Implementing clinical governance in English primary care groups/trusts: reconciling quality improvement and quality assurance

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Original Article

Objectives: To investigate the concept of clinical governance being advocated by primary care groups/trusts (PCG/Ts), approaches being used to implement clinical governance, and potential barriers to its successful implementation in primary care.

Design: Qualitative case studies using semi-structured interviews and documentation review.

Setting: Twelve purposively sampled PCG/Ts in England.

Participants: Fifty senior staff including chief executives, clinical governance leads, mental health leads, and lay board members.

Main outcome measures: Participants’ perceptions of the role of clinical governance in PCG/Ts.

Results: PCG/Ts recognise that the successful implementation of clinical governance in general practice will require cultural as well as organisational changes, and the support of practices. They are focusing their energies on supporting practices and getting them involved in quality improvement activities. These activities include, but move beyond, conventional approaches to quality assessment (audit, incentives) to incorporate approaches which emphasise corporate and shared learning. PCG/Ts are also engaged in setting up systems for monitoring quality and for dealing with poor performance. Barriers include structural barriers (weak contractual levers to influence general practices), resource barriers (perceived lack of staff or money), and cultural barriers (suspicion by practice staff or problems overcoming the perceived blame culture associated with quality assessment).

Conclusion: PCG/Ts are focusing on setting up systems for implementing clinical governance which seek to emphasise developmental and supportive approaches which will engage health professionals. Progress is intentionally incremental but formidable challenges lie ahead, not least reconciling the dual role of supporting practices while monitoring (and dealing with poor) performance.

Strategies to improve quality of care now play an important role in healthcare policy in the UK and internationally. There is evidence of variation in quality of care and medical errors in most healthcare systems, and this has prompted governments to seek improvements in quality of care. Moreover, societal changes have meant that people are now more consumer orientated, less deferential to, and expect greater accountability from, professionals.

Clinical governance represents an organisation-wide strategy for improving quality within the National Health Service (NHS) in the UK. Clinical governance is “a framework through which NHS organisations are accountable for continually improving the quality of their services, safeguarding high standards by creating an environment in which excellence in clinical care will flourish”. It seeks to combine previous managerial and professional approaches to quality management, such as quality assurance and quality improvement. Quality assurance refers to initiatives designed to assure minimum standards of (existing) care and the mechanisms created to identify and deal with those whose performance does not meet these standards. Quality improvement refers to approaches which seek to improve care, and prevent poor care, on a continuous basis as part of everyday routine. Both approaches seek to safeguard standards and improve quality of care.

Clinical governance forms part of a wider agenda, set by government, which places attention equally upon accountability for existing care and improving future care (box 1). This agenda includes national standards and guidelines and systems for monitoring quality and performance. These provide the structure which offer the opportunity for improvements in care, to implement processes to improve care, and to monitor the outcomes (box 2).

Primary care groups and trusts (PCG/Ts) set up in 1998 are charged with implementing clinical governance in primary care. The overall project aims to observe a group of PGC/Ts longitudinally as they discharge their core functions. The work presented in this paper describes progress made up to December 2000 and the approaches being used to implement clinical governance. It investigates the concept of clinical governance being advocated by PCG/Ts and potential barriers to its successful implementation, and then sets these issues within the available evidence for whether the strategies being used are likely to lead to the organisational and behavioural changes needed to facilitate quality improvement.

METHODS

The research presented in this paper uses a qualitative design employing semi-structured interviews and documentation review. A qualitative multiple case study approach was used in a purposive sample of 12 PCG/Ts chosen to reflect a range of characteristics including size, rurality, and group/trust status. Repeat visits to the sites will be conducted in autumn 2001 and autumn 2002.

A member of the research team (SC, SH, MM, AR, SP, RS), each an experienced interviewer, visited each site between August and December 2000 and interviewed key senior managers using a standardised interview schedule (box 3). Those

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Box 1 Organisations/initiatives discussed

**Clinical governance**
A framework through which NHS organisations are accountable for continually improving the quality of their services, safeguarding high standards by creating an environment in which excellence in clinical care will flourish. Combination of quality assurance (e.g. minimum standards) and quality improvement initiatives.

**Primary care groups/trusts (PCG/Ts)**
Primary care groups and trusts are responsible for implementing clinical governance in primary care. PCGs were created in 1998 with geographical groupings of about 30 general practitioners covering 100 000 patients, responsible for resource allocation to general practice and an advisory role on secondary/hospital and specialist care. PCTs are responsible for the overall healthcare budget for their populations, for primary and community care, and for commissioning specialist and secondary care. All PCGs will become PCTs by April 2004.

**Personal Medical Services**
An initiative, begun in 1998, that introduces new flexibility to primary care by allowing practices or groups of practices to negotiate new contracts for service provision different from general medical services.

**General Medical Services**
Standard general practice services provided by general practices governed by the “red book” contract.

**National Service Frameworks (NSFs)**
NSFs set minimum standards for the delivery and monitoring of health services (including primary care), confer a statutory duty on all NHS organisations, and constitute a key means of ensuring the implementation of clinical governance.

Box 2 Clinical governance in the United Kingdom NHS
- National Service Frameworks: setting national standards and developing national guidelines
- National Institute of Clinical Excellence
- Clinical governance: strategies for delivering and improving care (including quality improvement and quality assurance activities)
- National Performance Framework: monitoring performance/quality
- Commission for Health Improvement
- National patient surveys

Box 3 Interview schedule: topic headings used at each site
- What do you understand by the term clinical governance?
- What are your clinical governance priorities? How were they chosen? How are they being implemented?
- What organisational factors have influenced the implementation of clinical governance?
- How are users’ views being fed into the clinical governance agenda?
- What do you believe to be the successes of the PCG or PCT with respect to clinical governance?
- What do you believe to be the failures of the PCG or PCT with respect to clinical governance?
- What were (and are) the barriers to implementing clinical governance?
- How do you see clinical governance developing in the future?

Interviewed included all chief executives (n=12), clinical governance leads (n=14; 12 general practitioners and two nurse co-leads), mental health leads (n=9), and lay board members (n=12), as well as two board chairs and one executive committee lead who were identified as key informants by other interviewees. The anonymity of all interviewees and organisations was assured. Interviews were tape recorded with permission and these recordings were fully transcribed, augmented by observational field notes.

Researchers then wrote a detailed case study for each site based on these transcriptions. These followed a common format which concentrated on the structure and membership of the PCG/T (including consultation and partnership working), clinical governance policy (including concept and priorities), and issues relating to the implementation of clinical governance (including approaches being used, perceived successes, and barriers). These case studies, along with individual interview transcripts and relevant documentation such as annual reports and clinical governance reports were then used as the basis for a thematic/content analysis.13 Passages of text relating to a theme were identified and grouped into conceptual categories in a process of iterative review. Emerging themes and ideas were discussed within team meetings.

In addition, the emerging themes relating to the approaches being used to implement clinical governance were compared with data from the second NPCRDC/King’s Fund annual survey of 72 PCG/Ts.10 14

**RESULTS**

**Concept of clinical governance**
Most PCG/Ts emphasised that their priority was to establish the sustainable infrastructures and changes in culture necessary to implement quality improvement rather than quality assurance strategies. “Bottom up” and “softly softly” approaches were advocated to generate trust, goodwill, confidence, and rapport in practices by promoting a developmental, facilitative, and supportive climate. This was based on cooperation and informal persuasion, using (protected time for) joint learning and education, mentoring, and reflection on an informal and incremental basis. In essence, PCG/Ts are advocating the use of “the carrot and not the stick”.

“A lot of it was achieved and is still being achieved on goodwill” (site B, clinical governance lead)

Many interviewees were seeking to develop values rather than set specific priorities, and to develop an atmosphere in which practice staff viewed active engagement with clinical governance activities and involvement with their PCG/T as a positive and mutually beneficial experience. Meetings with practice clinical governance leads (invariably doctors) were a common device to open channels of communication with practices:

“(We need) to try to develop a rapport with all clinicians, to try and involve all professions and to try and develop an . . . atmosphere of trust” (site B, mental health lead)

Some participants argued that this strategy will be undermined unless a perceived blame culture—which is seen by many health practitioners to pervade the health sector—is replaced by a non-judgmental open and participative culture. Most of the senior managers in the sample were aware that many practitioners associate clinical governance with quality assurance and that it perpetuates a blame culture associated with monitoring performance (policing, accountability, the “big stick”) rather than quality improvement. Some interviewees stated that the government’s main agenda for clinical governance was policing orientated quality assurance; this generated suspicion among health professionals. Indeed, several managers stressed that they saw their role as a “buffer” between government and practices.

“I think people perceive the sort of wider government agenda as being much more about policing and about holding people to account, and making doctors, or all clinicians really, act in certain ways and
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limiting clinical freedom, I think that is a fear that many people have” (site E, clinical governance lead).

...the dual role of clinical governance (current accountability and future improvement). Some participants emphasised these implicitly but for others, especially chief executives, quality assurance systems were seen as an explicit part of clinical governance—for example, monitoring performance against standards or milestones and analysis of complaints; in essence, a systems based performance management and monitoring was a separate agenda to the she extent and activity of quality assessment (box 5).

Approaches used to implement clinical governance

PCG/Ts are using a variety of approaches for implementing clinical governance: “The list is endless, quite frankly” (site H, chief executive). The main approaches identified in this study are listed in box 4; the figures in parentheses show how prevalent these approaches are within a wider random sample of 72 PCG/Ts.

Other strategies included the use of Personal Medical Services (PMS) pilot contracts (29%), user evaluations (48%), and audit (43%). Some approaches were advocated by some PCG/Ts but not by others (including league tables and financial incentives), indicating that PCG/Ts do have autonomy in implementing clinical governance.

Many of the approaches and much of the infrastructure used in the name of clinical governance in primary care—such as audits, registers, clinical guidelines, risk management, and continuous quality improvement, and continuing professional education—are not new. However, many strategies being used were seen as new, centring upon the policy objective of fostering a more corporate identity within primary care, the sharing of data, the explicit focus on primary care itself, and the sheer extent and activity of quality assessment (box 5).

Shared learning activities and the openness of shared data about practices were seen as important drivers for change. In particular, half day educational events organised for the whole PCG/T have become a notable initiative. Anecdotal evidence suggests that attendance rates of 95% are not uncommon. Moreover, most PCG/Ts are now sharing anonymised or identifiable data about the performance of individual practices with PCG/T boards (28% anonymised, 36% identifiable), the practices themselves (36%/50%) and the general public (41%/
While such corporate approaches are “not rocket science, culturally (they are) an enormous leap” in primary care (site F, chief executive). These approaches represent a departure from previous initiatives which tended to be profession-specific, and reflect genuine attempts to foster a corporate ethos. Many interviewees regarded such initiatives as a significant success, as much for their very existence as for their likely impact.

Most senior managers argued that it was counter-intuitive to the concept of clinical governance to set specific priority areas, preferring to emphasise that clinical governance should be a strategic set of values and approaches that are relevant to all aspects of health care (sites A, C, D, E, J, K); in essence, a focus on the process of implementing quality improvement and developing infrastructures and supportive cultures within which quality improvement can prosper, rather than concentrating upon specific areas such as diabetes. However, unsurprisingly, all the PCG/Ts in the sample had a programme of priority areas for quality improvement (box 6). Areas covered by current or planned National Service Frameworks featured prominently.

“There are two answers to that question. The simple answer is … coronary disease and mental health. The truer fuller answer would be to say that the first priority . . . is cooperation and involvement, so it’s getting people involved in the process” (site D, clinical governance lead)

**Barriers to the successful implementation of clinical governance**

The 12 case studies highlighted that PCG/Ts face significant barriers in implementing clinical governance (box 7).

These barriers can be divided into structural, resource, and cultural barriers. Structural barriers include weak line management or contractual levers to influence General Medical Services practices, rather than Personal Medical Services practices. Resource barriers include a perceived lack of staff, skills, or information to implement clinical governance. Suspicion by practice staff of the aim of clinical governance, or problems overcoming the perceived blame culture associated with quality assessment, are cultural barriers which will take longer to address. It is arguably the structural barriers that leave PCG/Ts relying on “soft cop” methods such as persuasion and weak incentives.

Some participants felt that clinical governance will fail unless it is funded adequately and argued that the resources available (both budgets and staff) for implementing clinical governance were insufficient. Findings from the annual longitudinal tracker survey found that, 18 months after their creation, 41% of PCG/Ts had no specific budget dedicated to the implementation of clinical governance. For example, some activities depend on all practices having appropriate information technology systems and staff with the skills to use them; however, some interviewees stated that they do not have the funds to make such activities happen.

In theory, PCG/Ts have discretion as to how they implement clinical governance, both in terms of local initiatives and in addressing the government’s “top down” framework which includes implementing National Service Frameworks. However, some interviewees expressed scepticism about how much flexibility PCG/Ts will have in practice:

“I think the government’s approach is really . . . it’s all about performance management. The trouble with that, which is very much a ‘top down’ approach, is that if you’re not careful you can squash out all the innovations” (site K, clinical governance lead)

Other participants emphasised that they had had to focus on government set targets such as reducing waiting lists for cancer patients which, while important, were nationally set priorities, at the expense of local priorities.

**DISCUSSION**

Primary care groups/trusts are focusing on setting up systems for implementing clinical governance which seek to emphasise developmental and supportive approaches which will engage health professionals. These approaches incorporate—but move beyond—conventional approaches to quality assessment (audit, incentives) and involve approaches which emphasise corporate and shared learning. However, formidable challenges lie ahead, not least reconciling the dual role of supporting practices while monitoring (and dealing with poor) performance and overcoming structural and cultural barriers.

**Limitation of the study**

The interviews and case studies reflect a purely managerial perspective (key PCG/T senior managers) which may not reflect what is actually happening in practice. The views of primary health care practitioners, users, and local and health authority staff are not represented. However, the study aimed specifically to look at the attitudes and approaches of those responsible for clinical governance at the operational level of PCG/Ts, and to understand how senior managers in PCG/Ts are approaching the implementation of clinical governance.

**Reconciling quality assurance and quality improvement**

The interviews showed that the PCG/Ts have set up a wide variety of approaches for implementing clinical governance which fall into two overlapping systems: systems for assuring existing quality of care (quality assurance or service development) and strategies to improve future quality of care. The fact that this issue was so prominent in the interviews is unsurprising, given that clinical governance explicitly seeks to combine these two sets of approaches. Developmental quality improvement strategies and quality assurance monitoring are two sides to the same coin of the process of clinical governance. There is a potential tension between these two sets of approaches which has important implications for the successful implementation of clinical governance. It is based on reconciling different philosophies and sends mixed messages to health professionals, government, and users. It also highlights a potential flaw in the implementation of clinical governance which may find some PCG/Ts generating hostility from both above and below. On the one hand, despite
the educational and supportive approaches being advocated by PCG/Ts, the quality assurance element may threaten to fos-
ter continued disengagement and suspicion by some health professionals. However, educational and supportive ap-
proaches may fail to satisfy government demands for greater accountability and predefined minimum standards, and those
of the public, fuelled by high profile media cases.

Recognising that the successful implementation of clinical governance in general practice will require cultural as well as
organisational changes and the acquiscience if not enthusi-
amism of practices, PCG/Ts are focusing their energies on
supporting practices and getting them involved in multipro-
fessional and corporate clinical governance activities—that is,
facilitative non-policing approaches. Such approaches adhere
to a “quiet word” system of networking.16 It may be that such
“softly softly” approaches are designed to keep the
professions—especially general practitioners—on board, with
PCG/Ts seeking to manage the implementation of clinical
governance so that health professionals view it as something
that they have had a role in formulating themselves, rather
than as a policing mechanism. Such a facilitative role may be
important because many practitioners perceive that they
practise under a blame culture, and there are problems with
both the morale17 and recruitment and retention18 of general
practitioners. Lessons learnt from the introduction of clinical
guidelines also emphasise the importance of ongoing imple-
mation strategies and a sense of ownership by those
involved.19 The effective implementation of clinical governance
may also be facilitated by taking advantage of quality
improvement approaches which may have a long standing role
in different localities such as local audit groups.

These interviews suggest that some senior managers in
PCG/Ts, particularly clinical governance leads, are seeking to
differentiate the dual role of clinical governance. One possible
solution to resolving the tension between the “hard” and
“soft” roles would be to divide them between different
individuals—for example, clinical governance lead and
Chair—or institutions—for example, health authorities and
PCG/Ts. Anecdotal evidence suggests that some PCG/Ts are
leaving it up to health authorities to address issues of
monitoring poor performance. However, PCG/Ts are setting up
systems for monitoring performance and quality. Impor-
tantly, the government’s management agenda for the NHS does
have a strong quality assurance aspect (Commission for Health
Improvement and dealing with underperforming doctors).
The government explicitly includes both quality assurance
and quality improvement as core elements of clinical govern-
ance. PCG/Ts will need to balance these dual functions but are
aware of the importance of engaging (sometimes reluctant)
practices and staff in clinical governance activities and, as
such, emphasise quality assurance rather more implicitly.
The fact that some PCG/Ts are emphasising their developmental
role (“good cop”) rather than their role in monitoring
performance (“bad cop”?) is hardly surprising. Reconciling
these two models in practice represents a key task for PCG/Ts
in the years ahead. The balance could shift either way.
However, it is unlikely that clinical governance leads, or any
individual senior manager, will be able to wear both hats
without experiencing some conflicts between these two roles.

Effective strategies for change

It is interesting to refer to the evidence base of the approaches
for implementing clinical governance being advocated and
used by PCG/Ts. There is limited evidence for the effectiveness
of many of the approaches promulgated in terms of quality
improvement or for deriving the changes in organisational
and/or professional behaviour necessary to secure quality
improvement. These include audit, feedback, clinical guide-
lines, local consensus and the influence of opinion leaders,
continuous quality improvement, and total quality
management.20-24 However, there is evidence that strategies
that combine continuing education, audit, research, and clini-
cal effectiveness in unified multiprofessional educational
strategies which link learning to daily routine lead to changes
in behaviour.15 25 PCG/Ts are using methods such as audit and
clinical guidelines—which are least effective when used in
isolation—in combination with a variety of approaches.

Education and learning at the organisation level seem to be
the primary drivers for change.15 25 26 Real improvement comes
from changing systems.27 The developmental approaches
being used by PCG/Ts, which focus on team and corporate
learning, are therefore founded on a sound basis. To be truly
effective, primary health care teams need to learn to work,
learn, and plan together.28 Moreover, they require fundamental
changes in organisational and behavioural (professional)
culture which are far from straightforward and take time to
achieve.29 30 However, it is unclear whether PCG/Ts will be
given the time to implement what are medium to long term
strategies, faced with government demands for short term
evidence of improvements in quality and public accountabil-
ity.

The new arrangements represent some significant depar-
tures from past policy. Firstly, there is now a statutory duty on
all NHS organisations to put in place quality improvement
processes: it is no longer the preserve of volunteers or enthu-
siasts. Secondly, clinical governance is an organisation-wide
concept which applies to the whole health service, unlike pre-
vious quality strategies which were often fragmented or sector
specific. Thirdly, within this organisational focus there is now
an explicit agenda for improving the quality of primary care.
Lastly, previously independent contractor primary care practi-
 tioners and autonomous practices are being asked to work
within a corporate philosophy. Clinical governance is part of a
wider shift to corporate governance within PCG/Ts with a
focus on sharing budgets and collective responsibility for
investment decisions and clinical priority areas.

While the findings of this study are rooted within the con-
text of the UK NHS, some are generalisable to all healthcare
systems. For example, the effective management of new direc-
tives about quality of care and cultural change do not occur
overnight but require realistic timetables, resources and,
desirably, the co-ownership of both assessors and assessed.
There are also difficulties in employing open and non-
threatening approaches which engage practitioners while
ensuring patients that mistakes are not being made. PCG/Ts, in
common with all healthcare organisations, need to strike a
balance between checking the quality of care being provided
by practitioners and trusting health staff to deliver quality
improvement.

CONCLUSION

PCG/Ts face significant and formidable challenges and
barriers to implementing clinical governance. Government
will expect them to translate activity into improvements in
quality of care and patient outcomes. Changes are beginning

Key messages

- Primary care groups/trusts (PCG/Ts) are setting up systems
  of quality improvement for supporting practices and practi-
tioners and also quality assurance systems for monitoring
  performance.
- They are emphasising a developmental and supportive role
  in order to engage practices and practitioners.
- PCG/Ts face formidable challenges in implementing
clinical governance. These include reconciling their dual
role in improving overall quality of care and managing
poor performance, managing cultural change, and meeting
government targets for minimum standards.

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to take effect. However, so far, activity has been focused on setting up structures and processes rather than tangible outcomes in quality. Successful implementation of clinical governance cannot be imposed by decree. PCG/Ts appear to require appropriate time sensitive outcomes. The cultural and behavioural changes required for the successful implementation of clinical governance will require adequate levels of resources. Moreover, evaluations of the success or failure of clinical governance will require appropriate time sensitive outcomes. The cultural and behavioural changes required for the successful implementation of clinical governance are both a medium and prerequisite to take effect.

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