

# Clinical governance: opportunity or Pandora's box?

This edition of *Hospital Medicine* begins an important series on clinical governance (p. 505). 'Ho hum!' you might say — surely not again! It seems that every journal and every conference has this subject as its primary focus. My response to this is 'so they should'. The reasons for this come through clearly from the articles in this series. Four perspectives are covered — the historical and cultural context by Phil Ayres, the educational perspective by Peter Hill, a specialty perspective from Peter Connelly and a trust perspective by Ian Haslock. Different views but, in fact, the same message — clinical governance is the opportunity to get quality services addressing patients' needs to the top of the NHS agenda.

## OPPORTUNITIES AND RESPONSIBILITIES

The opportunity afforded by clinical governance is considerable — it potentially enhances, liberates and enables clinicians to lead the health-care agenda to the benefit of patients. With this opportunity, however, also come responsibilities and the requirement for increased accountability.

Phil Ayres charts the history of how ideas of quality have developed over the last 20 years. The advance that clinical governance makes over previous quality initiatives is largely one of coordinating activities such as clinical risk, clinical audit, evidence-based practice, complaints and other quality initiatives. Critically, however, it also acknowledges — possibly for the first time with respect to the quality agenda — the crucial role of leadership and the professional development of staff.

Although the *statutory* responsibility laid on boards and chief executives for quality is certainly new, most NHS

boards and chief executives would have readily acknowledged that the delivery of high quality services was always a key responsibility (Heard, 1997). The multitude of mission statements containing the word 'quality' is a testament to that.

The government's new human resources strategy, *Working Together: Securing a Quality Workforce*, acknowledges 'the link between quality service delivery and quality management of staff' (Department of Health, 1999a). This is perhaps the clearest statement of how the cultural change required to implement clinical governance is to be achieved.

## MAKING GOVERNANCE HAPPEN

So what is really new about clinical governance? It is its emphasis on professional staff development linked to performance management as a means of developing quality services. Creating a learning environment in the NHS which gives 'permission' for individuals to take seriously their professional development, and which makes it necessary for organizations to identify and resource it, is an important advance (Heard, 1998).

The challenge will be whether the Government is serious about resources being used in this way since either new, additional resources will have to be identified or current resources will need to be diverted from direct patient care in order to support staff development. Guidance on continuing professional development (CPD) and future investment in it is shortly expected. However it is to be done, the patient should ultimately benefit, since as Peter Hill points out: 'clinical governance offers a real chance to enhance the quality of patient care. It provides a coherent

framework within which education and training can be directed towards this particular goal' (Hill, 1999).

Will the Government and patient groups be persuaded that this is really the case? There will need to be a debate over whether it is the quantum or the quality of health care that matters. Inevitably a balance will need to be struck which will enable health-care staff to have sufficient time and resource to ensure that the necessary opportunities are available for them to pursue the professional development they require to support modern, evidence informed patient care. Is this a good enough reason to extend waiting lists and waiting times? Will the public buy into their responsibilities and give support to this initiative?

When a patient comes into a general practitioner's surgery with all of the latest information from the net — having spent hours 'surfing' in order to become expert on their own medical condition — there is an expectation that the doctor will have done the same. In a perfect world this would certainly be the case. But in a world of six and a half minute consultations and high patient/carer expectations there will be costs which need to become acceptable to patients and to the NHS if the governance agenda is to be implemented. It may be early days for patient participation in such questions (Dewar, 1999), but frameworks to involve them will need to be developed.

## APPROACHES TO GOVERNANCE

Strategies to implement clinical governance are being developed regionally and within health-care organizations. The Department of Health's most recent guidance, *Clinical Governance: quality in the*

*New NHS*, makes clear that: 'above all clinical governance is about changing organisational culture in a systematic and demonstrable way, moving away from a culture of "blame" to one of learning so that quality infuses all aspects of the organisation's work' (Department of Health, 1999b).

This is indeed a profound statement that is explored in the context of mental health practice in Peter Connelly's paper. The use of a 'local team implementation plan' acknowledges the place of the health-care team in managing patient issues and the need for team members to respect each other and their role in the team in order to achieve maximum benefit for the patient.

Ian Haslock, medical director at South Tees NHS Trust, describes the use of the European Quality Foundation model that was introduced into the trust in order to provide a framework for quality development. With the strong and personal commitment of the Chief Executive, South

Tees has positioned itself to address the requirements of clinical governance. Embedding a belief in the essential 'rightness' of governance into organizations will require, however, the commitment of everyone since as Haslock points out, 'we are all in this together'.

### OPPORTUNITY OR PANDORA'S BOX?

Clinical governance potentially presents an opportunity that could liberate and enable the NHS to become the best that it can be. It is a fitting gift to the NHS in this its fiftieth year, since it restates and invigorates the values of its foundation. But it could turn out to be a Pandora's box, creating more problems than solutions, more trouble for staff and patients than support and more tension in the delivery of health care than resolution of difficult issues. Which way it will go will depend on the success of the partnerships that can be created. Partnerships not only of health-care and other professionals, but

partnerships between politics and health and critically, between the people and health.

Health *is* a political issue. The opportunity offered by clinical governance is that it opens the debate on quality — what it is and, critically, how it is to be achieved. If the public want a health service which is about access and equity, but which is also about excellence then it — and its political representatives — must be prepared to consider what this really means.

It may mean hospitals which are larger groups of clinical teams, resulting in the closure of smaller, local services; it may mean longer waits for some clinical procedures or the cessation of some procedures all together if the evidence for undertaking them is insufficient; it will certainly require greater investment and care for the health-care professionals who deliver the service and who are committed to ensuring that it continues to develop for the benefit of patient care. **HM**

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### KEY POINTS

- Clinical governance brings with it both opportunities and responsibilities.
- Focusing and coordinating quality initiatives are major components of developing clinical governance.
- The emphasis on staff development and learning as a means of developing quality services is the really new aspect of clinical governance.
- The tension between the quantum of health care delivered and its quality requires public debate and resolution.
- Debate over how quality through governance is to be achieved must include its political dimension.
- Partnerships between health, politics and the public will be required if clinical governance is to be implemented.