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The Importance of Leadership in Making Clinical Governance Work

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Abstract

Clinical governance is about changing the way people work, demonstrating that leadership, teamwork and communication is as important to high-quality care as risk management and clinical effectiveness. Individual healthcare professionals need to embrace change, adopting reflective practice, which places patients at the centre of their thinking. Teams need to become true multi-disciplinary groups, where understanding about roles, about sharing information and knowledge and about support for each other becomes part of everyday practice. Leadership at every level from the Board and throughout management is clearly crucial to the success of clinical governance.

This study set out to discover whether managers in clinical services in three acute NHS Trusts are, in the view of nursing staff, exhibiting effective leadership skills in promoting clinical governance. The overall results indicated that nursing staff believe that inadequate leadership is being displayed by nursing and general managers across these three structures. The study provides some insight into the need for leadership, which supports the development of a learning organisation, and identifies the components of a programme to support the development of leadership skills.

Introduction

Health service staff have been encouraged in recent years to develop a commitment to the delivery of high quality care as part of everyday clinical practice (Scully and Donaldson, 1998). In the past many health professionals have watched as Trust management board agendas and meetings have become dominated by financial issues and activity targets (Davies, Nutley and Mannion, 2000). The government's white paper on the NHS in England outlines a new style of NHS that will redress this imbalance (NHS Exec, 1997). For the first time, all health organisations will have a statutory duty to seek quality improvement through clinical governance. In the future, well-managed organisations will be those in which financial control, service performance, and clinical quality are fully integrated at every level (Sec. State for Health, 2000). Clinical governance is to be the main vehicle for continuously improving the quality of patient care and developing the capacity of the NHS in England (Dewar, 2000).

- To maintain high standards (including dealing with poor professional performance)
- It requires an organisation-wide transformation; clinical leadership and positive organisational cultures are particularly important
- Local professional self-regulation will be the key to dealing with the complex problems of poor performance among clinicians
- New approaches are needed to enable the recognition and replication of good clinical practice to ensure that lessons are reliably learned from failures in standards of care

The new concept has echoes of corporate governance, an initiative originally aimed at redressing failed standards in the business world through the Cadbury report (HMSO, 1992) and later extended to public services (including the NHS). The resonance of the two terms is important, for if clinical governance is to be successful it must be underpinned by the same strengths as corporate governance: it must be rigorous in its application, organisation-wide in its emphasis, accountable in its

delivery, developmental in its thrust, and positive in its connotations (Wilkinson, Rushmer and Davies, 2004). The introduction of clinical governance, aimed as it is at improving the quality of clinical care at all levels of healthcare provision, is by far the most ambitious quality initiative that will ever have been implemented in the NHS (Halligan and Donaldson, 2001).

Although clinical governance can be viewed generally as positive and developmental, it will also be seen as a way of addressing concerns about the quality of health care. Some changes in healthcare organisations have been prompted by failings of such seriousness that they have resulted in major inquiries. Variations in standards of care between different services have been well documented. Under the previous government's market driven system for the NHS, many felt that the quality of professional care had become subservient to price and quantity in a competitive ethos. Moreover, some serious clinical failures for example, in breast and cervical cancer screening programmes, have been widely publicised and helped to make clinical quality a public confidence issue (NHS Executive, 1997).

Clinical governance is a system through which 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 (Scully and Donaldson, 1998).

Clinical quality has always engendered a multiplicity of approaches. Universally accepted definitions have been difficult to achieve, and some have even considered the term too subjective to be useful (Brotherston, 1962). The World Health Organisation is helpful in exploring the idea of clinical governance (WHO, 1983). It divides quality into four aspects:

- Professional performance (technical quality)
- Resource use (efficiency)
- Risk management (the risk of injury or illness associated with the service provided)
- Patients' satisfaction with the service provided.

These dimensions of quality are taken a stage further in the components identified in the new NHS white paper as being the attributes of an organisation providing high quality clinical care. The development of clinical governance is designed to consolidate, codify, and universalise often fragmented and far from clear policies and approaches, to create organisations in which the final accountability for clinical governance rests with the chief executive of the health organisation with regular reports to board meetings (equally as important as monthly financial reports) and daily responsibility rests with a senior clinician. Each organisation will have to work out these accountability arrangements in detail and ensure that they are communicated throughout the organisation.

The evidence based medicine movement (EMWG, 1992) has always had a major influence on many healthcare systems of the world. Accessing and appraising evidence is rapidly becoming a core clinical competency. Increasingly, neither clinical decisions nor health policy can any longer be comfortably based on opinion alone.

The NHS research and development programme has helped with the production and marshalling of the evidence needed to inform clinical decision-making and service planning. Clinical governance will require a greater emphasis at local level, where currently the infrastructure to support evidence based practice is not always in place

(NHS, 1997). Although presenting evidence, or providing access to it, is a necessary condition for adopting new practices, it is not sufficient. The field of behaviour change among health professionals is itself developing an evidence base, through which it is becoming clear that single measures are not effective and multifaceted strategies are needed using techniques such as input from a respected colleague, academic detailing, and individual audit and feedback (Oxman, Thomas and Davies, 1995).

Much of the evidence-based work to improve clinical decision-making has centred on specific interventions and clinical policies. However, clinical governance is also expected to address how good practice can be recognised in one service and transferred to others. Where whole services, for example, a community diabetic service or a service for women with menstrual problems, are concerned, it is much more difficult to identify the beneficial elements and replicate them elsewhere. A new major strand in the NHS research and development programme addressing so called service delivery and organisation is intended to tackle this problem.

Changes to the NHS complaints procedure in 1996 reduced the fragmentation and inconsistency of previous arrangements as well as introducing more openness and lay participation (NHS Executive, 1996). The health service has yet to develop a simple way to allow the important, generalisable lessons to be extracted from the extensive analysis, information gathering, and independent judgment, which now underpin the handling of complaints. Moreover, a wealth of other information on clinical incidents, which are the subject of internal and external inquiries is generated, but there is no obvious route for this information to be channelled to prevent similar errors from recurring. Clinical governance has the opportunity to address this weakness requiring organisational as well as individual learning.

The Importance of Leadership in Change

Clinical Governance was introduced to provide the means of developing mechanisms to facilitate continuous improvement in the quality of health care provided through effective leadership, detection and management of poor performance, continuous professional development of individuals within the organisation and collaborative working practices and partnerships (Sally and Donaldson 1998). One of the greatest challenges to the success of Clinical Governance has been the need to transform the organisational culture into a more open and participative forum by questioning traditional practices (Davies et al 2000).

Cultural changes require effective leadership with clear communication of the vision, benefits and arrangements for Clinical Governance to all levels in the organisation. To encourage ownership of Clinical Governance at local level, management style must facilitate an open participative environment empowering individuals to question and input into the day-to-day delivery of a quality service (Halligan and Donaldson 2001). A supportive leadership style should give confidence to clinical teams and other professionals to provide quality care (Griffiths 2003). However, effective leadership is difficult to quantify and those interviewed consider that insufficient resource has been input into providing professionals with the leadership skills required to take Clinical Governance forward.

With service users at the centre of Clinical Governance, it is essential that procedures are in place to identify and manage poor performance of practitioners with the positive aim of learning from adverse events and protecting safety. Rapid assessment of issues is required at local level to identify flexible and constructive

ways of managing such events (Scully and Donaldson 1998). The reformed system of professional regulation of medical practitioners (GMC 2000) will reinforce this at national level. Management of such issues in a fair and professional manner should see a move away from the traditional 'blame' culture of the 'old' National Health Service and will test policies and procedures in place.

Currie and Loftus-Hill (2002) argue that in spite of claims that organisational culture has changed to 'no blame', many clinical staff feel unable to comment on the poor quality clinical practice of others as the culture of fear and blame still exists in reality. For Clinical Governance to succeed, the NHS must fully recognise that its greatest asset is the employees, who have the potential to contribute to the achievement of a high quality service (Nicholls et al 2001). Direct participation of employees in developing quality strategies that are realistic and workable requires investment in respect of professional development (Wilkinson et al 2004). Development strategies that are based on evidence to advance quality aims of the organisation are a basic principle of Clinical Governance.

To achieve a quality service provision, individuals must be provided with the opportunity to equip themselves with the relevant skills via professional development. Wilkinson et al (2004) argue that to achieve a safe, quality service the NHS must adopt the principles of a learning organisation in a positive and constructive manner. They go on to claim that for an organisation to be critical, creative and responsive to change, it must capitalise on individual and group learning opportunities. Collaborative working practices within and between professional groups, managers and the public, are a key component of the success of Clinical Governance and central to the thrust of cultural change. The concept of quality should be discussed at local level between groups to formulate strategies for achieving quality (Dewar 2000).

The 'top down' approach of Clinical Governance bestows a responsibility at local level with Trust Chief Executives to establish mechanisms to achieve this. Dewar (2000) argues that individual accountability forms the basis for inter-professional collaboration and the change in traditional culture systems. However, the 'top down' approach is idealistic and does not account for the diversity of the NHS and the individuals within, or the increasing consumer awareness of the service user. Wilkinson et al (2004) claim that communication between the various stakeholders is paramount in order to provide a high quality service and this can only be achieved by bringing together the common goals under the Clinical Governance umbrella. The involvement of service users can and should influence service quality as defined in the NHS Plan (2000). Input from service users will influence Clinical Governance in respect of identifying quality improvements and initiatives to maintain continuous improvement (Halligan and Donaldson 2001). However, in spite of the obvious benefits of collaborative working and partnerships, there appears to be a mismatch between theory and reality. Traditional cultural barriers exist to the achievement of success, such as preservation of professional identities, perpetuated professional hierarchies, ineffective communication and poor leadership (Currie and Loftus-Hill 2002).

The evidence based medicine movement has always had a major influence on many healthcare systems of the world. Accessing and appraising evidence is rapidly becoming a core clinical competency. Increasingly, neither clinical decisions nor health policy can any longer be comfortably based on opinion alone (Donaldson, 1994).

The NHS research and development programme has helped with the production and marshalling of the evidence needed to inform clinical decision-making and service

planning (Berwick, 1989). Clinical governance will require a greater emphasis at local level, where currently the infrastructure to support evidence based practice is not always in place. The most obvious is information technology to enable access to specialist databases (NHS, 1997). However, libraries, for example, are a basic requirement for access to professional knowledge, and a recent review in one English region has shown wide variation in funding for and access to library services.

Although presenting evidence, or providing access to it, is a necessary condition for adopting new practices, it is not sufficient. The field of behaviour change among health professionals is itself developing an evidence base, through which it is becoming clear that single measures (such as general feedback) are not effective and multifaceted strategies are needed using techniques such as input from a respected colleague, academic detailing, and individual audit and feedback (GMC, 1995).

Much of the evidence-based work to improve clinical decision-making has centred on specific interventions and clinical policies (Brotherston, 1962). However, clinical governance is also expected to address how good practice can be recognised in one service and transferred to others. Where whole services for example, a community diabetic service or a service for women with menstrual problems are concerned, it is much more difficult to identify the beneficial elements and replicate them elsewhere (Currie and Loftus-Hill, 2002). A new major strand in the NHS research and development programme addressing so called service delivery and organisation is intended to tackle this problem (Sec. State for Health, 1997, 2000). Changes to the NHS complaints procedure in 1996 reduced the fragmentation and inconsistency of previous arrangements as well as introducing more openness and lay participation. The health service has yet to develop a simple way to allow the important, generalisable lessons to be extracted from the extensive analysis, information gathering, and independent judgment, which now underpin the handling of complaints. Moreover, a wealth of other information on clinical incidents, which are the subject of internal and external enquiries is generated, but there is no obvious route for this information to be channelled to prevent similar errors from recurring. Clinical governance has the opportunity to address this weakness requiring organisational as well as individual learning (Wood, et al, 1995; NHS Exec . 1998).

Methodology

A short e-mail based questionnaire was circulated to 200 nurses across three acute hospitals, of which 113 replied, 56.5 per cent of the total. Interviews with 20 nursing staff selected at random took place to discuss the results and the reasons why the nurses thought the way they did.

Do you believe that the leadership you receive supports the implementation of clinical governance initiatives ?

Frequently	Regularly	Occasionally	Rarely	Total
3.5%	24.7%	29.3%	42.5%	100%
4	28	33	48	113

The interviews were semi-structured picking up the main theme about leadership within the context of the changes being made for the introduction of clinical governance. The majority of those interviewed think that few of their managers have

been trained in leadership skills and those that have, have more often than not received ineffective training, training in leadership skills unrelated to the NHS culture and work environment or have had no training up-dates to help them perfect and retain their skills. The majority of interviewees also consider that the NHS culture is not supportive of quality initiatives or the 'no blame' approach to learning which must form, in the interviewees opinion, part of a culture where collaborative working and positive leadership skills are valued.

Various ideas were contributed to this study by the nursing staff participating in the interviews as to how a training programme might be developed which would prepare managers to lead on Clinical Governance. The nursing staff commented that they saw short-comings in the leadership skills of senior nursing management with no evident shared vision about the way in which clinical teams will operate, and with no evident commitment to the project. Senior managers do not display styles of management conducive to listening to staff, an important element in the encouragement of staff consultation, involvement and ownership. Interviewees believe managers do not understand the essence of the key components of communication with staff in the development of understanding, awareness and appreciation of the patient/carers experience.

The interviewees and survey participants all agree that successful implementation of Clinical Governance, as a means of developing mechanisms to facilitate continuous improvement, can only be achieved through effective leadership and management. Addressing poor clinical performance through continuous professional development of individuals within collaborative working practices is the only affective way of ensuring continuous improvement (Sally and Donaldson 1998). Such an approach needs a transformation of the organisational culture of the NHS into a more open and participative forum (Davies et al 2000).

Such cultural change, however, requires effective leadership, which has the ability to communicate clearly the vision, benefits and arrangements for Clinical Governance to all levels of staff within in the organisation. Success will only be achieved by accepted ownership of Clinical Governance at local operational level, encouraged and supported by a leadership and management style, which facilitates an open participative environment. By empowering individuals to question and input into the day-to-day delivery of a quality service this objective of ownership of performance and quality by front-line staff will be achieved (Halligan and Donaldson 2001).

The leadership style required to achieve this objective is not deemed by the interviewees to be present in the NHS and, therefore, the confidence, which such a style would give to clinical teams and other professionals, is lacking, and as a consequence the quality care sought is also lacking (Griffiths 2003). The interviewees describe effective leadership as being absent in the formal training and professional development of nursing staff, and as a group they agree with Sally and Donaldson (1998) that there is insufficient resource put into providing professionals with the leadership skills required to take Clinical Governance forward. Such skills are necessary if procedures are to be put in place and operated to identify and manage the poor performance of practitioners. Specialist skills are required to turn performance around with the positive aim of learning from adverse events drawing on an assessment of what issues are important at local level in identifying flexible and constructive ways of managing such events (Sally and Donaldson 1998). The positive leadership and management of such issues in a fair and professional manner should see a move away from the traditional blame culture of the National Health Service (Currie and Loftus-Hill, 2002), which even today causes many clinical staff to feel unable to comment on the poor quality clinical practice of colleagues.

Often they feel that adverse comments on the abilities of others supports and succours the culture of fear and blame which still exists in reality in much of the NHS.

In doing away with this culture of fear, the NHS will recognise that its greatest asset is the employees, who have the potential to contribute to the achievement of a high quality service, and who on a daily basis are learning better clinical practice (Nichols et al 2001).

Ensuring the participation of employees in developing quality strategies that are realistic and workable requires investment in respect of professional development for all staff and the specialist leadership skills, which support such a programme, are required now by managers who traditionally have not received such development as part of their professional training (Wilkinson et al 2004). Wilkinson et al (2004) go on to argue that to achieve a quality service the NHS must adopt the principles of a learning organisation to be critical, creative and responsive to change, developing a leadership style which capitalises on learning opportunities.

Developing and maintaining collaborative working practices within and between professional groups, managers and the public, will be a key component of the success of Clinical Governance and an essential part of the cultural change, which will deliver quality at local level (Dewar 2000). Dewar (2000) argues that individual accountability forms the basis for inter-professional collaboration. Wilkinson et al (2004) claim that communication is paramount in order to provide a high quality service under the Clinical Governance umbrella, with the involvement of service users being essential in providing feedback to the 'learning organisation' as to what is needed to develop the service quality defined in the NHS Plan (2000).

Input from service users will influence Clinical Governance in respect of identifying quality improvements and initiatives to maintain continuous improvement (Halligan and Donaldson 2001). The interviewees and survey respondents have clearly identified though that while there are obvious benefits in collaborative working, there appears to be a mismatch between theory and reality, with the traditional cultural barriers preventing the successful implementation of Clinical Governance. If leadership styles do not change and become transformational in form they will perpetuate the barriers that exist to the achievement of success, such as preservation of professional identities, perpetuated professional hierarchies, ineffective communication and poor leadership (Currie and Loftus-Hill 2002).

Discussion

Format and Aims of the Leadership Programme for Clinical Governance

The survey group and interviewees made some suggestions as to the content of a programme of training which would support the development of leadership skills for senior nursing managers. Many of these ideas came from the participants personal knowledge of deficiencies in the professional development programme for nursing staff and general managers and also from identification of the skills required to successfully implement change. Described below is a summary of the aims and purpose of the different elements of the Clinical Governance leadership programme:

Pre-programme Workshop

Placing the training in context is seen by the contributors to the study as important as is a recognition of the importance of team preparation for the event with staff contributing to the programme through their feedback on leadership behaviours of their managers. The suggestion made was for a one-day workshop at which the leadership delegates will be introduced to: the ethos and background of the Clinical Governance programme; a matching of their individual managers learning style to the learning methods that will be used in the programme; a clarification of the commitments required of individual participants to the programme; the establishment of a shared understanding of clinical governance and its place within the strategic agenda; introduction and acceptance of the concept of team diversity and the opportunity to consider how the multi-disciplinary team will function; followed by a discussion on the next steps and key actions to take prior to the main workshop programme.

Workshop 1

The first full workshop should focus on preparing the manager to lead on change, concentrating on the importance of the human factor in the successful implementation of clinical governance, an area identified by the interviewees as being of major weakness. The workshop should encourage managers to reflect on the experiences of service users and staff and then, as managers, explore and define the core values of clinical governance in relation to this reflection on the needs of these two groups. Overall the workshop should examine and focus on change management theories, looking at the aspects that govern the way people work and the positive and negative forces for change in relation to staff resistance to change, and in doing so consider how to engage others, humanely, in accepting and becoming committed to the creation of a shared vision.

Workshop 2

Ideally managers will have started talking to their staff about establishing a shared vision and about how the work team will operate, and having secured executive and senior management commitment to the ideas and approach they have. During this workshop the managers should be made aware of the power of staff consultation, involvement and ownership. The essence of the key components of communication in the context of the projects is covered and the workshop seeks to further develop managers' existing understanding, awareness and appreciation of the patient/carers experience, together with the tools that can be used to achieve this. Managers would be encouraged to consider a wide range of views about their current service by arranging and carrying out staff and stakeholder workshops/interviews.

Workshop 3

During this workshop emphasis will be placed on identifying areas for improvement using tools that would assist in the selection and prioritisation of projects at different levels, e.g. process mapping and creative thinking. It will also emphasise the importance of project management skills and demonstrate tools and techniques for managing individual projects to ensure that they have a successful outcome. Managers will be encouraged to commence the process of identification and project management arrangements for the implementation of change, including the identification of other stakeholders.

Workshop 4

The workshop itself will focus on methods of measuring the effectiveness of change and further prepare teams for implementation. Tools and tactics for negotiating situations are discussed and delegates are reminded about the human dimensions of change and how to manage transition.

Workshop 5

Ideally managers will now be aware of their leadership styles and skills, and their abilities to deal with individuals who may be resisting change. The purpose of this workshop is to focus on the learning model. It will focus on exploring continuous quality improvement, audit and the links with appraisal, as well as linking back to earlier sessions on creating measures for demonstrating change and improvement. The importance of communicating outcomes will be emphasised and managers will be introduced to a range of tools that can be used for this purpose.

Review Workshop

At the end of workshop 5, managers are likely to be at different stages of awareness and leadership ability but will be encouraged to continue their self-development work and move towards continuing improvement over the forthcoming months. Three months after workshop 5, the review workshop will take place. This provides an

opportunity for managers to present both to each other and senior sponsors from each organisation, their progress, learning and outcomes achieved.

Benefits of Participation in the Programme

The benefits from participation in the programme are wide ranging influencing the patient, the organisation and of course the individual manager. Benefits might include:

- Achieving tangible improvements in the quality of patient care and nurse interaction with patients
- Shared learning in a multi-professional and multi-organisational environment
- Equipping managers and their staff teams with the skills and tools needed to lead and achieve real improvements in service delivery and clinical care
- Providing a process for challenging traditions and assumptions, as well as creating solutions for sustainable improvement
- Supporting the achievement of key national and local targets
- Establishing new networks and a forum for learning, reflection and peer support

The programme is a demanding one, however both the programme delivery team and programme facilitators will be available to provide support and advice at each stage. The commitment expected of the individual manager participating in the programme are that they should create protected time to participate in all aspects of the programme. This includes attendance and active participation in all workshops, together with their commitment to taking forward the achievement of interval actions. Managers must also be willing to identify a service area/issue which could be used as the basis of a clinical governance review and be prepared to consider their service from the view point of others; a preparedness to challenge their own assumptions and beliefs and be open minded about the potential improvements is essential. It is also expected that there will be a commitment to sharing and evaluating the outcomes of the programme with others; both locally within their own departmental/functional teams, but also more widely within the organisation. The employing organization also has responsibilities, which requires a significant degree of commitment. It is essential that this commitment is matched by the organisation, and it is expected that this will take a number of forms:

- Enabling participants to be released from their workplace to attend all aspects of the programme – this would involve each delegate being released for a minimum of 1 ½ days per month
- Providing executive support to team members and a profile for the project within the organisation
- Providing team members with the legitimacy to test and implement change within the organisation
- Encourage team members to share the outcomes of their work, both the achievements and
- successes, with others both within the organisation and more widely

Conclusion

The success of such a programme will depend on partnership working in practise at a number of levels: programme delivery team; delegate team and organisational levels. This programme, its intended outcomes, structure of learning and development, together with the commitments required of both individuals and organisations would help the implementation of Clinical Governance.

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