[22] The explosion in scientific discovery and knowledge about causative agents led to the increasing professionalisation of medicine, and the creation of teaching hospitals and medical schools dedicated to the study of the human body. As such, it becomes necessary to posit the existence of a world that is, to some extent, independent of human consciousness in order to justify the title 'scientific'.

> For over 200 years in the western nations, professional health care has been associated almost exclusively with medicine and the medical establishment.[23]

This philosophical approach, however, was challenged by Karl Popper in 1966, who claimed that the procedures of science have a central social dimension to their practice. This approach stems from a common belief that reality is subjective and socially constructed in the minds of participants.

Reed points out that:

> between the late 1970s and the late 1980s an ever-widening range of theoretical perspectives were offered as alternatives to the unacceptable constrictions of orthodoxy.[24]

From the post-war years, through the 1960s, to the periods of cost containment in the 1970s and 1980s, and into the era of health system reform of the early 1990s, concepts and methods of quality in health care underwent a quiet revolution. In the early years of the NHS, quality was implied. Standards of care were undoubtedly high for their time and the nationalisation of health services and facilities brought about by the creation of the NHS undoubtedly improved many past inequalities in access and provision. However, quality was essentially viewed through paternalistic eyes, with the patient a passive recipient of care.[25] Changes in technology, our institutions and our values have resulted in the emergence of a radically different society. There has been a perceptible shift away from the rationalistic tradition towards a more interpretative one informed by a subjective epistemology.

Postmodernism is currently popular in organisation theory, as a philosophical stance, and emphasises the fundamental instability of organisations. The new organisational forms are said to be decentralised, flexible networks, re-professionalised, built upon flexible trust-based form of work organisation.[24] Gergen suggests effectiveness is bound up with meaning construction: effective organisations must be open to discursive forms from outside (heteroglossia). They must accommodate diversity to survive. He stresses the importance of locating meaning with people: it is through people that meanings are interpreted and definitions of reality shared.[26]

Definitions of quality

Quality is a subjective concept and therefore difficult to define. Maxwell's six dimensions of quality: accessibility,

equity, relevance to need, social acceptability, efficiency and effectiveness, are often used to guide judgements about quality in health services.[27] Peters and Waterman explain that remaining close to the customer, through listening to and learning from the customer, is a key attribute of excellence in service quality.[28] Morgan and Murgatroyd's philosophical approach to total quality management emphasises the customer's perspective as a critical constituent of quality.[29] In addition, Morgan and Murgatroyd believe that management influences have been important in redressing the quality balance in health care, as traditionally, quality has been defined by professionals alone.[29]

Box 1 Definitions of quality

Source	Definition of quality
Juran[30]	'Fitness for purpose'
Crosby[31]	'Conformance to requirements'
Maxwell[27]	'Quality is made up of six dimensions: effectiveness, acceptability, efficiency, access, equity and relevance'
Øvretveit[32]	'Quality is fully meeting the needs of those who need the service most, at the lowest cost to the organisation, within limits and directives set by higher authorities and purchasers'

The World Health Organisation Working Group suggested that quality must reflect at least the following four concerns:[33]

1 performance (technical quality)
2 resource use (economical efficiency)
3 risk management (the identification of and avoidance of injury, harm or illness associated with the service provided)
4 patient (or client) satisfaction.

In contrast to this, Donabedian describes just two preconditions for assuring quality in health care.[34] The first is accessibility, and the second is money. People have to be able to get care at the right time and in the right place. Donabedian describes quality assurance as having two components: system design and performance monitoring. Neither can succeed without the other.

Quality management – EFQM Excellence Model

The government explicitly 'commended' the use of the European Foundation for Quality Management

(EFQM) Excellence Model rather than develop their own framework for clinical governance. The European Union has recognised that most sectors, including health care, will face increasing competition in the 21st century due to globalisation. The EFQM undertook a major research and consultation exercise during 1997–99, the aim of which was to ensure that the EFQM Excellence Model migrated with the dynamic environment and continued to reflect up-to-date management thinking, resulting in an updated model launched in Geneva on 21 April 1999. A public and voluntary sector version of the model was also made available for organisations such as health care, education and other 'not-for-profit' organisations. A further characteristic is the EFQM definition of excellent results which: show positive trends and/or sustained good performance, are meeting appropriate targets, compare well with other organisations, and are caused by enablers.[11]

Eisenberg and Donabedian identified general characteristics of a quality assurance programme which are essential for success:[34,35]

- leadership – senior management should actively participate in quality assurance programmes
- organisational characteristics – the organisation should provide moral and material support
- characteristics of health professionals – they should be willing to take part in the programme and be responsive to findings
- technical quality of monitoring system – technical adequacy
- influencing the behaviour of health professionals – suitable, apt methods.

Conclusion

Clinical governance is considered to be a process of shifting accountability to the individual, strengthening professional development, and answerable to the local populace, the aim being to assure quality locally.[36] A high standard of clinical practice is a prerequisite of good medical care and, although many aspects are already acted upon, others will require additional resources and the commitment of staff who are continuously required to work harder, often ignoring the 'system', to maintain their high standard.

If primary care groups fail to live up to the electorate's expectations of the NHS, the government could act, not as the body responsible for the service, but as representatives of the consumers, the electorate. If the White Paper's proposals work, significant power will shift to the centre, whilst the responsibility will be well and truly devolved to those engaged in health service provision at a local level.

REFERENCES

1 Donabedian A (1966) Evaluating the quality of medical care. *Millbank Memorial Fund Quarterly* **4**: 166–206.

2 Irvine DH (1990) Standards in general practice: the quality initiative revisited. *British Journal of General Practice* **40**: 75–7.

3 Zuboff S (1995) The emperor's new workplace. *Scientific American* **273 (3)**: 162–4.

4 Department of Health and Social Security (2001) *Shifting the Balance of Power: securing delivery – human resources framework*. HMSO: London.

5 Department of Health (1997) *The New NHS: modern, dependable.* Department of Health: London.

6 Department of Health (1998) *Working Together: securing a quality workforce for the NHS*. Department of Health: London.

7 Department of Health (1998) *A First Class Service: quality in the new NHS.* HSC(98)113. Department of Health: London.

8 Gordon G (1991) Industry determinants of organisation culture. *Academy of Management Review* **16 (2)**: 396–415. The article is available on the Business Source Premier database at: search.global.epnet.com

9 Wells W (1997) *Report into Cervical Screening at Kent and Canterbury NHST*. The Stationery Office: London.

10 Horton R (1998) How should doctors respond to the GMC judgments on Bristol? *Lancet* **315**: 1900–1.

11 Jackson S (1999) Exploring the possible reasons why the UK government commended the EFQM excellence model as the framework for delivering governance in the new NHS. *International Journal of Health Care Quality Assurance* **12 (6)**: 244–53.

12 Griffiths R (1983) *The Report of the NHS Management Enquiry*. Department of Health and Social Security, HMSO: London.

13 Department of Health (1989) *Working for Patients*. HMSO: London.

14 Kanter RM and Summers DV (1987) Doing well while doing good: dilemmas of performance measurement in non-profit organisations and the need for a multiple-constituency approach. In: Powell WW (ed) *The Non-profit Sector: a research handbook*. Yale University Press: New Haven, CT.

15 Galbraith JR (1977) *Organisation Design*. Addison-Wesley: Reading, MA.

16 Mintzberg H (1979) *The Structuring of Organisations: a synthesis of the research*. Prentice-Hall Inc.: Englewood Cliffs, NJ.

17 Pettigrew A, Ferlie E and McKee L (1992) Shaping strategic change – the case of the NHS in the 1980s. *Public Money & Management* July–Sept.

18 Department of Health (1994) *Clinical Audit: 1994/5 and beyond*. NHS Management Executive: London.

19 Morton-Cooper A and Bamford M (1997) *Excellence in Health Care Management*. Blackwell: Oxford.

20 Park K (1992) Medicine and society in medieval Europe. In: Wear A (ed) *Medicine in Society: historical essays*. Cambridge University Press: Cambridge.

21 Wedding D (ed) (1995) *Behaviour and Medicine* (2e). Mosby: St Louis, MO.

22 Ree J (1974) *Descartes*. Allen Lane: London.

23 Seedhouse D (1988) *Ethics: the heart of health care*. John Wiley & Sons: Chichester.

24 Reed MI (1992) *The Sociology of Organisations, Themes, Perspectives and Prospects*. Harvester Wheatsheaf: London.

25 Donaldson LJ (2000) Clinical governance: a quality concept. In: van Zwanenberg T and Harrison J *Clinical Governance in Primary Care*. Radcliffe Medical Press: Oxford.

26 Gergen K (1992) Organisation theory in the postmodern era. In: Reed M and Hughes M (eds) *Rethinking, Organisation: new directions in organisation, theory and analysis*. Sage: London.

27 Maxwell RS (1984) Quality assessment in health. *British Medical Journal* **288**: 1470–12.

28 Peters TJ and Waterman RH Jr (1982) *In Search of Excellence.* Harper & Row: New York.

29 Morgan C and Murgatroyd S (1994) *Total Quality Management in the Public Sector: an international perspective*. Open University Press: Buckingham.

30 Oakland J (1989) *Total Quality Management*. Heinemann: London.

31 Crosby PB (1986) *Let's Talk Quality*. McGraw Hill: New York.

32 Øvretveit J (1990) What is quality in health services? *Health Service Management* June: 133.

33 World Health Organisation Working Group (1985) The principles of quality assurance. *Quality Assurance in Health Care* **1**: 79–95.

34 Donabedian A (1989) Institutional and professional responsibilities in quality assurance. *Quality Assurance in Health Care* **1**: 3–11.

35 Eisenberg JM (1986) *Changing Physicians' Practice Patterns: doctors' decisions and the costs of healthcare*. Health Administration Press: Ann Arbor, MI.

36 Chambers R (1999) *Clinical Effectiveness Made Easy: first thoughts on clinical governance*. Radcliffe Medical Press: Oxford.

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