Clinical Governance and Nursing – a Sociological Analysis

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Abstract

The primary focus for this Thesis is an account of the degree to which nurses and other stakeholders in one National Health Service hospital Trust have responded to the 'clinical governance' initiative, the effects on quality improvement and professional regulation and the practical accomplishment of legitimacy. 'Clinical governance' involves demonstrating that quality assurance is routine practice within every healthcare organization.

A case study was undertaken, using broadly ethnographic methods. The qualitative data were obtained by documentary analysis, non-participant observation of meetings and day-to-day ward activity and semi-structured interviews. In terms of the analysis of documents and observation of meetings, new institutionalism theory was found to be useful as a framework for understanding the political and ceremonial conformity that marked the clinical governance process. Errors and inconsistencies were found in formal documentation and the Trusts' reporting systems were fraught with problems. Nevertheless, during the same period the Trust obtained national recognition for having appropriate structures and systems in place in relation to clinical governance.

A grounded theory approach was adopted in the analysis of the semi-structured interviews. Emerging themes from interview data were identified under the main categories of: 'Making Sense,' 'Knowledge Construction,' 'Somebody Else's Job' and 'Real Work.' It was concluded that at a practice level, clinical governance was poorly understood and that the corporate organizational goals were ambiguous and seen as unrealistic on a day-to-day basis.

The study concludes that what is happening is not a 'failure' but an unintended consequence that has resulted from an inadequate understanding of how organizations work. It is suggested that the organization has conformed to the appropriate standards in order to survive legitimately, but the ultimate impact of clinical governance on the quality of care in practice is inconsistent.

Chapter One

Setting the Scene

1:0 Introduction and Need for this Study

My initial interest in clinical governance arose from my professional educational links with an elderly care directorate within one acute National Health Service (NHS) Hospital Trust. At professional development meetings with the senior nursing members within the directorate some years ago, I often observed requests by managers for increasing amounts of administrative documentation from nurses for 'clinical governance' purposes. Explanation of what was required for this documentation took up considerable time at these meetings. I was interested in the comments made by nurses regarding these seemingly pointless information requests from managers. It appeared that there was no feedback as to the use of this documentation, or reasons given for the request in the first place. I asked one G grade charge nurse how much of his time he thought he was spending on this type of paperwork and he estimated it to be about 25%. This seemed excessive to me and prompted further questioning. Hammersley and Atkinson (1995) suggest that such an event can precipitate social research.

I became fascinated by 'how' the formal structures and bureaucratic rules of clinical governance 'improved' the quality of care merely (it appeared) through the production of paperwork. I therefore wanted to observe day-to-day ward nursing activities to discover how qualified nurses delivered this 'improved care' in their practice. My aim then was to investigate how clinical governance was improving the quality of patient care, by exploring the knowledge and practice of nurses on the wards. When I was initially considering what was happening within the Trust, I thought I could achieve this by attending meetings at all levels of the organization and by interviewing nurses and other stakeholders involved in clinical governance. I also wanted to observe the nursing care given to patients within two large directorates at the hospital. This Thesis, therefore, had a central focus on nursing and clinical governance because nursing is in the front-line of the delivery of care and had been relatively neglected in studies of clinical governance.

During the course of my two-and-a-half years of fieldwork, I met some very dedicated, hard working staff, waiting for the next person to come along and tell them what they were doing wrong. Amongst many other meetings, I attended corporate Trust level clinical governance meetings and analysed organizational decisions. I tracked and asked about intranet

information resources available for hospital staff. I conducted staff interviews and observed everyday practice on elderly care and neuroscience wards. I also noted that during the course of my observation the Trust received national awards in recognition of having implemented the necessary systems and processes required for clinical governance.

What emerged from my study was an example of one institution experiencing rapid organizational change and having to comply with the increasing numbers of rules and regulations imposed on it, necessary for its survival. I quickly realised that I could not study nurses in isolation as they are part of, and dependent upon, how the organization within which they work functions. This ethnographic study therefore changed its original focus as the story unfolded and, whilst retaining a nursing perspective, became more of an organizational study of the rhetoric and reality of the everyday practice of nurses and other stakeholders within one NHS Trust, in their efforts to make sense of and implement clinical governance. (In this study, the term 'rhetoric' is used to identify formal policy statements and claims made by leading professionals and policymakers to promote the adoption and dissemination of clinical governance ideas and practice).

After careful consideration of various theories, I decided to utilise new institutionalism theory[1] as a framework for understanding the political and 'ceremonial' context of this one NHS organization in its process of change. With this perspective, therefore, the study will consider whether or not the process of clinical governance is '*promoting excellence, imposing control, or simply producing a symbolic image of the organization that reflects changing environmental notions of legitimacy'* (Meyer and Rowan 1977:41). It considers the degree to which nurses and other healthcare groups in one NHS Trust have responded to the clinical governance initiative, the effects on quality improvement and professional regulation, and the organizational challenges experienced in order to achieve the practical accomplishment of legitimacy, as proposed by neo-institutionalism.

Chapter One identifies my motivation to establish how clinical governance was affecting the bedside care given to patients on the wards in one NHS Hospital Trust. It explains how the focus of the study changed and it highlights and emphasises the need for studies of this kind in medical sociology. I explain the background to the clinical governance initiative, the current organization of the NHS in England and the introduction of New Public Management. The Chapter concludes with an outline of successive Chapters.

1 See Chapter 3:10 New Institutionalism Theory

1:1 The Importance of Studying Healthcare

The NHS Plan (2000a) constitutes the biggest change to health care in England since the inception of the NHS 1948. It would not be possible to conduct any study into an aspect of health care delivery without considering all the complex interrelated networks and fluid boundaries surrounding the organization. There also has to be a consideration of state intervention, professional regulation, inter-professional and lay relationships, commercial and administrative activities and the use of new health technologies, together with the nursing health care context. Nevertheless, fundamental and essential factors that must be included in the process are an evidence-base and systematic evaluations of any changes. As will be demonstrated,[2] this aspect appears to have been consistently overlooked.

According to Davies (2003), organizational studies of the NHS have not been prominent over the past few years. In particular, studies of the hospital as a social organization have declined significantly in the last thirty years. In the 1960s, it appeared to be a major area of study within medical sociology, as indicated by original work such as Freidson's (1970a) study on professional dominance: a general statement about those defining organizations and the staff within them. In presenting an account of the publication history of health care organizational studies, Davies (2003:183) states that, '*the new scholarship on governance, networks and open systems is coming from sources outside sociology.'* She continues, '*it would be ironic indeed if a discipline so centrally concerned with questions of institutional change, legitimacy, professional expertise and social inclusion were to neglect these topics*.' This amounts to an active encouragement to study the neglected field of the health care organization, especially in the current climate of continuous dynamic change. Davies also makes it clear that health care organizations are very different from the hospitals studied by medical sociologists forty years ago and therefore there is a particular need for research into the contemporary context of this modern arena.

1:2 Clinical Governance

One of the dominant features of recent organizational developments within the NHS has been the introduction of clinical governance. Broadly speaking, the intention of clinical governance was based on the philosophy of continuous quality improvement,[3] as will be discussed later. However, specific to clinical governance was the integration of all quality initiatives under one framework. There was an expectation that this quality strategy would

2 See Chapter 2:16 The Evidence-base for Clinical Governance

3 See Chapter 2:2 Griffiths Report, Total Quality Management; Continuous Quality Improvement and Standard Setting

embrace the fundamental role of culture and leadership in addition to emphasising the role of 'the learning organization,'[4] as aspects of developing quality services. Therefore, to all intents and purposes, clinical governance is an 'umbrella term' under which all aspects of quality can be collected and continuously monitored. Clinical governance aimed to develop a 'new' health service that met the criteria in *The NHS Plan* (DH 2000a).

The first acknowledgement of the concept of clinical governance for quality improvement from the Department of Health (DH); was in the Labour Government's White Paper on health, *The New NHS: Modern Dependable* (DH 1997). The subsequent paper, *The New NHS - a First Class Service* (DH 1998b), presented details of a ten-year quality agenda for the NHS. Promotional papers for clinical governance then became prominent in, for example, Scally and Donaldson (1998) and Lugon, and Secker-Walker (1999). The New Labour Government claimed that the NHS had to be modernised and proposed that quality had to be an explicit and fundamental design principle within it. It was stated (Scally and Donaldson 1998; Swage, 2000) that clinical governance would comprise components such as clear lines of responsibility, a comprehensive programme of quality improvement, procedures for identifying and remedying poor performance and policies for identifying and minimising risk. This marked the beginning of a quality improvement programme for the NHS, which aimed to guarantee fair access and high quality to patients wherever they lived. The White Paper (DH1997) identified the Government's aims of making the NHS *Modern and Dependable* and had the intention of retaining the health services' workable features such as health care audit and discarding the failures for instance that of the internal market initiative (McSherry and Pearce 2002). However, it might be argued that these are matters of intention rather than outcome, particularly as Labour went on to re-invent the internal market.

1:3 The National Health Service in England

The setting for this study is one acute NHS Hospital Trust in England. The NHS in England is a complex and wide-ranging institution consisting of various sectors for the provision of differing sorts of healthcare. In 2002 there were ten strategic regional health authorities (at the time the fieldwork took place), in charge of the development of health strategy in England and responsible for the management of the delivery of local health services within a designated area. These strategic health authorities also ensure that national health

4 The potential for the NHS to become a Learning Organization was emphasised in the Government Report, An Organization with a Memory (Chief Medical Officer 2000).

priorities are translated into local plans. Currently there are still ten strategic health authorities in England.

The first point of contact for healthcare is generally in the Primary Care Sector, from one of the one hundred and fifty two Primary Care Trusts (PCTs) that provide services through health, or walk-in, centres within the community. These offer care from general practitioners, nurses, dentists, pharmacists and opticians. The Primary Care Trust sector deals with preventative services and with certain types of injury and illness that do not require hospitalisation. It controls 80% of the total budget for the NHS and has the responsibility for commissioning healthcare services from other sectors within the NHS. These include hospital emergency care, inpatient and outpatient services. The second sector consists of thirteen Ambulance Trusts that are responsible for responding to emergency calls and for routine work such as transporting patients to hospital or for day service provision.

The third sector is the one hundred and sixty five Acute Hospital Trusts in the NHS. Some of these also provide services within the community, for instance, in the provision of clinics for visiting hospital consultants. At present there is a move towards acute hospital Trusts becoming 'Foundation Hospitals'[5] within a Foundation Trust. In effect, this gives a hospital Trust both financial and managerial freedom from other Trusts (Healthcare Commission 2006). It is important to note that the numbers of organizations involved in care provision are rapidly growing and the Government's various agendas appear to be blurring the boundaries between the NHS, independent sectors and voluntary organizations.

The total expenditure on healthcare in the UK is estimated at £77,847 billion in real terms (Written Parliamentary Answer, Wednesday 1 November 2006).[6] The NHS as a formal organization is a substantial employer of staff. The latest available figures from April 2007 indicate that of the 1.3 million staff in the NHS over 80% (1.13 million), are front line staff. Of these, 60% (675,000) are professionally qualified clinical staff, e.g. 126,000 doctors and 398,000 qualified nurses. 454,000 staff in Trusts and GP practices support them. The remainder (209,000) are NHS infrastructure support staff, with nearly half (102,000) of them in central functions, just over a third (71,000) in hotel, property & estates and just under a fifth (37,000) employed as managers (Information Centre 2007).

5 'Foundation Hospitals' are hospitals run by NHS Foundation Trusts - a new type of NHS body introduced by the Health and Social Care Community Health and Standards Act (2003). Foundation Trusts differ from mainstream NHS Trusts in a number of ways: firstly, they have greater freedom to decide how to meet local health obligations; secondly, they are intended to be more directly accountable to local people; and thirdly, they are authorized and regulated by a separate Independent Regulator for NHS Foundation Trusts. In all other respects, Foundation Trusts have the same responsibilities as NHS Trusts. However, they have a different legal basis, as independent 'Public Benefit Corporations.'

6 http://www.theyworkforyou.com/wrans/?id=2006-11-01c.93889.h

The estimated number of people admitted to NHS hospitals as in-patients in the UK is 10.7m, roughly divided in a ratio of 2:3 male to female. The number of hospital beds available in the NHS is 233,000, or 3.9 beds per 1,000 of the population. Comparative figures for 1980 were 458,000 beds, or 8.1 per 1,000 of the population. The average length of stay in an NHS hospital is 4.7 days, compared with 19 days in 1980 and 45 days in 1951.

It is evident therefore that NHS activity in England is substantial and that the NHS is an extremely large, complex organization with multiple levels of management and planning. In primary care in 2004 for example (latest available figures), GPs and nurses carried out an estimated 314 million consultations, dispensed 720 million prescriptions in the community (to December 2005) and carried out 656,000 operations in the year-end 2005/2006. In the Acute Hospital Trusts, 13.7 million people had their first outpatient appointment in 2005, and 5.7 million people had planned operations (Healthcare Commission 2006:14).

1:4 New Public Management in the NHS

The NHS has been subject to continuous reform and reorganization since its inception in 1948, with politically driven institutional reforms being a consistent feature in the elusive search for effectiveness, efficiency and quality (Pollock 2004). Ferlie *et al.* (1996) argued that, in the past, the impacts of these reforms were superficial and concerns about poor performance have prevailed as, traditionally, the NHS is slow or resistant to implementing Government policy. Miles, Hill and Hurwitz (2001:27) claim that these factors are due to the sheer size of the institution and the fact that '*levers capable of exerting power at the level of service provision were largely disconnected from central policymaking.*'

It is not surprising, therefore, that the NHS has become increasingly influenced over the last twenty-five years by ideas from management experts in applying the principles of general management from business organizations (Flynn 1992; Baggott 2004). In 1979, the Conservative Government promoted the idea of value for money and commitment to the control of cost and reduction of expenditure. '*The introduction of general managers and of 'managerialism' into the NHS in the 1980s was intended by the Government as a move towards more coherent planning and cost control*' (Malin, Wilmott and Manthorpe 2002:127). In order to take control of the service, The Griffiths Report[7] (DH 1983), recommended changing the organizational culture of the NHS by introducing general management with general managers, not administrators, at each level. The language and implementation of performance targets, budgetary and workload ceilings therefore began to apply. This

7 See Chapter 2:2 The Griffiths Report, Total Quality Management; Continuous Quality Improvement and Standard Setting

inevitably caused confrontation between managers and other healthcare professionals, notably doctors, because of the threat to their previously high levels of reward, status and autonomy. Governments used *'New Public Management'* as a philosophy to enable the modernisation of the Public Sector. *'New Public Management'* is a very broad term to describe public sector reforms for efficiency and control purposes taking place since the 1980s (Hood 1995).

New Public Management involved two elements, challenging health professionals in the NHS and incorporating them into the structures of control of health management (Flynn 1992; Harrison and Pollitt 1994). The structure and balance of control altered in favour of the new managers in the health service, with doctors becoming more accountable to these managers for their expenditure. In practice, however, managers were still unable to influence the medical sphere of power to any significant degree and therefore concentrated on tangible results (such as the closing of beds), as doctors still had autonomy for their medical work and dominated the system. However, in 1989, with the publication of a White Paper, *Working for Patients* (DH 1989), enacted through the NHS and Community Care Act (1990), there was a definite reallocation of power in favour of managers resulting in their clear financial involvement in consultant awards, contracts and job descriptions. Concurrently, a growing abundance of performance and quality assurance indicators, together with the advances in information technology, increased the possibilities for managers to take control of the work content, resource use and productivity (Flynn 1992).

Simultaneously, doctors were incorporated into part-time management positions at every level, voluntarily before the 1989 White Paper and forcibly after it (Gabe *et al.* 2004). Flynn (2002) identified this as a solution to a problem, in that the socialisation and co-optation of the medical profession into alignment with managerial views would help doctors accept the need for regulation. In other words, it was a form of 'soft bureaucracy.' By taking on positions such as clinical directors, doctors became subordinate to managers and responsible for managing their own colleagues. In this way, doctors retained a certain amount of management control and, in so doing, could focus on an alternative approach to managing clinical problems. On the other hand, it is argued that this approach allowed the medical profession to re-professionalize in order to retain control, although it is becoming increasingly clear that these roles do cause fragmentation within the profession (Thorne 2002).

In 1999, the New Labour Government introduced the initiative of 'clinical governance.'[8] In effect, this meant that there was a statutory duty on Trust Chief Executives to become responsible not only for financial performance, but also for clinical performance and quality. Suitable evidence is now required from Trusts to indicate that their clinical practice is evidence-based, as directed by, for example, the National Institute of Clinical Excellence (NICE),[9] and the National Service Frameworks,[10] and that this practice is restricted to approved treatments. The organization must also have systems, processes and policies in place to monitor quality improvements in a systematic fashion. Everything is subject to external scrutiny. In this respect, some critics argue that clinical governance is just a further mechanism to increase managerial control of health professions (Gray and Harrison 2004; Flynn 2004; Gabe *et al.* 2004).

All these dynamic changes indicate that the National Health Service is subject to continuous innovation. This can be seen firstly, with the change of power from doctors to managers and the consequent threat to professional autonomy, and an increasing public mistrust of self-regulation as in, for example, the Bristol Royal Infirmary Inquiry (2001) and the Shipman Inquiry (2001).[11] Secondly, it is evident in the erosion of professional boundaries and the abundance of external scrutiny.[12] Thirdly, it is manifested in the introduction of a statutory duty for quality performance and continuous performance management.

Ultimately, all these changes give rise to some fundamental questions. If a new method of managing quality has as strong an evidence-base as any new clinical treatment, there is no issue. In this instance, however, I argue that the evidence-base for clinical governance is questionable. It is necessary to establish whether and how clinical governance is working and what the effects are on the organization, on professionals and, most importantly, on clinical care.

1:5 Summary

Chapter One of this Thesis *Setting the Scene* has provided an introduction and given some indication of why there is a continuing need to study healthcare from a sociological

8 See Chapters 1:2 and Section B Chapter Two Clinical Governance

9 NICE is an independent organization responsible for providing national guidance on promoting good health and preventing and treating ill health.

10 National Service frameworks (NSFs) are long-term strategies for improving specific areas of care. They set measurable goals within set periods.

11 See Chapter 2:11 The Origin and Background of Clinical Governance The 6th Report – Shipman: The Final Report, published in January 2005 www.the-shipman-inquiry.org.uk/reports.asp

12 See Chapter 3:5 State Intervention and Regulation of Healthcare

perspective. I identified my initial interest in this subject and briefly introduced the concept of clinical governance as an 'umbrella' term and stated that overall its intention was to embrace the fundamental role of culture and leadership in addition to emphasising the role of the learning organization in the monitoring of quality. The Chapter continued in setting the organizational context by presenting an overview of the National Health Service structure and its day-to-day work and commented on New Public Management, a general management approach introduced in an attempt to find the elusive effectiveness, efficiency and quality felt necessary for the bureaucratic health service. In order to indicate the structure of the Thesis, a summary of the content for each Chapter follows.

1:6 Overview of Chapter Content

Chapter Two

The purpose of this Chapter is to demonstrate that clinical governance is just one of many quality management initiatives that have arisen in the National Health Service since its foundation, which may help to explain the varying attitudes towards it. This Chapter comprises two sections: *The Quality Debate and Clinical Governance*. As the quality management history of the NHS is based on principles adopted extensively from business organizations, **Section A** briefly reviews some historical background and the various quality initiatives introduced into the health service. It commences with a discussion of the basic question of what constitutes quality and quality assurance. The importance of knowledge management and the learning organization are introduced as being significant in the link between learning and continuous improvement that is central to the quality literature. As this Thesis has an emphasis on nursing, the section continues with a short consideration of the major quality initiatives that have taken place in nursing, together with a reflection on the lack of an evidence-base for nursing. It concludes by highlighting the need for evaluative studies into these quality initiatives. **Section B** concentrates on *Clinical Governance.* There is an introduction to its origin and background, together with a focus on the specific clinical governance nursing remit, identified as the 'Essence of Care.' In reviewing the literature in relation to clinical governance, there is debate on the way the term is used. There is discussion on the evidence-base for, and the limited research conducted on the integrated approach of clinical governance. There is an examination of nursing research studies on clinical governance, and general research studies on organizational culture change, fundamental requirements for clinical governance implementation. With a focus upon clinical governance, there is a review of the relevance of organizational learning and knowledge management literature. The Chapter concludes with a discussion on quality as a 'social construct.'

Chapter Three

Chapter Three, *Professions, Division of Labour, Professional Regulation and New institutionalism Theory,* reviews the main theoretical perspectives used and is divided into two sections. **Section A** commences with an introduction to the professions. As the Thesis has a nursing emphasis, there is a discussion about the social and regulatory status of nursing as a subordinate profession. The focus then changes and considers the division of labour in healthcare and the implications for nursing in this. The section then continues with a discussion on the *State Intervention and Regulation of Health Care.* **Section B** addresses *New Institutionalism Theory* and the rationale for its use within this Thesis. New institutionalism theory is described both historically and with the mention of: top-down/bottom-up, structure-agency, and homogeneity-variation. The relevance of 'organizational legitimacy,' 'ceremonial conformity' and 'isomorphism' is explained. An explanation is also given of how three change mechanisms, coercive, normative and mimetic (DiMaggio and Powell 1991), are used to achieve 'institutional isomorphism,' so that the structures, procedures and practices become 'similar' across organizational fields. The Chapter emphasises the importance of organizational culture as the main driver for the use of new institutionalism theory.

Chapter Four

Chapter Four, *Methodology and the Research Process,* discusses the rationale for the qualitative methodological approach undertaken during this study and how data were obtained in respect of documents, observational field notes and semi-structured interviews. It gives a broad description of the NHS Hospital Trust where the study took place, the ethical considerations and a detailed account of the grounded theory methodological process adopted. It also considers the advantages and disadvantages of the case-study research design.

Chapter Five

Chapter Five, *Corporate Documentation and the Organizational Process of Clinical Governance,* uses evidence from the analysis of formal documentation considered by the Corporate Clinical Governance Committee. It discusses whether there is a 'ceremonial' management of clinical governance as a means to achieve 'organizational legitimacy.' Using official meeting records, three detailed examples of action taken by this committee are tracked and discussed. In relating this to the theoretical basis of new-institutionalism, I debate the function and purpose of this committee.

Chapter Six

In this Chapter, *Meetings and the Organizational Process of Clinical Governance* I discuss my observations of meetings taking place at other levels of the organization and within the elderly care and neurosurgical directorates. Using evidence from official documentation as to the function of these meetings and my field notes, I present findings as to how these meetings work in relation to clinical governance. Where appropriate, I include comments made by nurses and stakeholders within the Trust.

Chapter Seven

This Chapter, *Nurses and Stakeholders and the Organizational Process of Clinical Governance,* utilised a grounded theory analytical process to present findings structured under the categories and sub-categories that emerged from the semi-structured interviews. The categories identified were 'Making Sense,' 'Knowledge Construction,' 'Somebody Else's Job' and 'Real Work.' I present findings as to how nurses and stakeholders made sense of clinical governance, how it affected their role in their real work, and which groups related it to somebody else's job. I consider communication issues in respect of ward visits and the reliance on communicating at meetings. I debate the process of corporate responsibility when systems go wrong. I also present two detailed accounts of days in practice.

Chapter Eight

The final Chapter, *Clinical Governance, Conclusions – Organizational Legitimacy, Professional Regulation or Clinical Excellence* draw the strands of the Thesis together. There is also reflection on cultural change and the importance of knowledge management and organizational learning. There is a consideration of the study's contribution to medical sociology and new institutionalism theory and of the limitations and subsequent research implications of this work.

In order to put clinical governance into a context of just one of the many quality initiatives introduced into the NHS, Chapter Two will describe some of the major quality initiatives that the NHS in England has been subject to over the past few years. It will also provide some further detail of clinical governance.

Chapter Two

Section A

Quality in the National Health Service

2:0 Introduction

The running of the NHS has been significantly influenced over the past twenty years by ideas from general management experts and business organizations. For instance, the corporate board structures introduced into the NHS in the 1990s were based on the strategic decision making bodies in the private sector. Nevertheless, the core of the National Health Service is steeped in tradition and culture, and hierarchical structures and culture are difficult to change. Interestingly, Ovretveit (1992) predicted that there would be a crisis in health services in the 1990s, together with the problems of trying to meet rising demand with fewer health care workers and differing demands. In respect of quality issues, he commented that quality was not a purchaser requirement but a philosophy, a set of methods and an organizational revolution, essential to the competitive position and the survival of a service driven by the service provider. This calculation may have been a few years out, but appears today to be an accurate prediction.

In the NHS, the dominant medical profession has been mainly averse to managerial control of quality assurance as a distinctive concept. The medical profession historically retained a very high level of control by means of a number of methods; for instance, monitoring the content and standards of the training provided for new, or established, members of the profession and penalizing doctors who failed to uphold the required professional standards. Nevertheless, with the complex changes in health care, these methods are no longer sufficient and the medical profession has had to adjust to both external and internal scrutiny of its practice. Interestingly, in the same context, Ellis and Whittington (1993) identify the nursing profession as the most active of the health care professionals in developing quality assurance, by having an open boundary to the outside world in terms of the scrutiny of its practice. Nevertheless, nursing also has a strong tradition of command and control dating back to the Nightingale era, although critique in the 1960s related to the underdevelopment of the management aspects of nursing (The Salmon Report 1966).[13]

13 The Salmon Report, in 1966 recommended and set up a new hospital nursing structure under the direction of a Chief Nursing Officer.

To explain this further and put 'quality' into the context of the National Health Service, **Chapter Two, Section A** addresses some aspects of the history and definition of quality. Utilising an explanation from a background of industrial influence on the NHS, Section A will clarify how, over the years, there has been promotion and abandonment of various quality initiatives by the NHS. This may to some extent help to explain possible indifference of NHS staff to new quality initiatives. Reference is made to knowledge management, organizational learning, the learning organization and organizational knowledge. Attention then focuses on the historical aspect of the development and measurement of 'quality nursing care' and identifies difficulties with the evidence-base for nursing.

Section B of this Chapter reviews the 'official' definitions of what clinical governance is supposed to be. There is a focus on the 'Essence of Care' initiative, the nursing component of clinical governance. It is noted that there has been a disproportionate volume of promotional papers published on clinical governance, in comparison with the limited amount of available empirical or evaluative research conducted on clinical governance's success as an integrated process, at national, regional and nursing level. There is some consideration of how knowledge management links with clinical governance. Organizational and cultural studies, which contribute to the understanding of the 'healthcare organization', are also reviewed.

2:1 General and Healthcare Quality Assurance – Historical Aspects

It would appear logical when writing about quality to explain how it is defined within any context in which it is used. This, however, is an 'elusive quest' (Wiener 2000), as it would appear from the general literature that there is no universally agreed definition of 'quality,' or 'quality assurance.' The problem with formal definitions is the way in which they decontextualise meaning. 'Quality' is in effect what people do with the word, not what a dictionary or a guru stipulates. However, putting quality into a measurable context, such as 'quality control' or 'quality outcome' it appears to be more substantial, as will be explained.
The Oxford Dictionary (Thompson 1996:1119) defines quality as 'a degree of excellence of a thing,' but academic criticism of this type of definition is that it is too broad or meaningless, and it is interesting that the 'gurus' of quality initiatives tend to avoid its definition (Gaster 1995). Oakland (1995:3/4), is rather more specific as he states *'quality is often used to signify 'excellence' of a product or service.'* He adds, *'if we are to define quality in a way that is useful in its management, then we must recognise the need to include in the assessment of quality the true requirements of the 'customer.'*

I would therefore suggest that 'quality' is a normative term and any organization needs to establish the underlying quality that drives its organization. Quality could be compared with 'efficiency': *'Quality seems to have become as much of a public sector buzzword as 'efficiency' was a few years ago. As a slogan, 'efficiency' gains much of its power from ambiguity between a number of quite precise meanings…quality, in contrast, is a rather vague term'* (Harden 1992:58). This would seem a more appropriate statement for the current quality focus in the NHS.

The term 'quality assurance' also does not have a universally accepted definition, but it is customer orientated and most commonly involves the design of quality standards (Mulcahy and Lloyd-Bostock 1992). Whilst it is evident that in any organization there are large processes (and groups of smaller processes) that have to be carried out 'effectively' in order to achieve mission and objectives, quality control can only take place at the point of operation, and the checking of this activity is known as quality assurance. Quality in this context is measurable and may be about the enforcement of a particular normative vision. Nevertheless, this does in fact *'disguise to some degree the underlying social dynamics'* as in, for instance, the historic dominance of medicine (Malin, Wilmot and Manthorpe 2002:125) which has been a major influence in health quality development.

It is perhaps easy to write a general statement about what can be achieved in the form of a quality outcome, but it is more difficult to establish the extent and features that are required to 'measure' the characteristics that give the dimensions of the quality of the outcome. 'Quality control' embraces the activity and techniques employed to achieve and maintain the quality of a product, process or service, and quality assurance is the prevention of quality problems through planned and systematic activities (Oakland 1995). Discussion about quality systems has focused on the dimensions of this measurement, in the form of monitoring and setting standards. Gaster (1995:2) states: *'Systematic attention to detail, within a strategic framework of policies and values, is possibly the key to quality, so defining the detail is essential to any quality policy, it is the guide to deciding priorities in implementation, it gives a starting point for developing service standards, and it is the basis for monitoring and evaluation.*' However, there is still a fundamental problem about turning a normative term like 'quality' into a positive term like 'quality by measurement.' This gives rise to the many different approaches that have existed in the form of quality management systems, the more popular ones being: quality control, quality assurance, total quality management (TQM), quality standards and customer care. A brief history of these will be given.

The Japanese learnt how to manage quality following the Second World War from American 'gurus' such as Joseph Juran, Edward Deming and John Crosby, who were influential in quality management initiatives in industrial organizations. These 'gurus' marketed various quality management systems, for instance Deming (1982) presented a fourteen-point management agenda. This placed the responsibility for quality within the sphere of management and gave a high value to people and a system of ongoing training. Juran's (1988) ten steps to quality improvement had an emphasis on the importance of the customer and the need for improving quality by a project-based approach, which included quality planning, quality control and quality improvement. Crosby's (1989) 'four absolutes for quality model' consisted of definition (conformance to requirement), system (prevention), performance standard (zero defects) and measurement (price of non-conformance), and further proceeded to present fourteen steps to quality. Crosby (1989) emphasised early commitment at the 'top' and total involvement through teamwork. As will be seen, these early initiatives have been influential in the quest for quality in the NHS.

While these developments in management techniques evolved in industry, they were not initially evident in the NHS. Although the National Health Service, when founded in 1948, had explicit values of fairness and public service, a quality agenda appeared to be seen as inherent in the system, '*sustained by the ethos and skills of the health professionals working within it'* (Donaldson and Gray 1998:37). Before 1980 the NHS had made little use of regulation but relied on *'traditional bureaucratic central direction with the Department of Health issuing instructions, guidance and rules to health authorities and NHS Trusts through a blizzard of policy papers, health circulars, executive letters and other means every year'* (Walshe 2003:112). It clearly met needs as a large-scale standard provider of care but it was the providers, not the 'consumers,' (patients, taxpayers) who defined the acceptability of that care (Malin *et al.* 2002). At this time, health reforms and various reorganizations in health policy were influenced by the increasing demands for efficiency and economy, but the focus centred on tangible service components: those of equipment, facilities and staff (Nicholls *et al.* 2000). Thus, '*Quality in health care has traditionally been defined by providers, with reference to technical criteria,'* (Mulcahy and Lloyd-Bostock 1992:51).

Ellis (2000:217) states that *'the concept of quality as it relates to health care has seldom been defined and it has been widely accepted that it is a complex multidimensional concept in constant need of analysis and clarification.'* However, Ovretveit (1992:1/2) introduces health care quality as *'a service that gives people what they need, as well as what they want, and does so at the lowest cost.'* He continues: *'quality is an umbrella term for a coordinated set of staff and organisational development activities'* but defines health care quality as '*fully*

meeting the needs of those who need the service most, at the lowest cost to the organization within limits and directives set by higher authorities and purchaser.' It is evident therefore that financial control is implicit in this model.

Navarro (1994:136-7) describes the management strategy, 'Fordism' (named after the US industrialist Henry Ford), as working on the rule that goods and services were mass-produced and the user was seen as having a consistent and conventional set of requirements. This was applicable to general commodities as well as health and social care commodities and kept costs under control. It worked on the principle of '*mass production requires mass consumption.'* Fordism is often associated with its precursor Taylorism, or scientific management. Taylorism is a theory of management that analyzes and synthesizes workflow processes in order to improve labour production and to find the most efficient structures of command and control for the achievement of organizational goals. These work management principles introduced by Frederick Taylor (1856-1915) were designed to transfer control of the work process to management and to achieve the greatest rate of productivity from workers through dividing labour and having work performed in a manner detailed by management. Scientific management comprised a method of work organization where management implements a specialised division of labour and sets out detailed instructions for the performance of work. Taylor looked at interaction of human characteristics social environment, task, physical environment and various other factors. Associated with the methods introduced by Taylor (1996), the aim of scientific management was to separate workers from their knowledge of the work process, to divide labour to pay only for the specific skill required to perform a narrow function and to establish management as the controller of work and the work process.

In respect to health care, Alaszewski and Manthorpe (1993:653) proposed that quality assurance is a post-Fordist phenomenon, that is the product of an increasingly disjointed and individualized relationship between consumer and producer, as *'standardized'* health is no longer seen as being acceptable within the new institutional form of *'public management.'*[14] They suggested that the *'new cult'* of quality was associated with the development of post-Fordist type management, transferred from the private to the public sector as part of the new public management. Hospitals had organizational structures related directly to Fordist and post-Fordist ideas (Walby *et al.* 1994). Critics of this argue that there are some problems with a post-Fordist explanation and that there should be a wider explanation, in that connections should be considered in political strategy, regulation, structures and

14 See Chapter 1:4 New Public Management in the NHS

accumulation regimes and that *'the post-Fordist changes … do not completely conform with post Fordist theory'* (Flynn 1992:190). With the increasing move towards patient choice and different specialisation, it is apparent that these connections are no longer viable, so it does to a certain extent explain the need for the move towards a 'value for money' situation where expenditure can be managed. However, there is perhaps also recent evidence of a partial return to Fordism in the setting up of walk-in treatment and assessment centres within the NHS.

Therefore, the post-Fordism era is a partial explanation for the emergence of quality assurance. It would seem that the establishment of external agencies such as the National Institute for Clinical Excellence (NICE) and the central production of policies, protocols and guidelines encouraged a move back to prioritizing, rationing and a standardized method of care. It is therefore necessary to build on the post-Fordist explanation and look at the specific processes in the history of quality in health care to provide a broader explanation.

In relation to health care, Donabedian (1969) conceived much of the theoretical basis of quality assurance. Faced with the difficulties of defining quality in respect of health care, he based his theories on the naming of parts and made a distinction between the technical and interpersonal aspects of quality health care and between the quality of structure process and outcome in respect of each aspect. Technical care equated to material things, for instance the technical skill of a joint replacement in theatre by a surgeon on an unconscious patient. The interpersonal aspect became apparent when the same surgeon reassured the conscious patient about his operation. This was a more unpredictable aspect of heath care. Cochrane (1999) made a similar distinction in his original publication on evidence-based practice in 1972. This book had a profound influence on evidence-based medicine and on the evaluation of medical interventions.

As quality components began to be analysed in the 1970s, Donabedian's (1969) structure/process/outcome approach as a method of categorizing quality dimensions became popular within the NHS. Donabedian (1969) defined *'Structure,'* as the subtle features of organization, for example differentiation, coordination and power, specification of work procedures and visibility of consequences. However, although standards for the 'structural' aspects of care were set and modified, the grounds on which these judgments were made appeared obscure. *'Process'* indicated the delivery of care from the initial patient consultation to the time of discharge, or the point where no further care was possible. *'Outcome'* related to the results of care, 'the quality of life;' this could include, for instance, health status, improvement of function, longevity and comfort.

Donabedian (1991) also referred to the 'moral' aspect of health care. This incorporated the choices made about types of provision and judgments concerning the levels of access within attainable resources. This third category was therefore concerned with issues of social justice and political philosophy. Donabedian's focus on the science of health care (that determines efficacy), individual values and expectations (that determine acceptability) and social values and expectation (which determine legitimacy), stimulated the discussion that quality cannot be judged by professionals alone, but should include both patient and societal views. Nevertheless, conflicts arise with this theory when there are different social groups with dissimilar expectations of the care provided.

Donabedian has been criticised in that these divisions are 'categories' of care rather than those of 'quality' of care (Ellis and Whittingham 1993), but despite the fact that other models do exist, for instance those of Maxwell (1984) and Wilkinson (1990), this definition was the most popular in the health service for some time. However, implementing quality initiatives remained very much a problem in the NHS, with Donaldson and Gray (1998) portraying a disorderly service, which had focused on meeting the demands of acute hospital care since the 1980s. Rising costs had led to administrative re-organization, but this, and strategies of cost containment, had failed to affect the increasing demand for health care services. This resulted in a focus on management rather than quality aspects following an enquiry in 1983 and the production of a report, which subsequently became the Griffiths Report (DH 1983).

2:2 Griffiths Report: Total Quality Management, Continuous Quality Improvement and Standard Setting

The introduction of some elements of personal accountability for the service provided became highlighted with publication of the Griffiths report in 1983. Griffiths concentrated on the lack of management accountability at local level in the health service and this report was instrumental in the appointment of general managers to lead health care units, together with medical staff involvement within management teams. The aim was to produce an element of personal accountability for the services provided and managers became responsible for output measures under the remit of target setting by the Department of Health (DH). Examples of these are apparent in the Conservative's Government papers *Working for Patients* (DH 1989); *Health of the Nation* (DH 1992) and *Our Healthier Nation* (DH 1998a). The Griffiths Report promoted managerialism and the establishment of clinical directorates and budgets and introduced the internal market in 1990. Although there were highlighted terms in specific relation to quality, such as 'patient satisfaction' and 'quality of care;' the focus was still on performance, accountability, reducing costs and increasing efficiency.

The giving of 'high quality care' still relied on professional competence based on qualifications and experience.

Following Griffiths, there were other attempts to incorporate quality into health service practice with Total Quality Management (TQM) becoming the next initiative. TQM or the Continuous Quality Improvement movement in the NHS began in the early 1990s and sought to embed *'a philosophy of continuous improvement within the culture of an organisation'* (Baggott, 2004:213). TQM is a quality-orientated approach that consists of applying a selection of quality management techniques throughout the organization with the aim to increase profitability through customer focus. TQM evolved from industrial work by Juran (1979) and Deming (1982) who recognised that by putting quality first organizations could reduce costs and improve productivity.

It is useful to remember that the political background at this time involved policy changes that focused on clinicians and the need for them to monitor clinical outcomes, ensure patient satisfaction and measure performance. Thus, the theoretical definition of TQM emerged as *'an approach to improving the competitiveness, effectiveness and flexibility of a whole organization. It is a way of planning, organizing and understanding each activity and depends on each individual at each level'* (Oakland 1995:18), and it appeared consistent with the aims of the policy initiative. However, in this respect the NHS has never been very good at involving the 'whole organization.'

There seemed to be two main approaches to the implementation of TQM that may be relevant to either industry or health care. The first was to change the system under which people worked and this in turn should change the behaviour of the people who work within the system. The assumption was that the right system should improve the quality of the work people do. This is a systems-orientated approach regulated by the British Standards Institute and is based on British Standard (BS) 5750. BS5750 (or International Organisation for Standards (ISO) ISO9000), is a National System Quality Standard, which is widely used in the industrial sector. It requires the production of formal procedures covering all activities undertaken by the industry. The ISO9000 standards are maintained by ISO and administered by accreditation and certification bodies (Ellis and Whittington 1993).

The second approach was to improve people's understanding of and skills in quality management and then to adjust the system according to the needs of the people, to enhance their performance; in other words, a 'people orientated approach.' The assumption was that both people and systems needed to change for TQM to be successful. In many ways the 'people orientated approach' was a more ambitious approach, placing greater emphasis on

management support and commitment in changing the NHS operating culture. It allowed individuals working in teams to innovate and improve processes that they were involved with and increased the speed of response for change. TQM appeared to be an enabling philosophy, which generated small incremental changes that were totally committed to quality, management led and depended on teamwork and the participation of all employees. It involved the setting of targets and performance indicators that provided steps towards quality measurement. It sought to release the organizational potential for continuous quality improvement, which emphasised the dynamic and ongoing nature of achieving quality. In retrospect, it would appear that total quality management was a system advantageous to the National Health Service management and employees. Nevertheless, this system required a substantial change of culture from a crisis-problem response to the prevention of problems from ever happening.

Nevertheless, quality issues in the NHS were still wrapped around very strong organizational issues of personality, professionalism, power and culture. Whilst professionals operating within the health service worked to define levels of quality and follow written procedures, there were, as might be expected, large gaps. Under the TQM option there needed to be set in place, 'a feedback loop' based on drawing up written procedures for all activities and checking and reporting that they had been done; nevertheless this also assumed standardization of the product, which can cause difficulty in many areas of medicine. In realistic terms, TQM relied heavily on staff time to draw up and follow comprehensive procedures and only guaranteed the process, not the product. At this time, *'criticism of this approach was that it was not appropriate to health care because of the difficulties of evaluating the quality of a highly personal service'* and was mainly unheeded (Baggott 2004:214).

An example of the confusion around quality assurance in the NHS was evident in the Bristol Inquiry (Bristol Inquiry Secretariat 2001) which reported on the mortality rates of twenty-three paediatric cardiac surgical patients between 1984 and 1995 at the Bristol Royal Infirmary. The report acknowledged the fact that whilst TQM had involved high levels of quality activity (in that, for example, in 1989 there were 1,478 initiatives in 116 districts), the quality strategy had failed to involve all parts of the NHS organizations and as such, paragraphs of the reports are indicative of the chaos apparent at that time:

'At a national level there was confusion as to who was responsible for monitoring quality of care. The confusion was not, however, just some administrative game of `pass the parcel.' What was at stake was the health, welfare, and indeed the lives of children. What was lacking was any real system whereby any organisation took responsibility for what a

layperson would describe as `keeping an eye on things.' The Supra Regional Services Advisory Group (SRSAG) thought that the health authorities or the Royal College of Surgeons was doing it; the Royal College of Surgeons thought the SRSAG or the Trust was doing it, and so it went on. No one was doing it. We cannot say that the external system for assuring and monitoring the quality of care was inadequate. There was, in truth, no such system' (Bristol Inquiry 2001:6: note 16).

Quality assurance processes then focused on operational performance and patient satisfaction with the service. An important feature of quality assurance became the identification of potential problems, in the recognition that customer needs and business goals were inseparable. Therefore, there was emphasis on the attributes of the service or clinical environment that promoted satisfaction. There was consequently an increase in requesting feedback from patients by means of surveys, post-care interviews and focus groups. There was notification of patients /clients'/employees' rights by means of local initiatives, for example those for acceptable waiting times. Nevertheless, for a realistic measurement of quality, standards have to be valid and include acceptable definitions of the quality of care, and this was one of the dilemmas in their setting.

Quality assurance systems and the quality of clinical aspects of care increased between 1984 and 1995, with the expansion of appropriate mechanisms for assessing and improving quality, but setting standards, collecting data, recording and reporting performance, and making improvements were still disorganized. Different threads developed along separate lines, mechanisms were not co-ordinated, and there was little synchronization in the many organizations that became involved (Ham 2004). At this time, roles and responsibilities were ill defined. This led to confusion as to who was responsible for what between the range of parties (as in the Department of Health, the Royal Colleges, regional and district health authorities, the Trusts and various bodies outside the NHS, and professional healthcare workers).

Ham (2004) writes about the 'explosion' in auditing and evaluating health policy at this time but it appeared that few, if any, of these initiatives considered clinical judgment, the professional competence aspect of quality, as many quality assurance ideas originated from industry. Initiatives appeared to be independent of each other and developed by different professional groups, but, more often than not, professional groups were not involved. It seemed that a standard of care was still a matter of individual professional conscience. It was only after the publication of *'Working for Patients'* (1989), that action to maintain medical audit was taken at regional level, with centrally paid finances. The view changed in that audit was fundamentally a professional educational activity and that professionals (rather than Health Authorities and managers) were competent to make judgments on the technical

quality of medical care. The next quality initiative therefore involved clinical audit. It was evident that there was a variety of pressures on the doctors to examine their practices: Ellis and Whittingham (1993) showed that the medical profession was aware of the need to tighten its internal mechanisms to ensure standards of practice.

2:3 Clinical Audits and Clinical Effectiveness

In the White Paper *'Working for Patients*' (DH 1989) the need for clinical audit was formally set out for doctors to *'improve the quality of patient care'* (Sale 2000b:91). At this time, there was both political and internal pressure within the medical profession to maximise quality. It was acknowledged that there were large unexplained variations in practice between individual clinicians (Harrison and Pollitt 1994) and that there had been some un-coordinated voluntary attempts to conduct medical audits at both national and local level. There was also increasing scrutiny from social scientists and economists with the suggestion that *'a good deal of what doctors do is unlikely to maximize their output as purveyors of good health'* (Malin, Wilmot and Manthorpe 2002:128).

Clinical audit was said to give professionals the opportunity to review clinical practices but it was evident that *'measures to control expenditure at the macro-level have been increasingly complemented by measures to control the allocation of health care resources at micro-level'* (Blank and Burau 2004:132). Nevertheless, restrictions of available treatments were seen as being one of the quality management consequences.

Clinical audit is an established part of medical practice with the National Clinical Centre for Clinical Audit established in 1995 (Sale 2000a), now, the National Clinical Audit Support Programme (NCASP). NCASP provides an infrastructure for the collation, analysis and feedback of local clinical data to support effective clinical audit across the NHS. Clinical audit was instrumental in the increasing emphasis on the use of research to improve patient care. The linking of research to practice is also referred to as 'evidence-based practice,' (EBP) 'clinical effectiveness,' 'research based practice' or 'implementation of research findings' (Sale 2000b:148; Baggott 2004).

The main concerns leading to this initiative, as demonstrated by clinical audit, were that current clinical practice was not informed by accurate and up-to-date research findings, was ineffective, wasted resources on inappropriate interventions and created unacceptable inequalities through variation in the use of effective treatments (Baggott 2004). The Culyer Report (DH 1994) introduced a single research and development budget that had both

national and regional research priorities. Other separate streams of funding for NHS priorities followed. These initiatives won support from health care professionals who saw them as enabling them to retain control over their work and provide a professional impetus for evidence-based practice. Managers believed that it would make the health budget go further and patients saw it as improving the quality of their care (Baggott 2004).

This programme had a massive impact on health research and development, instigating budgets, national and regional priorities, funding, Health Technology Assessment Programmes, applications of Technology Programmes, and the Service Delivery and Organization Programmes (Baggott 2004). Dissemination of this information was linked to the proliferation of evidence database developments, for example Cochrane, Bandolier, Clinical Evidence, Effective Health Care Bulletins and vast numbers of internet resources, one such being the National Electronic Library for Health.

By the 1990s, the Conservative Government expected the commissioning of healthcare to be evidence-based and further guidance was issued in the form of, for example, Clinical Guidelines, National Service Frameworks and the forming of the National Institute of Clinical Excellence (NICE). However, as already noted, some viewed this approach as the rationing of health care, in that limited options were now on offer. The discretion of Primary Health Care Trusts to use their own judgment is not always possible due to the mandatory nature of, for instance, NICE guidelines, but as NICE is an agency set apart from the Government, criticism of it '*absorbed the effect of its decisions'* (Ham 2004:258). Interestingly though, NICE has agreed to more interventions than it has rejected and added over £6000m to the cost of the National Health Service's medicine cabinet (Lilley, 2003).

These information systems were therefore changing the way in which healthcare was provided. At this stage there existed considerable raw data, information and knowledge, and consideration was needed as to the management of this knowledge. An organizational discipline identified as organizational learning and knowledge management became popular and has developed rapidly over the last ten years, with increasing diversity and specialization (Easterby-Smith and Lyles 2003). It is a method of making use of the experiences and understanding of individuals within an organization, with the intention of enriching its intellectual capital. Knowledge management, organizational learning, the learning organization and organizational knowledge will therefore be considered in the following section.

2:4 Knowledge Management, Organizational Learning, the Learning Organization and Organizational Knowledge

Knowledge management may appear similar to organizational learning, the learning organization and organizational knowledge, but as Easterby-Smith and Lyles (2003) explain, there are differences. Knowledge management *'adopts a technical approach aimed at creating ways of disseminating and leveraging knowledge in order to enhance organizational performance'* (Easterby-Smith and Lyles 2003:3). Organizational learning refers to the academic study of the learning processes of and within organizations, in order to understand and comment on what is taking place. The learning organization is viewed as an entity, an ideal type of organization that has the capacity to learn effectively and progress. Organizational knowledge is often identified as adopting a *'philosophical slant'* in *'trying to understand and conceptualize the nature of knowledge that is contained within organization.'* According to Easterby-Smith and Lyles (2003:3) in a process/content dichotomy model, organizational learning and organizational knowledge veer towards the theoretical side and the learning organization and knowledge management are directed towards the practice side. However, as Easterby-Smith and Lyles (2003) acknowledge, these may overlap at times, for instance the case of *'a critical study of a learning organization would fit into the organizational learning box and a study of the way knowledge is constructed within corporate knowledge management systems would belong to the organizational knowledge box.'* Nevertheless, each term will be considered in more detail.

Knowledge management involves the transformation of unconnected data or information into meaningful and connected knowledge. Knowledge management could be viewed as the creation of an environment, of infrastructures and processes that enable the achievement of organizational objectives. Davenport and Prusak (2000) comment that knowledge management was still in its infancy in 1998; however, it gained legitimacy with Nonaka's work (Nonaka 1988; Nonaka 1991; Nonaka and Takeuchi 1995), driven by an interest from major consultancy companies wanting to utilise advanced technology for the sharing of information. '*The knowledge to be managed includes both explicit documented knowledge and tacit, subjective knowledge'* (Rowley 2000:11). However, Seely Brown and Duguid (2000) (from a 'social' school of organizational learning theorists' perspective) criticise this approach for its neglect of the *'social architecture'* of knowledge exchange within organizations, as knowledge is the product of the society and cultural environment within which it is created (Easterby-Smith and Lyles 2003:12).

Whilst the idea of knowledge management emerged in the 1990s, it is possible to trace references to organizational learning back to the early 1960s, the main influences being those of Cyert and March (1963). There appear to have been both surges and rapid declines of interest in the various topics that might be explained by changes in the environment, such as literature trends and technological advances (Easterby-Smith and Lyles 2003). Organizational learning is based on the idea that '*organizations may learn independently in ways that were independent of the individuals within it'* (Cyert and March 1963:9). In this sense, organizational learning is connected with the organization's own survival and future success. This apparent alliance encouraged publications on the process of organisational learning (e.g. Pearn *et al.* 1995; Starkey; 1996). With reference to quality, Honey (1991) recognises the link between learning and continuous improvement that is central to the quality literature and Lessem (1991) progresses this concept in proposing a link between quality and learning, such that learning is the process, and quality is the end (Rowley 2000).

In essence, Cyert and March (1963) propose that there is an adoption of rules, procedures and routines within an organization as a response to any external shock, whether or not this is positive for the organization concerned. By doing this through *'organizational learning processes'* (1963:100) *'the firm adapts to its environment'* (1963:84). Cyert and March (1963) distinguish between single and double-loop learning in that *'an organization…changes its behavior in response to short-run feedback from the environment according to some fairly well-defined rules. It changes rules in response to longer-run feedback according to some more general rules, and so on'* (1963:101/2). Criticism of this model has been in terms that it may be *'appropriate for established organizations in stable circumstances, but it has limited relevance to organizations developing within dynamic circumstances,'* (Easterby-Smith and Lyles 2003:9), a point very pertinent to the NHS.

Ideas concerning the 'learning organization' emerged towards the end of the 1980s. This was mainly European work, noticeably with UK authors such as Garrett (1987) and Pedler *et al.* (1989). Argyris and Schon (1978) used the term 'organizational learning' to introduce the belief that organizations (like organisms) adapt to a changing environment. They suggest that learning within organizations requires the development of both systems and processes, so that changes in the external and internal environment filter through to attitudes, procedures and practices in order to facilitate the review of operating norms at a variety of levels throughout the organization. More flexible approaches to learning, for example action learning (Revans 1980), have been promoted as being successful in developing the learning organization. A further major influence in this field was Senge (1990), who stated

'*the most successful corporation of the 1990s will be something called a learning organization'* (Senge 1990:4). The ideas in this book were utilised by both academics and practitioners (Easterby-Smith and Lyles 2003). The main emphasis here is that there is a recognition that organizations must change and develop if they are to survive and prosper in a global economy. However, in general, the whole literature has a focus on the process of learning, but there appears to be little attention to what is learnt which would presumably include some knowledge and skills (Easterby-Smith and Lyles 2003).

The study of organizational knowledge has been mainly from within the economics community, one of the major influences being that of Nonaka (1988) who recognised the concept of 'top-down' deductive management and 'bottom up' inductive management both of which are involved with an organization's capacity to process information. However, this needs to be amalgamated with knowledge creation. Nonaka (1991) argues that the key to competitive advantage lies with the organization in its memory and potential. Management, in this case, provides a conceptual framework to help employees make sense of the information. In this sense, the internalisation and articulation of knowledge creation, is the most important concern. Nonaka and Takeuchi (1995) explain that the notion of knowledge creation within an organization is through the recognition of extending a tacit knowledge base for all (internalisation). Nonaka (1991) also identifies other patterns of knowledge creation in the transfer of tacit information between individuals and the transfer of explicit information across an organization, through the exchange and dissemination of print and electronic documents. Further examination of the relevance of this discussion (knowledge management, organizational learning, the learning organization and organizational knowledge) to clinical governance will continue later in the Thesis.[15]

This last section has reviewed the historical developments related to quality developments in the NHS and concluded with giving some background to the management of knowledge, which is relevant to the discussion. It is evident from this that the NHS has been subject to many changes in 'value for money' quality initiatives. In order to present a holistic picture, it is useful to demonstrate the concurrent progress within nursing in this respect. The following section, therefore, looks specifically at the historical context of quality initiatives in nursing, together with the evidence-base for nursing practice.

15 See Chapter 2:14 Knowledge Management and Clinical Governance

2:5 Quality and Nursing

Whilst there has been confusion in defining terms relating to quality, nursing has an added difficulty with the constant debate as to what constitutes 'quality' in nursing care. Glen (1998) argues that the difficulty of defining what quality in nursing care is has produced images of anxiety about what nursing is. She suggests that it is still not clear what quality in nursing care itself is, and different concepts of quality determine different definitions of nursing. She further states that 'quality' nursing care may be perceived in many different ways, as a labour, a craft, a profession or an art and that these may be viewed as a continuum, from competence to excellence. It is suggested that, in this respect, the quality of nursing cannot be assessed in terms of performance-referenced criteria but only in terms of personal qualities displayed in the performance. Koch (1992), whilst recognising that nurses should engage in quality assurance activities, also argues that nursing has a more complex nature and is not measurable. Glen (1998) offers support to these statements and suggests that the key to improving practice may be in the improvement of emotional and motivational tendencies, but states that nursing is often seen as an unreflective technical process. Historically, nursing has had a chequered history as a profession.[16]

It is evident, therefore, that there are different opinions on the concepts of quality in nursing, but despite this, over the years, nursing has also had its practice subjected to various forms of quality and cost effectiveness measurement. Sale (2000b) provides some useful data in the tracing of quality assurance in nursing. Early accounts in Britain include notes kept by Nightingale (1863), in evaluating the care delivered to the sick that formed the basis for the information required to establish the level of care provided and to improve it when required. However, much of the very early quality work in nursing took place in the USA. From 1917 onwards, American initiatives were evident in the use of quantitative tools to measure professional opinion and multidisciplinary records, effectiveness of types of care and the measurement of patient satisfaction with care. It is interesting to note that the USA too had its problems in that a study undertaken by Drew (1964) in California established that in twenty-one hospitals, forty-two different quality assurance techniques were apparent.

In the UK, the Royal College of Nursing (RCN) has a long history in promoting the development of nursing standards and quality patient care, dating back to The Study of Nursing Care Project in the mid 1960s (Inman 1975). In the 1960s, nursing in Britain, influenced by the Salmon Report (DH 1966) and Donabedian (1969), introduced industrial

16 See Chapter 3:2 Nursing as a Subordinate Profession

management techniques into nursing. Other tools have included, Monitor, Qualpacs and the Dynamic Standard Setting System (RCN 1990, 1994).

Monitor (Goldstone 1982; Ball *et al.* 1984) for example, had a patient-orientated approach with two concepts: individualised patient care and needs, and the monitoring of support services. There were 455 questions concerning patient care, with a retrospective focus. A typical question was *'Do records document the effect of the administration of 'as required' medication?'* The dependency of any patient was noted on a four-section category scale ranging from minimal care to maximum care and the evaluation of care based on the specific dependency category of patients in each section, again by the use of a questionnaire. However, as might be imagined, the paperwork for initiatives like this took extensive periods to complete and was not popular.

The Qualpacs sixty-eight point scale was divided into six subsections, psychosocial/individual, psychosocial/group, physical, general, communication and professional implications. It focused on the assessment of the quality of care delivered to specified groups of patients, but was designed to be used in any nursing setting. The final score 'produced' a measurement of the quality of care delivered by a ward or unit. Use of the scale involved observers of care to work in pairs (to reduce bias) over a period of two hours. Data would then be reviewed on a five-point scale from poor to best care for one hour, and a mean rating produced for each item and section and an overall score decided (Ellis and Whittingham 1993).

In 1985, the Royal College of Nursing set up a '*Standards of Care'* project. The evidence in support of this was in *Standards of Nursing Care and Towards Standards*' (RCN 1980; 1981). The initial remit of this project was to develop a methodology to enable practising nurses to take responsibility and control for the quality of their patient care by defining and monitoring the standard of care and implementing any necessary action to improve quality if required. In 1987, the Royal College of Nursing (1987) published a position paper, *In Pursuit of Excellence,* which gave nine statements to enable nurses to move to the provision of a quality service based on three main principles: equity, respect for persons and caring.

The Standards of Care Project further developed into the Dynamic Quality Improvement Programme, which encouraged an academic focus on evidence-based practice to support the implementation of clinical effectiveness and quality improvement in practice. From this programme, the Dynamic Standard Setting System (DySSSy) evolved (RCN 1994). The base for the DySSSy was a cycle of describing, measuring and taking action to improve care. A relevant group of professionals set standard statements in the describing phase, identifying

the intentions and the necessary criteria for implementation (resources required, activities, and anticipated results). The standard statement was reviewed as necessary and, in order to measure practice against the standard, the group performed an audit, within a pre-defined period. The final phase involved action planning when the group summarised the data, interpreted the findings, and decided on any further necessary action. Concurrent with this development, integrated care pathways (also described as care profiles, care protocols, critical care pathways, or disciplinary pathways of care) originated from America during the late 1980s. Integrated Care Pathways remain evident today.[17] However, these initiatives experienced the usual problems of resource issues and understanding (Harvey and Kitson 1996). This study (Harvey and Kitson 1996:185) found that there were: *'a number of important system-related, contextual and practical issues of implementation for the various promoted nursing quality systems used in Britain, underpinned by two factors, ownership for quality and action to improve.'* The study concluded that nursing quality programmes were failing to embrace the two concepts simultaneously. These early tools are being replaced by the current initiative, the *Essence of Care*.[18] Discussion of this follows in a later section.

The drive for quality and quality assurance in the NHS has initiated and rejected a variety of approaches of quality management initiatives in nursing. In summary, to date, quality assurance tools have included the setting and monitoring of standards, clinical audit and patient satisfaction studies and integrated care pathways. However, many of the early quality assurance tools really depended on making a decision based on a given criterion that offered set questions. One can begin to appreciate a comment made to me by a senior nurse in relation to new quality initiatives, who stated that she found if she ignored it for long enough, it generally went away. Whilst this attitude perhaps is debatable, there have been disputes as to whether or not these tools were evidence-based (Sale 2000b). One can then begin to investigate the evidence-base for practice in nursing.

17 An integrated care pathway determines locally agreed multidisciplinary practice, based on guidelines and evidence where available for a specific patient/client group. It forms all, or part of the clinical record, documents the care given, and facilitates the evaluation of outcomes for continuous quality improvement (National Pathways Association, 1998). Integrated care pathways are structured multidisciplinary care plans that detail essential steps in the care of patients with a specific clinical problem and describe the expected progress of the patient (Campbell, et al., 1998). By facilitating the evaluation of outcome, they can be a quality improvement tool for use as part of clinical governance.

18 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005475 The Essence of Care' has been designed to support the measures to improve quality, set out in 'A First Class Service', and will contribute to the introduction of clinical governance at local level. The benchmarking process outlined in 'The Essence of Care' helps practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice. See Chapter 2:15 The Nursing Element of Clinical Governance – the Essence of Care

2:6 Research and Evidence-based Practice in Nursing

Although there are many definitions of evidence-based practice, evidence-based care and evidence-based medicine Sackett *et al.* (1997:2) have defined the term 'evidence-based practice' as *'the conscientious explicit and judicious use of current best evidence about the care of individual patients.'* It is noticeable that the emphasis here is on *'current best evidence'* not 'research evidence' as this has implications for nursing, as will be explained.

Traynor (1999) states that as part of its identity and power structure, any professional group seeks to establish a unique body of knowledge. He emphasises the importance of nurses being able to identify evidence to justify their practice in order to be credible. Nevertheless, early surveys of nursing as to whether there was use of research in clinical practice indicated that research was not being utilised to any great extent (Bircumshaw 1990). This finding may have originated from the requirements of nursing as a profession (Melia 1987; Witz 1992), or a more altruistic notion of providing the most appropriate and humane care. It is also evident that nurses do encounter barriers in practice towards locating, appraising and implementing research findings as will become apparent within this case study.[19]

A study by Appleby *et al.* (1995) recognized a clear lack of nursing evidence to inform practice. This study acknowledged that in respect of information for nurses working in the community, out of the evidence-base for 79% of activities relating to the medical profession, only 15% related to an evidence-base within nursing. The conclusion was that the evidence-base for nurses in the community was very limited. Work by French (2002) is useful in this respect. He presents an interesting epistemological perspective in stating that there is little evidence to support the existence of evidence-based nursing as a distinct construct or process. He concludes that evidence-based practice is commonly a euphemism for information management, clinical judgment, professional practice development, or managed care. The term adds little more to the existing long-standing tradition of quality assessment and research-based practice. He further argues that nurses must avoid the inefficiency bought about by the intense enthusiasm followed by sad disenchantment that has been associated with other attempts to introduce innovation into health care.

Nevertheless, the development of evidence-based healthcare and the availability of information and advances in technology have clearly widened the portals for providing an

19 See Chapter 6:6 Knowledge Management and Chapter 7:2 Knowledge Construction – The Learning Organization

evidence-base for practice, together with learning opportunities for both the organization concerned and its staff. To this end, as previously mentioned, many National Service Frameworks and guidelines have been developed, which set standards for all healthcare professionals. Some professionals see these as placing unacceptable restrictions upon autonomous professional practice, but it would appear that when there is evidence and a stated outcome for care given (as within the National Service Frameworks or NICE guidelines) there is less argument. The issue arises when the context of care varies, as do the needs and desires of individual clients (Ellis 2001).

There still is a requirement to develop an 'evidence-based culture' in selecting a strategic direction for evidence-based practice, then applying and evaluating the appropriate use of the subsequently developed skills in practice. Currently, evidence-based practice and evidence-based nursing have a very strong emphasis in the clinical governance agenda of quality improvement (Elcoat 2000). In respect to nursing, attempts to clarify outcomes have been made in the Essence of Care guidelines. These move some way to providing a focus for acceptable standards in care, but it is still interesting to note that the views, experience and opinion of respected authorities receive the lowest score, the highest score accorded to 'evidence.'[20] Nevertheless, quality assurance in nursing has now become focused on the 'Essence of Care' as will be discussed.[21]

2.7 Organizational Culture and Quality Improvement

It is a commonplace view amongst organizational theorists that major changes require alterations in people's attitudes, beliefs and behaviour. This is usually referred to as 'organizational culture' and highlights the importance of the issue of culture and subculture within any organization. There appear to be broad definitions of what 'culture' is. Martin (2002:3) defines culture as *'how things are done around here.'* She states that a cultural observer is *'interested in the surfaces of these cultural manifestations because details can be informative, but he or she also seeks an in-depth understanding of the patterns of meaning that link these manifestations together, sometimes in harmony, sometimes in bitter conflicts between groups, and sometimes in webs of ambiguity, paradox, and contradiction.'*

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20 http://evidence.ahc.umn.edu/ebn.htm Evidence-based nursing is the process by which nurses make clinical decisions using the best available research evidence, their clinical expertise and patient preferences. Three areas of research competence are interpreting and using research, evaluating practice, and conducting research. These three competencies are important to EBN. To carry out EBN the following factors must be considered; sufficient research must have been published on the specific topic; the nurse must have skill in accessing and critically analyzing research; the nurse's practice must allow her/him to implement changes based on EBN.

21 See Chapter 2:15 The Nursing Component of Clinical Governance – the Essence of Care

Another example given is that 'culture' is usually defined as *'that which cultural members share'* (Martin *et al.* 2002:16) and examples of what people share are given by Mannion Davies and Marshall (2003:2) as: *'beliefs, values, attitudes and norms of behaviour, routine, traditions, ceremonies and rewards, meaning, narratives and sense making.'*

Throughout the previous section, there is frequent reference made to 'culture' and 'organizational culture' in that any progress with quality initiatives generally requires a 'culture change.' I also noted that the core of the National Health Service was steeped in tradition and culture and that quality issues in the NHS were still wrapped around very strong organizational issues of personality, professionalism, power and culture. I stated that there is a drive to develop an 'evidence-based culture', and that evidence-based nursing had a very strong emphasis in the clinical governance agenda of quality improvement (Elcoat 2000). However, there is a problem with any definition of culture. Culture is what people do, so that actions are mutually recognizable as signifying the shared membership of a group. They do not necessarily rest on 'objective' differences between groups, as much as on an ability to render differences objective through talking about them. Effective managers command rhetoric in ways that talk their goals into existence, for example an evidence-based organization is one where everyone can use the rhetoric of 'evidence-based' but may not otherwise look or act differently.

'Culture' therefore, as in what 'people do;' is highly relevant to this Thesis, as it was expected that clinical governance would embrace the fundamental role of culture and leadership in addition to emphasising the role of the learning organization, as aspects of developing quality services.[22] It is therefore important to consider 'culture' in respect of any organizational change as clinical governance is seen to produce a 'cultural change.'[23] Later in the Thesis, I discuss organizational cultural studies that indicate there are different cultures within the health service, and note the emphasis on the importance of organizational culture as being the main driver for the use of new institutionalism theory in providing a framework for the Thesis.

Whilst it is evident that there have been many attempts to *improve* quality in the NHS, it is apparent that there has been some difficulty in the *evaluation* of quality improvement and this difficulty will be discussed in the following section.

22 See Chapter 1:2 Clinical Governance

23 See Chapter 2:17 Promotional Clinical Governance Literature and 2:23 Organizational and Organizational Culture Studies

2:8 Evaluations of Quality Improvement Initiatives

Despite the many different attempts to improve quality and quality assurance in the NHS as outlined, the promotional literature for the 'integrated' approach of clinical governance states that 'disjointed' approaches had previously been used in an attempt to improve the quality of health care in England. In evaluation, whilst this process has had isolated successes, it usually resulted in inefficiency and duplication of overlapping systems, due to a lack of association between the processes (Nicholls *et al.* 2000), and there was acknowledgement that many of these were not effective (Freeman *et al.* 1999). However, over the years, it has been this notion (that the complex multidimensional concept of quality could be identified, managed and evaluated) that has driven the various approaches to quality management.

Ham (2004) commented on the inherent difficulties in evaluating health policy in the health service. The Department of Health did not have the means to do this until the 1972 reorganisation of the DHSS when there was a parallel development of the Department's policy analysis capability. Walshe and Freeman (2002) highlighted the real need to learn from evaluations of quality improvement. They recognised that research suggested that quality improvement interventions had variable effects which depended heavily on the context in which they were used and the way that they were implemented. They suggested three important implications of this. Firstly, that the approach to quality improvement perhaps matters less than how or who uses it. In this respect, organizations should consider options carefully, choose one quality improvement intervention and make that work. Secondly, that research should consider how and why interventions worked. Thirdly, that evaluation should be a component of any quality improvement progress so that effectiveness is monitored and information gained is used to improve the systems. They identified factors known to help and hinder the progress of quality improvement: leadership, direction, organizational culture, training, resources and practical support are all important. Ultimately, they comment that every quality improvement is an experiment and that the programme itself should produce information about its effectiveness. They suggested that practitioners should become active participants in such evaluation, seek to incorporate this into their own work and have a say in future research agendas.

2:9 Summary on Quality in the National Health Service

Section A of this Chapter has presented a history of a variety of quality initiatives introduced into the health service. By doing this, I highlighted that no definition of quality or quality

assurance will fit all situations and that there was confusion around quality in the NHS. It would appear that all definitions are open to criticism and that interpretations of the quality management initiatives vary widely when used in different locations. There are tensions between political, managerial, professional and personal values and organizational mission that drive any organization, and the day-to-day activity may be different. This, together with the dominant and resistant cultures within the health service, may account for the constant discontinuation of quality initiatives. The section continued with an emphasis on quality initiatives in nursing, together with the debate as to what constitutes 'quality' in nursing care. There is reflection on the lack of an evidence-base to inform nursing practice as a distinct entity, which further adds to the confusion. It is emphasised because of this lack that quality assurance in nursing has become focused on the 'Essence of Care' The section concludes by highlighting the need for further evaluative studies into implemented quality initiatives.

In discussing the various discarded quality initiatives within the health service, it is easy to see why National Health Service staff become disillusioned. It would seem that there was a real need for some re-organization of the system and it appeared logical that the aim of clinical governance (to bring all these quality improvement concepts and interpretations under one umbrella) was pertinent. Clinical governance, the focus of **Section B**, is the current quality initiative within the NHS.

Section B

Clinical Governance

2:10 Introduction

As **Section A** has indicated, it is apparent that the health service has a chequered history concerning quality measures, and the lack of evaluation of previously implemented quality systems is evident. **Section B** addresses how the principles of clinical governance came to be seen as a solution to some of the problems inherent in the NHS system. There is discussion of its origins, background and definition, and, in particular, a description of the 'Essence of Care.' Identified research studies pertinent to the evidence-base for the integrated approach to clinical governance are discussed. As a change of culture is promoted as the main driver for clinical governance, organizational and cultural studies are also considered.

2.11 The Origin and Background of Clinical Governance

McSherry and Pearce (2002) state that the expression 'clinical governance' evolved out of the term 'corporate governance' that originated in the business world. The original goal was that of corporate legal protection. Following the collapse of Barings Bank, the Cadbury Committee was established and reported in 1992 that corporate governance was the way forward, by which companies would be directed and controlled. This became known as the 'Cadbury Code.'[24] The principles of corporate governance (those of open channels of communication, safeguarding public and employees and demonstrating value for money) were introduced into the NHS in 1994 by the Conservative Government in an attempt to *'demonstrate their commitment to improving public services'* (McSherry and Pearce 2002:14). The introduction of corporate governance was a three-stage process; firstly, in the development of a framework of corporate improvements in the organization; secondly, in the staffing of internal audit and, thirdly, in the development of controls assurance. Nevertheless, it was recognised at this time that 'corporate governance' only addressed the 'non-clinical' aspects of healthcare provision and that to gain total corporate 'management,' 'clinical' governance would need to be addressed as well.

Three years later, The Labour Government's White Paper on Health, *The New NHS: Modern Dependable* (DH 1997) and the subsequent paper, *The New NHS - a First Class Service (*DH 1998b), did just this by presenting details of a ten-year quality agenda for the NHS. The White Paper identified the Government aims of making the NHS modern and dependable and had the intention of retaining health service *'workable features,'* such as health care audit and discarding or reinventing the failures in different ways, for instance that of the internal market (McSherry and Pearce 2002:16). It is important to acknowledge that, in the broader political context at this time, there was a background of critical scrutiny of public spending and unjustified variation in service provision. The assumption that '*the professional competence of the medical profession was the best guarantee of an acceptable level of medical care'* had increasingly been questioned (Malin, Wilmott and Manthorpe 2002:127). Evidence had also become public on the activities of, for example, the GP Harold Shipman, the Bristol Royal Infirmary paediatric cardiac incidents and cancer screening failures in the south-east of England - *'Highly visible cases that were collectively so egregious as to constitute an indictment of the NHS by any definition of quality'*

24 The Cadbury Code is the unofficial name for the first Code of Best Practice on corporate governance, published in 1992. The Greenbury and Hampel Committees produced other codes, and together they formed what is known as the Combined Code on Good Governance.

(Leatherman and Sutherland 2003:4). These cases helped to invoke further the general impression that the NHS was failing.

The reason for introducing clinical governance into the NHS was therefore a perceived decline in clinical standards, service provision and delivery, reinforced by the media coverage at this time of major clinical failures (Harvey 1998; Scally and Donaldson 1998; Swage 2000). There was also a more informed consumer- orientated public and combinations of societal, political demographic and technological advances. The Government's reaction to these problems was an epidemic of new regulatory controls, but whilst it might appear the objective of this was admirable, Flynn (2004:20), states that if clinical governance is viewed as a *'mentality of rule*' it merely embraces a legitimate authority and only apparently devolves empowering capabilities in that the activities provoked are governable by different methods. Clinical governance has therefore prompted much discussion and criticism about its definition, nature and effectiveness in practice. The next section will highlight some of the major concerns, firstly in terms of its definition.

2.12 Defining Clinical Governance

Since its appearance as an important element in the Government's focus on improving quality in the NHS, clinical governance has generated considerable discussion on its true meaning, substance and essential nature, in that there are problems in the widely used 'official' definition. Clinical governance was defined in the Department of Health (1998b:33) consultation document *A First Class Service: Quality in the New NHS* as:

> *'A framework through which NHS organizations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish.'*

This explanation is criticised because it soon becomes obvious that various connotations can be utilised for 'governance,' for example; that of supremacy, domination, power or authority and that in this context it is not entirely clear who is doing the governing and who is to be governed. This is further confused when the same document (DH 1998: para.1:1.2) also describes clinical governance as a 'process.' Loughlin (2001) argues that without a clear rationale, governance, as such, becomes repression to those governed, who then have every right to seek a rigorous intellectually credible explanation. The definition is vague and circular (Maynard 1999; Loughlin 2001). Therefore, explanations of what clinical governance is are perplexing and explanations such as '*clinical governance is inclusive, making quality everyone's business…clinical governance is doing anything and everything*

required to maximise quality' (Chambers and Boath 2001:117) are not helpful as they give insufficient explanation.

Flynn (2002) also argues that NHS definitions of clinical governance were ambiguous and varied and this could be demonstrated in the descriptions of what it aspired to be. At its most general, the portrayal of clinical governance was part of a new approach to quality (DH 1998b; Kings Fund 1999). As well as the official definition, clinical governance has been described as an organizational innovation (Walshe *et al.* 2000), an integrated approach with organization-wide implications (Som 2004), a framework (Halligan and Donaldson 2001), and a system to improve quality of care that will facilitate excellence (Campbell *et al.* 2002). At the same time, there was some caution. Donaldson (2000:2) described clinical governance as a major improvement on the previous system of clinical audit, but emphasised that this was an *'ambitious and long term programme necessitating the transformation of NHS organizational culture.'* This comment is relevant to this Thesis as it considers a set period within the long-term programme. Other studies also emphasise caution in the reality of clinical governance implementation (Viccars 1998; Walshe *et al.* 2000; Walshe 2001). It is evident therefore that official or 'stakeholder' attempts to explain what clinical governance is, are confused and varied. For this Thesis, the 'general umbrella term' is adopted in the following section, for identifying the various components commonly understood to be included under this phrase.

2:13 Components of Clinical Governance

Clinical governance is most commonly portrayed as a 'general umbrella term' for standard setting in the form of protocols and policies, identifying risk management, performing audits, adverse incident recording and training, and reflection and professional development in the form of a 'Learning Organization,'[25] as will be discussed in the following section. There is also the need to address such components as safety, quality improvement and maintenance, culture and professional and organizational accountability. Swage (2000:5) describes clinical governance as *'providing an umbrella under which all aspects of quality can be collected'* and as a *'process,'* which comprises both an action and a structural element, in that there are:

'Clear lines of responsibility and accountability for the overall quality of clinical care.
A comprehensive programme of quality improvement activities.

25 See Chapter 2:4 Knowledge Management, Organizational Learning, the Learning Organization and Organizational Knowledge. The learning organization is viewed as an entity, an ideal type of organization that has the capacity to learn effectively and progress.

Clear policies aimed at managing risk.
Procedures for all professional groups to identify and remedy poor performance.'

A more coherent explanation is one offered by the National Audit Office (2003)[26] in that the main components of clinical governance can be grouped as follows:

Learning mechanisms (clinical risk management, clinical audit, adverse incident reporting, learning networks, continuing professional development).

Patient empowerment (better information, patient complaints, patients' views sought and patients involved throughout the NHS).

Knowledge management (information and information technology, research and development, education and training).

This explanation emphasises the importance of learning mechanisms and knowledge management, which is the focus for the next section.

In essence, therefore, clinical governance should work within an 'integrated' system, which advocates that safe and effective care is essential for all healthcare services. This involves checking and demonstrating that quality assurance, quality improvement and patient safety are part of the everyday routine and practice of everyone within every organization that provides healthcare. As has been previously described, some components of clinical governance, such as clinical audit and clinical effectiveness programmes, were already in use with varied success within the health service, but the more 'systematic holistic approach' and the requirement for the production of policies, protocols and reporting mechanisms was new.

Nevertheless, a fundamental fault with the above is that it implies a common understanding as to what quality, safety, culture, effective care and clinical effectiveness all are, yet the variation in definition is clear. As Flynn (2004:14) points out, the proliferation of mixed metaphors for clinical governance (*umbrella, model, framework, culture mindset etc.)* indicates its *'inherent ambiguity.'* In the abstract, it might be viewed just as a *'particular form of governmentality, where audit is linked with regulation, accomplished through new forms of self-surveillance*' (Flynn 2004:20) in the form of a *'soft bureaucracy.' Soft bureaucracy is a form of organisational governance which, particularly in the case of professionals, attempts to fuse internal and external legitimacy'* (Flynn 2004:21).

[26] http://www.nao.org.uk/pn/02-03/02031055.htm

2:14 Knowledge Management in the NHS and Clinical Governance

In 1997, health policy documents began to focus on the improvement of patient care through the better use of information and on the sharing and implementation of good practice. Key documents at the time included *The New NHS Modern and Dependable* (DH 1997), which promised an interface that would promote faster healthcare information through the internet, NHS direct, NHSnet, online booking services and quicker test results. This was followed by *Our Information Age* (DH 1998d), which concentrated on the improvement of an information communications technology. *Information for Health* (DH 1998e) outlined a programme of modernisation in information strategy and *A First Class Service: quality in the new NHS* (DH 1998b) promoted a clinical governance framework, addressing quality through effective underpinning knowledge systems. *A Health Service of all the Talents* (DH 2000b), proposed a comprehensive review of information needs to support education training and workforce planning, and, *An Organisation with a Memory* (DH 2000c) made the case for knowledge management systems to capture and disseminate the learning and tacit knowledge generated through work.

Fundamental to the advance of the processes and systems for clinical governance and improvement within the NHS therefore, was the identified need for the development of a 'Learning Organization' (DH 1998c). Whilst clinical governance focused on the statutory duty to develop the system, standards and processes necessary to improve health care quality and manage risk, organizations also had to seek new ways in which this learning could be retained and deployed widely in the promotion of 'organizational learning' and an 'organization with a memory' (DH 2000c). It was recognised, in conjunction with clinical governance, that learning was the key to a better future and an essential part of quality and important for professional personal development. At the time, it was envisaged that the introduction of individual learning accounts and the NHS 'university' (Working together, learning together, DH 2001c) would promote this initiative, but they did not. Therefore embedding such learning became a responsibility of the organization itself. Organizations that have the desire and capacity to make learning a core characteristic become known as 'learning organizations.' In applying these learning organization management theories to clinical governance, there is both overlap and synergies, as will now be described.

The management and avoidance of risk is fundamental to clinical governance (Lugon and Scally 2000). This involves staff undertaking risk assessments and audits related to the cost of getting things wrong. The ultimate function of this activity is to ensure that staff are properly trained and that procedures and protocols are in place to certify that the

environment is safe. A learning organisation endorses the belief that technical skills are not enough and that learning needs to be guided by the necessary processes and protocols (Wilkinson, Rushmer and Davies 2004). Early detection and intervention of any poor performance, with subsequent provision of support and feedback, is a primary function of clinical governance. The opportunities are utilized to learn and improve rather than for 'blame.' There is recognition within a learning organization that performance needs to be 'managed,' in that mistakes and complaints are identified (within limits) as opportunities to learn in a supportive environment and those individuals improve through learning (Denton 1998).

Using clinical governance as a framework, the quality of care, evidence-based practice and the sharing of good practice form an integral part of care delivery. The learning organization sees quality as affecting everybody within the organization, and the organization itself has an ethos of quality and a sharing of learning for improvement (Wilkinson, Rushmer and Davies 2004). A desirable culture, together with good leadership and recognition of the importance of education and research, has been promoted for clinical governance (Scally and Donaldson 1998). A learning organization, too, places a high importance on these, together with interpersonal and transferable skills, innovation and use of initiative. Customer opinion also plays an important part in the development of the learning organization (Denton 1998).

The NHS Executive (1999) identified that within the management of risk, integrated systems and processes were required for clinical governance quality improvements, including the use of, and access to, good information technology systems (IT). Allowing time for the training, appraisal and continuing professional development of staff is also viewed as an important component. A learning organisation is recognised as being a 'systems thinker' and this stretches beyond the organization itself (Senge 1994). Denton (1998) explains this further by identifying that systems that can be developed within an organization are usually 'teams' (team working is given a high emphasis in that individuals can see their own contribution fitting into the 'system' in order to feel valued (Clark 2001)). Those beyond the organization can be 'networks' but both have the same goals, mainly to learn and improve. Clinical governance also emphasises the importance of communication within the organization and the need for all individual, team and organization goals to be aligned (Lugon 2002). A learning organization values a shared 'coherent vision' (Clarke 2001) and that learning is the core of their work (Bell *et al.* 2002).

However, whilst there is evidence of overlap and synergy, there also appears to be some contradiction in that there are as many definitions of what the 'core' characteristics of a learning organization are as there are of clinical governance (Wilkinson; Rushmer and

Davies 2004). The two could also be seen as conflicting in their logic of action, in that clinical governance is fundamentally a 'top down' Government-imposed initiative and organizational learning emphasises a drive coming from within an organization itself at grass roots level, a 'bottom up' approach (Clarke 2001) in the changing of values, beliefs and motivation (Wilkinson; Rushmer and Davies 2004). The reasons for an improvement in quality may also differ. Clinical governance is focused on quality improvement that has arisen from an external political pressure and is open to external scrutiny and target achievement; whereas a learning organization is often focused on securing a competitive advantage (Easterby-Smith and Araujo 1999). The relevance of this is that learning within the clinical governance framework may be stifled and limited, due to the rigidity of the imposed systems, whilst there may be less restriction within a learning organization.

The context of the background for clinical governance and learning organizations also differs. Clinical governance was introduced by policy into a large complex public sector organization; it has a hierarchical accountability factor and *'encroaches on clinical autonomy with its legitimization of managerial interest in clinical quality'* (Wilkinson, Rushmer and Davies 2004:111). However, learning organization concepts arose from within the private sector, with devolved responsibility and accountability to colleagues and teams (Finger and Burgin Brand 1999). Clinical governance relies on compliance with rules, regulations and standards to achieve change, but tends to lack the ownership of a 'bottom up' approach of internalized values and motivations, as encouraged by learning organizations. However, learning within learning organizations in this instance may not accrue as it is supposed to with a clinical governance system implementation.

This section has identified some of the difficulties inherent in conflicting definitions and understanding about what clinical governance is thought, or said to be, and the possible tensions that may be experienced in its implementation. To continue to provide the necessary background context to set the scene for the study, the next section will address the specific nursing component linked to clinical governance, that of the Essence of Care. This is also relevant in providing a background to the interview data analysis,[27] addressed later in the Thesis.

27 See Chapter 7:4 Real Work

2:15 The Nursing Component of Clinical Governance –

The Essence of Care

The Essence of Care[28] initiative related to the commitment made in 'Making a Difference,' the National Nursing, Midwifery and Health Visiting Strategy (DH 1999a). The document proposed the area of 'benchmarking' as a process through which health care professionals could identify best practice and improve practice through a structured comparison and sharing of information about patient care, within a set framework.

The origins of benchmarking are from within industry. In the past, Health Service benchmarking data has focused more on organizational issues, e.g. waiting times, staffing ratios, etc. (Ellis 2000), but in this context the application of benchmarking is to clinical practice. The promotion of the 'Essence of Care' (DH 2001a) as a best clinical practice-benchmarking tool for health care professionals was in order to support measures to improve quality. The Essence of Care benchmarking toolkit is a significantly long (175 pages) document, described as having a 'qualitative' approach. Varieties of types of evidence used to establish the benchmark standards were national guidelines, policies, systematic reviews and large-scale studies (DH 2001a). It is stated that '*Patients, carers and professionals worked together to agree and describe good quality care and best practice'* (DH 2001a:7).

There was originally, identification of eight aspects of care. These included Principles of Self-Care, Food and Nutrition, Personal and Oral Hygiene, Continence, bladder and Bowel Care, Pressure Ulcers, Record Keeping and Safety of Patients with Mental Health Needs in acute mental health and general hospital settings. Since its inception, there have been additions to the original eight aspects of care: those of Communication in 2003, Promoting Health in 2006 and Environment in 2007.[29] These acknowledged benchmarks were derived from consideration of what patients wanted from care. '*The elements were identified by*

28 'The Essence of Care has been designed to support the measures to improve quality, and can contribute to the introduction of clinical governance within organizations. Clinical governance is a powerful tool that can support such improvements particularly if benchmarking activity is a part of this agenda' The benchmarking process outlined in 'The Essence of Care' helps practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice' (DH2001).

29 Essence of Care benchmarking is a process of comparing, sharing and developing practice in order to achieve and sustain best practice. Changes and improvements focus on the indicators, since these are the items that patients, carers and professionals believed were important in achieving the benchmarks of best practice. See Appendix B2a and B2b for more detail on the Essence of Care.

patients and professionals as crucial to the quality of a patient's care experience' (DH 2001a; Ellis 2001:1202).

In the context of nursing, benchmarking is a method of identifying the best nursing provision within a ward/department, measured along a qualitative continuum. The 'Essence of Care'[30] is essentially a toolkit for practitioners, relevant to all those involved in providing direct care, but primarily nursing led. The Essence of Care 'toolkit' considers an evidence-base for practice, in the attempt to measure the quality of care, using a hierarchy of evidence, as indicated in the Essence of Care document.[31] The anticipation was that by explicitly stating what these benchmarks are, practice quality in the designated areas would improve. The Essence of Care was about supporting practitioners to achieve the standards that patients want in fundamental aspects of care and recognizing that the clinical governance activity is concerned with the quality of the whole health care experience for the patient (Ellis 2001:1202). The intention was to advance the clinical governance agenda (Castledine 2001).

Although the document mentions 'practitioners,' the initiative was generally viewed as being nursing led, with other practitioner groups expected to take part. Benchmarks are *'designed to be used to structure discussion between identified groups'* (Ellis 2000:125). There was an expectation that multi professional groups of practitioners, under the remit of clinical governance, would apply patient-focused benchmarks in the area of practice under consideration within a category of the benchmarking scoring tool[32] and that there would be identification and dissemination of best practice. However, despite the research evidence-base for nursing being debatable,[33] in the Essence of Care there is consideration of the evidence-base for benchmarks of best practice, using a hierarchy of evidence, and of the different evidence available. The Essence of Care benchmarks therefore can supply a suitable basis for observable standards of good practice on the wards.[34]

This section has discussed the various components that are 'officially said' to constitute clinical governance and the specific nursing-related component of the Essence of Care within it. I have argued that terminology in respect of clinical governance is varied and confusing

30 The Essence of Care arose from a commitment to help improve the quality of what are described as fundamental and essential aspects of patient care. The National Plan (2000), reinforces the importance of 'getting the basics right' and of improving the patient journey and experience.

31 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005475

32 See Appendix B2a and B2b.

33 See Chapter 2:6 Research and Evidence-based Practice in Nursing

34 See Chapter 4:18 Ward Observation

and that it has prompted much discussion and criticism as to its definition, nature and effectiveness in practice. The introduction of clinical governance into the NHS was at a time when there were extensive reforms, structural and internal regulatory changes, together with a substantial increase in investment and the setting up of the many external NHS monitoring agencies. All were promoted as a means to improve quality and remedy perceived 'failures' within the existing system. As the rhetoric for clinical governance emphasises the use of evidence in practice, attention will now focus on identifying the evidence-base for this initiative.

2:16 The Evidence-base for Clinical Governance

The fundamental principle underlying clinical governance is that care is based on the best evidence from well-conducted research. Under this remit, clinical governance has given all health organizations a statutory duty to seek quality improvements in health care within their own organizations. Indeed, Scally (1999; 2000) states that the framework for clinical governance 'reporting' should include some research on the effectiveness of clinical governance and its impact on the culture and creation of best practice. Yet, interestingly, this does not appear to apply to the promotion of research into the integrated system of clinical governance. The literature on this aspect is relatively sparse in comparison with, for instance, published promotional articles identifying its virtues.

Thomas (2003) studied the published literature to establish whether evidence existed to support the claim that clinical governance had been advanced as a mechanism for continuous quality improvement within the NHS. He found that there was little published evidence that clinical governance had made any measurable difference. He established that out of 335 papers retrieved, *'114 were potentially relevant, but only 10 attributed changes in quality to clinical governance directly. Of these, only three attempted to provide data to support the assertion'* (Thomas 2003:251). I was therefore interested to look in any further published literature for evidence to support the claim that the use of clinical governance had improved the quality of patient care in the NHS and to identify whether three years later this situation had changed.

There are differing lists of good bibliographical information available from computerized databases such as The King's Fund Information and Library Service (2006),[35] the Wisdom

35 The King's Fund Information and Library Service is a unique source for information on health and social care policy. It is freely available to managers and leaders in health and social care, and anyone else working or interested in these areas. A team of expert information professionals staff the service. http://www.kingsfund.org.uk/resources/information_and_library_service/index.html

Centre, and the NHS clinical governance Support Team (CGST). The usual extensive academic resources of research databases, for example, the Social Science Index, Ovid, Medline, Emerald and the Cumulative Index of Nursing and Allied Health Literature are useful, but there is no single comprehensive evidence-base index for all the so-called 'integrated features' of clinical governance research which have been so heavily promoted.

A literature search therefore, as might be expected, involves looking through several different resources. Another difficulty arises from the key words 'clinical governance,' as it would appear that this expression broadly encompasses all documents from national research studies to a single component, such as an audit, or description about changes in practice and individual opinion. Nevertheless, the published literature on clinical governance can be separated into distinct categories. The promotional [36] literature is the first category and definitely the most prolific.

2.17 Promotional Clinical Governance Literature

As the new framework of clinical governance intended to integrate the disjointed approaches to quality, one would expect, after seven years of implementation, on a ten-year plan, an evidence-base to support this. Since the idea of clinical governance appeared, there has been an explosion of literature extolling its virtues (Donaldson and Gray 1998; Scally and Donaldson 1998; Donaldson 2000; 2001; and Halligan and Donaldson 2001). There is an overwhelming abundance of books, policies, opinion papers, websites and discussion papers. These concentrate on what clinical governance is, how it should be done and how to do it, together with 'eureka' type experiences, as in, for example, Lugon and Secker-Walker (2006); McSherry and Pearce (2002); Miles, Hill and Hurwitz (2001); Swage (2000) and Chambers and Boath (1998).

Many papers have focused on its definition, as in Scally and Donaldson (1998), Gray (2004) and Som (2004), or on any separate component, with some on leadership aspects (Goodwin 2000; Hackett *et al.* 1999 and Boggust *et al.* 2002). There are papers on clinical audit (Burke and Lugon 1999); professional roles, as in chief executives (Sausman 2001); managerial and clinical approaches to quality (Buetow and Roland 1999); clinical guidelines (Hall and Eccles 2000; Rashidian and Russell 2003); risk management (Harris, 2000; Stein, 2002; Cowan 2003) and individual descriptive implementation studies (Mynors-Wallis *et al.* 2004; Armstrong 2006). Some papers focus on the challenge of organizational implementation, as in Latham *et al.* (1999); Sweeney *et al.* (2000); Wallace *et al.* (2001a) and

36 See Chapter 1:0 Introduction and Need for this Study

Walshe (2000). A few express concern about the gap between the rhetoric and reality of clinical governance as seen in Black (1998); Buetow and Roland (1999); Bunch (2001); Crofts (1999); Goodman (1998) and Walshe (2000; 2001).

Further examples of promotional literature can be located on the Clinical Governance Support Teams website,[37] in categories such as, appraisal; clinical audit; communication; continuing professional development; cultural change; essence of care; knowledge management/website development; large group work; leadership; origins/implementation of clinical governance and patients' experience. However, these articles are mainly theoretical, rhetorical and promotional, concerning separate components within clinical governance, with little or no comment on how the integrated approach might have an advantage in improving care. There is no consideration of these books and papers here, as they do not provide a research orientated evidence-base.

2:18 Research Studies on Clinical Governance

The second distinct category is that of published clinical governance research studies. This section will address the studies conducted at national, regional and local level in reference to hospital Trusts. There will also be some comment on critical and discussion documents, to establish if, after seven years, research studies have produced any evidence that the integrated approach of clinical governance is providing better quality care. Very notably, and most importantly, there are a very small number of large-scale national research studies on clinical governance as an integrated approach. Studies identified include, Wallace *et al.* (2001a; 2001b); Freeman *et al.* (2001); Walshe *et al.* (2003) and Taylor *et al.* (2003). There is also some discussion of Leatherman and Sutherland's (2003) midterm evaluation of the ten-year quality agenda. Finally, studies about the importance of organizational culture in relation to the implementation of clinical governance are considered.

2:19 National Clinical Governance Research Studies

National research on clinical governance is fragmented, with studies conducted by academics, health care organizations or civil servants. These do not relate to any improvement in the quality of care. An early study by Walshe (2000) indicated that although there did appear to be support for the concept of clinical governance, the implementation was hindered by available resources, time and skills. At this time, the setting up of structures and the writing of strategies was more apparent, rather than factors related to

[37] http://www.cgsupport.nhs.uk

leadership, information systems and any analysis of practice. Work by Wallace *et al.* (2001a; 2001b) focused on a postal survey and interviews with senior managers in Trusts. The research found that the attitude towards clinical governance was undecided and that many Trust leaders utilised clinical governance as a new label for staff development activities. It was suggested that clinical governance 'leads' should show leadership by evaluating the efficacy of strategies to install an evaluative learning culture, as there appeared to have been a reliance on clinicians acquiring best practice through unspecified diffusion processes. Wallace revisited some Trusts three years later (Wallace *et al.* 2004) and found that external reviews and league tables had an adverse impact on the Trusts where results were poor but minimal impact if results were positive. Conclusions from this study recommended more effective means of catalysing change; for example, in providing more resources, intensifying effort on mandatory systems and having more information systems.

Another major national study, conducted again by Walshe *et al.* (2003), from the Centre of Healthcare Management, University of Manchester (commissioned by the National Audit Office 2003) presented the findings of a survey of NHS Trusts in England as to their progress in implementing clinical governance and the impact of the clinical governance initiative. Walshe *et al.* (2003) surveyed 270 Trusts by questionnaire and achieved 100% response, although Trusts did not answer all the questions asked and *'it was completed by a number of individuals at varying levels within the organisational hierarchy in NHS Trusts*' (Walshe *et al.* 2003:11). Both qualitative and quantitative data were obtained. Results are presented in a series of tables in relation to each question asked. The sections in the report covered: support provided to NHS Trusts to implement clinical governance; structures and frameworks for clinical governance; resources and processes for clinical governance; external evaluations of clinical governance and chief executives' perspectives on the progress of clinical governance. The summary of conclusions for the study included the finding that clinical governance was well established and embedded at the corporate level of hospital Trusts, with many regarding having systems and structures in place as being sufficient.

However, the evidence suggests that *'existing systems are fragmented, far from comprehensive in their coverage and of very mixed effectiveness*' (Walshe *et al.* 2003:39). It was also evident that the costs of the implementation of clinical governance were not generally known, as there was a considerable variation in the figures given and in what had or had not been included. NHS Trusts were also reluctant to commit themselves in rating the effectiveness of clinical governance in bringing about these changes. The main barriers

to the implementation of clinical governance were those of time, resources, culture, behaviour and attitude of the staff and the organization.

Information from Walshe *et al.'s* (2003) final report on 270 Trusts was further utilised by the National Audit Office in the same year, in their report on the implementation of clinical governance by NHS Trusts. This report also included information from other sources, particularly the Health Services Management Centre, Birmingham, which, on the Audit Commission's behalf, had conducted surveys of board members and senior managers with a representative sample of NHS Trusts. Reviews of reports from the Commission for Healthcare Improvement (2002)[38] were also incorporated in this work, together with the results of interviews with Department and NHS staff and other 'relevant bodies,' and through the consultation of an expert panel (Taylor *et al.* 2003:3). A description of this report follows.

The National Audit Office acknowledged that the implementation of clinical governance had, together with mergers, taken place against a background of considerable organizational change and that this was cited by one in six chief executives as being a barrier to the progress of implementation. The Commission for Healthcare Improvement found that this had sometimes not been anticipated and managed. In addition, '*the large number of regulatory and inspection bodies impose burdens on Trust resources with overlapping and duplication of requirements' (*Taylor 2003:13), a point which will be referred to later in the study.[39] Chief executives saw clinical governance as being moderately successful. Cultures and attitudes appeared more receptive, with clinicians being more accountable for the quality of care they provide. Nevertheless, the replies were cautious and again very few regarded clinical governance as a complete success as there were still many barriers and problems. In contrast, the report also stated that barriers to the implementation of clinical governance were overwhelmingly found to be resource constraints, the culture, behaviour and attitude of staff and lack of organizational direction and impetus for clinical governance. Any function that was externally scrutinised was especially robust, but clinical audit and patient and public involvement was said to be the most underdeveloped areas. Most respondents indicated that clinical governance had promoted a more systematic integrated

38 The Commission for Healthcare Improvement (CHI), originally established as an independent, inspection body for the NHS, renamed the Commission for Health Audit and Inspection (CHAI is now known as the Healthcare Commission (HC). It is the independent watchdog for healthcare in England. It promotes continuous improvement in the services provided by the NHS and independent healthcare organizations.

39 See Chapter 3:5 State Intervention and Regulation of Health care

approach to the previous separate and un-coordinated initiatives but that initiatives within the system varied in their individual progress; it was acknowledged that this was difficult and too highly subjective to assess. There was considerable overlap in forms of requirements for external review, but overall comment indicated that the Commission for Healthcare Improvement inspections had made the biggest impact.

Following these inspections, the study suggested that action plans formed by Trusts needed to be monitored, as the implementation of any designated action was too slow. This study presented a very clear descriptive survey of the effects of clinical governance on a number of hospital Trusts and does give some direction for action. Nevertheless, the limitations are clear: it relies on information collected in terms of a survey and from chief executives (who have a statutory duty of clinical governance placed upon them) and one might question whether they would agree that clinical governance has had little effect in their Trust.

In 2002/03, The Nuffield Trust commissioned a study by Leatherman and Sutherland (2003) to *'conduct a review of the quality agenda as articulated by the newly elected Labour Government.'* This, in effect, resulted in a detailed mid-term appraisal, or, as also described, a mid-course evaluation of the ten-year Quality Agenda that the New Labour Government first articulated in 1997/8. The objectives were to establish *'achievements to date and identification of prudent mid-course corrections to best attain further successes and sustain gains*' (Leatherman and Sutherland 2003: x). Leatherman and Sutherland (2003:289) state that two questions were fundamental to their evaluation: whether the policy initiatives for building predictable systemic capacity for quality improvement were coherent and cogent and what evidence of impact existed to date. Although the report looked at quality reforms to the NHS in England in a broader context than just clinical governance, it provided quantitative data from a variety of sources with specific regard to improving the quality of care. In the study, there were internationally accepted domains of quality applied to evaluate impact: those of access; effectiveness; system capacity; patient-centredness and disparities.

Leatherman and Sutherland (2003) provide the resulting data in 110 graphs divided into the six domains. In doing so, it might be argued that they merely present a synopsis of mostly official Government or Government agency sources of facts, on, for example, ease in attending GPs' surgeries, waiting lists, screening rates and the use of NHS Direct as there is relatively little summary or discussion of these. Appleby (2005) also criticises the report and comments that there is no comparative data as most of the sources come from Government figures. He remarks on the different aspects of care and the difficult dilemmas

of choice for intervention; for example, shorter waiting lists rather than treatment for childhood leukaemia, which are not addressed in the report (Appleby 2005). In terms of clinical governance, the report comments on the findings in both the Walshe (2000) study and the Wallace (2001a; 2001b) study. A NHS performance rating for acute Trusts, specialist Trusts and ambulance Trusts 2002/2003 (CHI 2002) does not significantly add anything to the debate. Interestingly in quoting this review (CHI 2002), Leatherman and Sutherland (2003:150) state that clinical audit is satisfactorily implemented, yet other reports (Walshe *et al.* 2003; Taylor *et al.* 2003) find it to be weak or underdeveloped.

2:20 Regional Clinical Governance Research Studies

There are relatively few conducted regional research studies on the integrated process of clinical governance. Publications include a qualitative study by Walshe *et al.* (2001) and a cross-sectional qualitative study by Grainger *et al.* (2002). Some studies focus on primary care (Walsh and Small 2001) and there are a small number of individual organizational research studies on NHS Trusts (Peak *et al.* 2005). Many discuss the difficulties of organizational cultural change. For example, one study on a culture change in an English healthcare setting, comments that the need to respond to conflicting Government policies caused tension amongst individuals, and the 'top down' target-driven regime *'acted to mitigate the transformational and reconstitutive effects of a discourse of empowerment aimed at achieving this change*' (McDonald 2005a:189).

Walshe *et al.* (2001) conducted a qualitative study that explored the use of external approaches to quality improvement in health care organizations in one region. There was a descriptive evaluation of the process and impact of external reviews of clinical governance arrangements at health care provider organizations in 47 NHS Trusts in the West Midlands. The methodology consisted of personal and telephone interviews with senior managers and clinicians. It found that preparing for reviews was a substantial and time-consuming task, but overall did not generate wholly new knowledge and did not lead to major new policy change. The study concluded that there was little research on the effectiveness of external quality reviews, and that more attention to the design and impact of external review would help maximize its benefits and minimise costs and adverse effects.

Grainger *et al.* (2002) performed a cross-sectional qualitative study based on in-depth interviews and observation of 43 acute and non-acute Trusts in the West Midlands region in order to determine the rating of the Trusts' competencies across five areas of clinical governance. 'Turbulent' environments were found in three-quarters of the Trusts in the

study, but it was stated that the 'top team' Trusts exhibited characteristics of clear leadership, a recognition of both clinical and managerial components in clinical governance, senior team vision and a facilitative approach. It was found that there was a focus on the patient, an open culture, minimal blame and collaborative working with the Health Authority and access to resources present in the 'top team' Trusts. The study concluded that there must be attention paid to resources and to the organizational and cultural environment within Trusts if high quality clinical governance was to become the norm. Nevertheless, one might wonder whether these Trusts would still do well with these components anyway, if good leadership were apparent.

Using a case study approach to focus on one hospital Trust, Peak *et al.* (2005) found that if there was consideration of the core functions of clinical governance these related to well-established structures and roles within the modern NHS. It identified that a description of the implementation of clinical governance using a self-developed theoretical model was an example of a robust system for clinical governance implementation. However, the article does not really add anything further to the very limited evidence that clinical governance improves patient care. Murray *et al.* (2004), in a study identifying the knowledge and attitudes about clinical governance from 539 staff in the South of England, concluded that although there were varying degrees of knowledge about clinical governance the general attitude towards it was positive. The questionnaire in this instance, audited clinical governance implementation and identified the training needs of staff and managers.

Generally, it is evident that regional empirical studies are sparse; however, the findings of these are similar to the national studies. Freeman's *et al.* (1999) quantitative study relied on a self-completion postal questionnaire that provided a baseline assessment of the early progress and development of clinical governance across all thirty-nine Trusts in the South West region. Results indicated that despite some early progress made in establishing structures, there was a considerable way to go below board and sub-board level in linking clinical governance to existing systems. The main barriers to implementation were seen as resource issues and the need for a change in culture, and a view that this organizational culture cannot be changed to 'order.' Issues around organizational hierarchies, clinician-manager relationships, difficulties in changing clinical practice and the need for interventions at all levels to facilitate the necessary changes were apparent.

In summary, perhaps the most noticeable aspect of the empirical evidence on the integrated approach of clinical governance is the lack of research studies showing how the integrated approach of clinical governance is working. Studies also tend to involve the same small

groups of researchers and regions, so the results may be limited. Nevertheless, both national and regional studies generally indicated similar difficulties in the implementation of clinical governance. These included lack of resources, knowledge management and culture change. Progress is variable. This gives justification to the production of the disproportionate number of discussion and critical papers, as presented in the following section.

2:21 Discussion and Critical Papers

There are numerous discussion documents on clinical governance, as in, for example, Buetow and Roland (1999); West (2000); Ritchie (2002); Scott (2002); and many critical papers as in, for example, Ritchie (2002); Kmietowicz (2003); Grosch (2004); Som (2005) and Goodman (2006). These are mainly theoretical papers, apart from a research study by Som (2005) which is briefly discussed, as it does generally support the opinion voiced in these documents.

Som (2005) used a qualitative instrumental case study approach, where thirty-three doctors with 'important responsibilities' for clinical governance were interviewed, using a semi-structured interview format. The results indicated that understanding of what clinical governance is varied, and that doctors were not generally enthusiastic about it. It is not receiving their wholehearted support as they feel it is a management-led initiative. The research highlights the tensions between an organization attempting to bring clinical care under management control and the resisting doctors, who do not want the old arrangement of clinical care based on *bureau-professionalism* (Som 2005:474) replaced. As this was a small study, the results are limited, but it does indicate the scepticism voiced in discussion papers. The study also highlights the lack of an evidence-base for this health policy initiative.

2:22 Nursing Research Studies on Clinical Governance

There are again, few nursing research studies on clinical governance. Viccars (1998), Crofts (1999) and Maynard (1999) have all expressed some caution about the gap between the official 'rhetorical' literature and the reality of clinical governance. The Royal College of Nursing consulted their membership about it in 1998 in the form of discussion groups and used the resulting feedback to inform and respond to RCN policy on clinical governance.
In relation to the RCN study (Currie and Loftus-Hills 2002), specific comments were made in respect of the need to integrate existing systems, create the right culture, place the patient at the centre of all developments and make clinical governance meaningful to all (Harvey 1999;

RCN 2000). There was emphasis on the need to change culture in 1999 with the second round of consultation. At this time, there were some reports of shifts in culture, but it was apparent that there was still confusion about the roles, responsibilities and contributions of the different professional groups. It was identified that organizations needed to do more to inform frontline staff. In this consultation, the RCN membership identified barriers to implementation as being lack of funding, time, continuing professional development and resources (Currie and Loftus-Hills 2002).

A third round of ten expanded discussion groups (which included clinical staff and managers), was held in December 2000 and February 2001 in order to obtain nurses' views on clinical governance and the results were reported in some detail (Currie and Loftus-Hills 2002). This study found that there was commitment to clinical governance in principle and that it encompassed many existing activities. There was some concern as to what individual responsibility would mean and participants felt that there needed to be a clear balance of control, support, commitment, ownership and resource allocation. Many practical difficulties such as skill-mix, nursing shortages and patient dependency were highlighted and thought relevant enough to be taken into account. Nurses were merely *'trying to survive their shifts without any adverse events or incidents'* (Currie and Loftus-Hills 2002:41). The overriding perception in these clinical groups was that the managers did not understand clinical governance and the decisions that they made were based on financial, rather than clinical, justification.

The importance of creating a *'culture in which clinical governance could thrive'* formed a significant section of this study report. As with other studies previously mentioned, the organizational problems with the *'open transparent learning culture*' (Currie and Loftus-Hills (2002:41) that was required for clinical governance were recognised. The desired learning culture was found to be inconsistent with the organizational culture experienced. This was still seen as being rooted in fear and blame with individuals being held accountable for systems failure. This professional accountability and decision making was a problem as it was felt that clinical governance could limit decision-making. Participants also complained that when they reported areas of concern, they received little or no feedback and this created further difficulties. The report also highlighted that multi-professional working, for a variety of reasons, was difficult to achieve. Other problems included the culture of secrecy in medicine and the need to create effective partnerships between clinicians and managers.
Currie and Loftus-Hills (2002) refer to the importance of general organizational culture identified in studies such as Feldman (1986) and Case (1994). They acknowledge that the vigorous debate in this area should be recognised in relation to clinical governance as

identified in studies such as Wright (1998); Davies *et al.* (2000); Savage (2000) and Degeling *et al.* (2001) and argue that the 'right' cultural change strategies are required. However, Currie and Loftus-Hills (2002) observed that nurses still endorsed the belief that this is not as easy as has been suggested by the various authors who promoted the change, for instance: Boden and Kelly (1999); Firth-Cozens (1999); Hackett *et al.* (1999); Dewar (2000); Lugon and Scally (2000) and Jones (2001). The study concludes by stating that although nurses were committed to the principles of quality and accountability, it would appear that there was little evidence of bringing about the necessary cultural change. The variable successes in the implementation of clinical governance should be of note, as the same previously identified problems were recurring. It was suggested that unless there is clear understanding about what clinical governance is, it was highly unlikely that it would happen and that clinical governance should not be seen as a *'coercive force'* (Currie and Loftus-Hills 2002:42). In view of the importance of the debate on organizational culture, the next section will discuss both organizational and organizational culture studies in more detail.

2:23 Organizational and Organizational Culture Studies

In respect to organizational studies, Griffiths (2003), in exploring the question of how certain relevant published work has contributed to the understanding of 'healthcare organization,' covers a period of twenty-five years comprehensively to address and analyze this subject. Whilst there are many important points made, comment on only a few relevant issues is made here. Griffiths (2003) emphasises the importance of referring to theories and methods from other disciplines and to previous studies within medical sociology. She suggests that they provide a valuable insight into a range of healthcare settings and their social organization. She states that certain studies have focused on how healthcare settings are formally organised, directed and managed. Further studies include work on the division of labour between healthcare workers and *'issues of relative status, power and occupational identity including those around professions and professionalization and relationships between different occupational sectors and between patients and healthcare workers'* (Griffiths 2003:156). It would appear that, firstly, 'in *order to understand organisations we must understand people accomplishing organisation in a multitude of locally situated interactions' (*Griffiths 2003:158). Secondly, *'Government reforms in healthcare are subverted and reshaped in numerous face to face interactions producing consequences which, in many cases, have increased costs and reduced transparency, apparently inverting the original intention behind the development'* (Griffiths 2003:159).

Griffiths presents a synopsis of further published studies and highlights work on relationships

between policies, their implementation and working practice, and professions, professionalism, negotiated order and the division of labour. She comments that few studies have explored the relationships between healthcare levels and it is necessary to '*begin to map out the crossover between formal and informal aspects of organisational life.''* She suggests that these may offer some improved understanding, which could be put to some practical use, and that there is enormous scope for building on published work.

The general relevance of organizational culture change and clinical governance has previously been discussed.[40] The study of organizational culture appears to have a clear relevance to the observation of working life in an NHS Trust as demonstrated by clinical governance studies. Mannion, Davies and Marshall (2003) identified evidence in that there are key points of divergence in the 'cultures' of 'high' and apparently 'low' performing hospital Trusts. Similar groups of researchers have conducted many studies on culture related to performance in health care (Mannion, *et al.* 2003; Scott *et al.* 2003a, 2003b, 2003c, 2003d). Studies in this area present evidence on the relationships between organizational culture and organizational performance and suggest that organizational culture may be a relevant factor in health care performance. It is acknowledged, nevertheless, that *'articulating the nature of that relationship proves difficult'* (Scott *et al.* 2003c:105). Implementing culture change recognises that whilst managing organizational culture is viewed as essential, it is a *'complex, multi-level and uncertain process, comprising a range of interlocking strategies and supporting tactics unfolding over a number of years'* (Scott *et al.* 2003a:111).

Dingwall and Strangleman (2005), writing about organizational culture in the public services, begin by introducing the idea of culture, trace its history in organizational studies and examine contemporary debates about the way in which an understanding of culture may contribute to successful management. They argue that UK Governments have assumed that public sector organizational cultures are different from those in the private sector and that this difference has consistently been associated with inferiority. They refer to neo-institutionalism theory and the idea that organizations often change their form and structure to imitate other organizations, either because they are constrained (or 'coerced') to do so, or because they choose to do so voluntarily. They state that the pressures for isomorphism are 'coercive'[41] rather than normative or mimetic and that these 'coerced' changes do not lead to worker ownership of the culture. In doing so, it is argued, in relation to the NHS for example, that: '*Hospitals meet targets for reducing the waiting lists for surgery by introducing pre-waiting lists and only admitting patients to the waiting list proper when a date can be set*

40 See Chapter 2:7 Organizational Culture and Quality Improvement

41 See Chapter 3:13,Coercive Isomorphism

*for their operation. These experiences are said to increase the mistrust of Governments and reopened the culture debate' (*Dingwall and Strangleman 2005:482). They conclude by considering the extent to which there are differences between public and private sectors that are relevant to this task.

Scott (1995: x) is particularly interested in the professional organizations in which *'professionals share in the determination of goals and standards.'* This work has relevance to the National Health Service that has a clear history of medical dominance. Scott (1995: x) describes professionals as exerting control on institutions by three mechanisms, cognitive (in that they alone are qualified to make decisions), normative (in deciding rights of authority and who should decide), and regulative (determining which actions can and cannot be used). Scott (1995) emphasised the importance of recognising that most types of organizations confront multiple sources and types of symbolic or cultural systems and that they exercise some choice in selecting the systems with which to connect. This is typical in any health care organization.

Currie (1997; 1998) carried out a case study that addressed the contribution of management development to culture change in relation to the Griffiths Report and subsequent reforms by means of the examination of a managerial development programme. He found that the *'cultural change promoted in Government policy reforms is not translated to the organizational context'* and suggested the reasons for this as *'a mismatch between the expectations and desires of those managers who are the participants in the management development programme and other stakeholders in the process'* (Currie 1997:304). Currie further emphasises the high importance of sensitivity to context (Currie 1998:24).

There is therefore a clear belief that effective health care performance relates to culture change. The '*NHS reforms are based on the idea that major cultural change must be secured alongside structural and procedural changes if improvements in performance are to be achieved'* (Scott *et al.* 2003c:111) and this, in turn, is relevant to the decision in the use of new institutionalism theory, as will be discussed.[42]

2:24 Summary and Concluding Comments

The aim of the first section of this Chapter was to illustrate some history and the evolving and elusive nature of quality and quality assurance, as evident in the literature. The second section concentrated on clinical governance and raised some fundamental conceptual issues about assumptions made by policy makers. The Chapter has highlighted the existing variations of definition, explanation and understanding for both quality and clinical

42 See Chapter 3:16 Rationale for the use of a New institutionalism theory Framework

governance. Problems in defining 'quality' are summarised well in the following: *'Herein lies the constraint, the fundamental problem of reducing any complex human experience to measurable units'* (Malin; Wilmott and Manthorpe 2002:132). Ultimately, quality is a social construct, it illustrates personal conceptions about a view of the legitimate role that health care organizations should play and what health is. In respect of health care, a value judgment is attributed to the concept of health service quality in that it: *'portrays our conceptions about health, our expectations of the client/health unit relationship and our view of the legitimate roles of the health care industry'* (Koch 1992:785).

The promoters of clinical governance confidently portray it as part of a new approach to assuring health care (King's Fund 1999). Hill (1999:1) describes it as a *'breathtaking idea, whose simplicity belies its complexity.'* They claim that the introduction of clinical governance into health care in the UK has had a major impact and that much energy and enthusiasm has gone into the task of producing cultural change (Lugon and Scally 2000). However, I have emphasised the issue and importance of 'culture' and 'organizational culture'[43] and that many studies have commented that attention must be paid to the vision of a 'culture of openness' and the organizational and cultural environment within Trusts, as well as resource issues, if clinical governance is to become part of normal practice. Alternatively, critics of the promoters for clinical governance have suggested that quality assurance has been utilised by various Governments as a means of controlling the performance of the care providers. Mays (2003:205) states that: *'the history of health care in the UK over the last 150 years mirrors the trend in all advanced Western countries towards greater Government involvement in health care in response to calls for better access to and coordination of services.'*

It is argued therefore that clinical governance is just another means of increasing control of the professions by the Government (as considered in the following Chapter), as the empirical evidence of clinical governance to assure health care is disputable. There is limited research on the effects of an integrated approach to clinical governance and any resulting improvement in patient care. Most studies are quantitative, aimed at senior personnel and provide no detailed analysis of the day-to-day working practice within a Trust, which is the focus of this study. Critics of clinical governance have suggested both that the '*current epidemic of 'initiatives' within clinical governance could be said to be unfocused, ill coordinated and poorly managed,'* (Maynard 2003:18). Others question how money can be spent on implementing a policy '*before anyone has taken the trouble to explain clearly what*

43 See Chapters 2:7 Organizational Culture and Quality Improvement, 2:17 Promotional Clinical Governance Literature and 2.23 Organizational and Organizational Culture Studies

that policy means or how its central claims are justified' (Loughlin 2001:2). Various studies report that Trusts have structures, committees and procedures in place only at board and sub-board level (Walshe 2001; Grainger *et al.* 2002; Freeman *et al.* 2001) but that the actual implementation is variable. The 'evidence gap' my study will fill is about the contestability and the practical accomplishment of meaning in use through a study of people 'doing' clinical governance and an attempt to understand what clinical governance is as a practical matter.

In continuing to set the theme, background and context for the study, the next Chapter consists of two sections. The first section concentrates on further aspects of the professions, the division of labour and regulation. Brief context detail is given about professional regulation in nursing. The second section addresses the theoretical background of new Institutionalism, as this provides the theoretical foundation for the study.

Chapter Three

Professions: Division of Labour: Professional Regulation and New Institutionalism Theory

Section A

3:0 Introduction

The purpose of the first two Chapters in this Thesis was to review the history of the various previous NHS quality initiatives that have been introduced and abandoned, and to explain the introduction of clinical governance (the current quality initiative), into the NHS. There was discussion of the Essence of Care, the nursing remit of clinical governance. Although this study primarily examines the experience of clinical governance in nursing, it is recognised that nurses work within the health care team with other health care professionals and that the provision of healthcare is becoming increasingly complex with boundaries of care constantly changing. This Chapter reviews two important sociological theoretical literatures that are of critical relevance to the study: the professionalisation of health care and the 'institutional' explanation of organizational change. The balance of power is also shifting between the professions, with increasing specialisation and team involvement, so attention to the professions and the division of labour is pertinent in **Section A** of Chapter Three. **Section A** continues with a discussion on healthcare regulation and addresses the recent changes in the regulation of health care professionals. **Section B** of this Chapter introduces new institutionalism theory as a theoretical basis for the study.

3:1 The Professions

The term 'profession' is problematic, difficult to define and has a contradictory everyday usage, which also makes it hard to determine how one might distinguish a 'profession' from other occupations. Evetts (2006:135) whilst emphasising that *'it no longer seems important to draw a hard definitional line between professions and other expert occupations,'* offers two alternative explanations. Firstly, *'for most researchers, professions are regarded as essentially the knowledge-based category of service occupations that usually follow a period of tertiary education and vocational training and experience.'* Secondly, *'as the structural, occupational and institutional arrangements for work associated with the uncertainties of modern lives in risk societies. Professionals are extensively engaged in dealing with risk, with risk assessment and through the use of expert knowledge, enabling customers and clients to deal with uncertainty.'*

Durkheim (1964) the nineteenth-century sociologist (1858 -1917) saw profession as a form of moral community based on occupational membership, or, in other words, 'occupational professionalism.' He argued that 'occupational specialization' was a necessary feature of work in modern society and that it promoted freedom and individuality. 'Social cohesion' developed out of the functional interdependence and mutual reliance of the various specialized occupations in the division of labour. In this process, morality and ethics developed alongside the occupation in the form of organic solidarity. Ruef and Scott (1998) identify rational-legal forms of authority in work organizations with the rise of bureaucratization, organizational rationalization and centralized control of any professional work. In comparison with Durkheim's model, this is a form of 'organizational professionalism.'

The recruitment, socialization and education of the professions has been a question of debate since the nineteenth century, when a professional class first emerged (Mackay, Soothill and Melia 1998). Early work initially focused on definitions of a profession. Classic studies include that of Carr-Saunders and Wilson (1933) who attempted to identify the characteristics of any occupation considered a 'profession.' This work set the trend for studies related to the 'traits' of a profession, but these were criticised for ignoring the relationship of professions to structures of social and economic power. The more or less contemporary, functionalist approach acknowledged these, exemplified by Parsons (1951). The functionalist approach viewed society as a social system with interdependent parts, a homogeneous community where the members share identity, values, definition of role and interests. Functionalism became less popular in the 1970s under the influence of more critical approaches such as Freidson (1970a) and Johnson (1972).

Studies concerning the power of the professions became a topic popular in the 1970s and 1980s (Freidson 1986; Johnson 1972). Here, sociologists, with reference to Weberian sociology, became interested in how professions were useful for society and how trainees were socialized (Mackay, Soothill and Melia 1998). Some classic power studies (Hughes 1956; Merton *et al.* 1957) focused on the medical profession and emphasised the 'institution' as keeping 'professional culture' alive, with the student as a passive recipient within a medical school. Here, norms and codes govern the behaviour of these professionals towards both insiders and outsiders. The focus here was on the politics of obtaining and maintaining 'occupational closure' or professional status and on the power, autonomy and dominance one profession had over other occupations.

The interactionist perspective sees professions as a part of a wider and more general classification of occupations, with some differences in degree rather than kind, as identified by Abbott (1988). The theory of closure concentrated on the techniques professions utilised to achieve closure and control, together with managerialism perspectives. An interactionist study by Melia (1987), on the occupational socialization of nurses examined the differences between the idealised versions of work as presented to student nurses in comparison to the daily practised work. Melia developed Bucher and Strauss's (1998) declaration of conflict and segmentation in that the assumption of professional homogeneity might not be entirely useful, as within professions there are multiple 'segments' with many identities, values and interests. This is particularly relevant to nursing, with the fragmentation of nursing roles into different clinical specialisms and status.[44] Bucher and Strauss (1998:160) develop the idea of professions as *'loose amalgamations of segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular period in history.'*

Allsop and Saks (2002:7) state that *'while professions have diverse histories of professionalization, the form of state licensing in this country has been based on the model of the medical profession in the mid-nineteenth century.'* Gabe *et al.* (2004:163) agree and comment that *'there has been a general consensus that if any occupation warrants being called a 'profession' it is medicine.'* Nevertheless, whilst there has been much discussion about the concepts of autonomy and dominance of medical professional power, it is evident that the focus has changed in the division of labour over the years. During the 1960s to the 1980s, for example, medical sociologists were concerned with the origins and persistence of medical autonomy and its social consequences, but in the 1990s, the centre of attention had changed to the decline of medical dominance and autonomy and the possible negative effects of this (Gabe *et al.* 2004). Some have also argued for the need to think about the professions' role in the solution of problems of governance and market failure (Dingwall; Rafferty and Webster 1988; Rafferty 1996).

Freidson (1989: xv) originally argued that the word 'profession' had a dual meaning, firstly as a *'special kind of occupation'* and secondly as an *'avowal or promise.'* He suggested that it is helpful to think of a profession '*as an occupation which has assumed a dominant position in a division of labor so that it gains control over the determination of the substance of its own work.'* Therefore, *'unlike most occupations, it is autonomous or self directing.'* However, Freidson (2001) then re-evaluated the significance of professionalism and its positive and

44 See Chapter 3:4 Implications for Nursing in the Changing Division of Labour

negative effects and endorsed its normative value; he argues that professionalism is now a desirable method in the provision of discretionary services to the public and that market-based and that organizational and bureaucratic methods decrease the quality of service to clients and decrease motivation in practitioners. This also reflects the normative social order identified by Parsons (1951) and Dingwall (1996), who suggests that professionalism might make a normative and value contribution to meeting a need for social order in the global economy and international markets (Evetts 2006). Durkheim's ideas about a moral community are echoed in Freidson's more recent work (Freidson 2001).

Since the nineteenth century, health professions in the UK have had close involvement with the state through the licensure of self-regulating monopolies. This in turn related to a substantial operational autonomy for practitioners (Harrison and Macdonald 2008). However, in the context of the NHS the term 'organizational professionalism' can be identified in the increasing 'regulation' of health service personnel, with standardized procedures, accountability performance, reviews and target setting. It can be argued that this now runs in contrast with the 'occupational professionalism' inherent in the NHS since its inception, particularly concerning the profession of medicine. Evetts (2006:139) argues that: *'the adoption of new public management theory and policy in the operation of service institutions, clearly illustrate the changed usage of the concept of professionalism…..these occupational changes are often perceived by the workers concerned as more paper work and additional responsibilities'* and, in effect, *'the quality of the service to the client is perceived by the workers to decline.'*

These aspects are all important to consider in the context of this Thesis, where issues arise with the historical association between professions' normative values and autonomy and the way that these are compromised by clinical governance. This subject will be revisited in Chapter Eight.[45]

3:2 Nursing as a Subordinate Profession

The belief in the subordination of nurses to doctors in the division of labour has been a focus of study since the 1960s (Stein 1967; Svensson 1996; Porter 1995). There are historical difficulties with the vague and broad definitions of 'nursing,' (UKCC 1999; RCN 2002) as nursing knowledge and practice have always been difficult to define, so it is not easy to protect and expand existing areas of expertise (Annandale and Field 2003). It is usual to refer to nursing as a 'profession.' Nurse leaders promote this notion, by continuing to claim

45 See Chapter 8:4 Imposing Control – Professional Regulation

autonomy and professional status for their workers, as exemplified in published documents such as 'The Scope of Professional Practice' (UKCC 1992b) and Code of Professional Conduct (UKCC 1992a). However, this everyday description of a 'profession' may indicate little more than the acknowledgement of a certain social status and level of knowledge, expertise and autonomy, because it has been difficult to analyse the development of British nursing in the conventional terms of the sociology of the professions.

If one looks at the principal events that have occurred in the regulation of nursing it is apparent that statutory registration, '*traditionally seen by sociologists as the pinnacle of achievement for a profession, has been somewhat of a poisoned chalice for nursing….'* '*Even as they have engaged in innovation, nurses have been locked in contradiction that reflected back images of them as quarrelsome, inadequate for the task of policy making, and for setting and enforcing regulatory standards'* (Davies 2002:105). Davies further states that *'Nursing is a managed occupation, subordinated to employers, doctors and the state.'*

Davies (2002) presents an account of the subordination of nurses following the Nurses Act (1919) with regard to how the State intervened and blocked the desired actions of the General Nursing Council, by constraining them in the various actions that they wished to take, with, for example, the content of a training syllabus. Firstly, this resulted in a lack of confidence by nurses in their own professional body and the continued use of student nurses as pairs of hands (Davies 2002). Secondly, there was a social division in the education and training of nurses in the 1960s, with education taking place in universities for some, threatening the more traditional training establishments based within hospitals. The gender issue also gave rise to some discontent in that male nurses secured senior positions that were disproportionate to their numbers in comparison with female, part-time, auxiliary and second-grade nurse numbers, which continued to rise. Thirdly, there was the prescriptive strategy by which the General Nursing Council maintained standards in regard to the content of the curriculum, which created *'a hierarchical, militaristic, rule orientated culture with a checklist mentality in education and a top down allocation of tasks*' (Davies 2002:97). It is evident, Davies (2002) argues, that nurses have always been a managed labour force, with an inability to act as independent practitioners as opposed to the dominant medical profession.

Walby *et al. (*1994:77) suggested that nursing was undergoing a renewed strategy of professionalization with attempts to develop a stronger scientific and philosophical basis to nursing care. Following the Judge Report of 1985 and the Peach Report (UKCC 1999), other reports began to make suggestions about the blurring of professional boundaries and

the idea of substitution (DH 2000b). Arguments began to appear for a new generic healthcare worker who would be able to replace the traditional roles of doctors and nurses. The major factor was the surge towards the replacement of the bureaucratic occupational model of nursing with one that had a vision of a 'professional practitioner' with the aid of higher levels of education. The idea was that nursing *'was a therapy in its own right'* (Walby *et al.* 1994:77). Critics of this still insist that nursing has to have a distinctive knowledge base in order to claim independence, which makes the 'care' element more important than the 'treatment.' 'Treatment' is complicated and related to other health care professionals, but 'care' is notoriously difficult to define (Macdonald 1995).

One of the continuing features of ambiguity about professionalism in nursing is that as an occupational group it shares many problematic aspects of 'caring' work. Various sociological commentators have highlighted some of these (Witz 1992). Macdonald (1995) raises the issue of patriarchy as a relevant factor in professional projects. Abbott and Wallace (1990) also state that nursing and midwifery constitute a part of the gendered 'personal caring professions.' In a comparison of 'caring professions' (such as nursing and midwifery) with professions not normally identified as caring, such as law for example, 'social closure' as applied to female professional projects and 'gendered discourse' are evident. However, Abbot and Wallace tend to neglect the class closure of nursing in their discussions of gender. Historically, leadership has come from women of a higher class than the ordinary people; the development of degree programmes was partly about maintaining a closure previously sustained by the recruitment practices of the elite hospitals. Nevertheless, it is a general view that nurses and nursing represent a gendered occupation within a patriarchal society and labour market and it is useful to review the nursing role within this division of labour.

3:3 The Division of Labour in Healthcare

The division of labour is one of the oldest concepts in the social sciences. It denotes any stable organization, co-ordinating individuals, or groups carrying out different but integrated activities. Its origins lie in a classical political economy, the antecedent to modern economics. Adam Smith[46] suggested that the division of productive labour greatly increased the wealth-creating capacity of a society. Unrestrained by Government or administrative rules, the free market encourages producers to specialize in activities where they have a natural advantage. By this specialisation, they benefit from greater dexterity, more resourceful use of materials and time, and from mechanization. Concurrently, the hidden

46 http://www.econlib.org/library/Smith/smWN.html

hand of competition penalizes inadequately specialized (by suggestion inefficient) producers, and encourages the cautious exchange of goods and services. The division of labour concept is also associated with Durkheim (1964) who examined the way interdependence promoted social bonds as a form of solidarity. Durkheim believed that in pre-industrial societies the division of labour was low in that jobs were interchangeable and the loss of one member did not pose any threat to the 'social solidarity' of the community, and that as society modernised, so did the complexity and different specialisation in the division of labour. In early society Durkheim thought that all members were identical and substitutable so there was little or no mutual dependence. Therefore, there was little solidarity. Paradoxically, modern societies had more solidarity than traditional ones. However, rather than dividing specialist groups, Durkheim believed that these differences actually increased the 'social solidarity' in groups, in that there was a dependency on others if things went wrong (although there was an increased likelihood that things could go wrong). Durkheim argued therefore that individual autonomy would not be a threat to 'social' groups.

In respect of the division of labour in healthcare, it would appear that the provision for health care depends on a balance between a public demand for a service and the supply of staff for the delivery of a service. Although there is still homogeneity of the culture within each profession, health policy changes in the organisation of the NHS in workforce planning, boundaries between health care professionals, flexible working and the concentration on skills rather than job titles, have had implications for the division of labour and the development of new roles. The Wanless Report (2002), in a consideration of the resourcing of the NHS, emphasized a continued need for growth in spending, together with the expansion of activity (determined by capacity) within the system. The argument here was that money alone could not address a mismatch between demand for and use of services. A sufficient workforce with the right skills was also required. In this context, Annandale and Field (2003:214) suggested that Government policies and the increasing professional developments in nursing had created more opportunities for nurses 'to *expand their field of influence and to exercise greater control over their work'*

3:4 Implications for Nursing in the Changing Division of Labour

The context of nursing work is also undergoing major change. Government policy and the strategies of nurse leaders emphasise the increasingly autonomous role of nursing within the wider healthcare division of labour. Nevertheless, there is a trend towards greater Government control over nurses' day to day work which can be seen in a stream of *'new rules and requirements governing their tasks and responsibilities; working conditions, the*

quality of the equipment they are expected to use and the treatments they administer' (Taylor and Field 2003:206). Taylor and Field (2003:222) also suggest '*that the extent to which negotiation about roles is felt to be necessary and the manner in which it takes place seems to be strongly related to the organisational context of work and the demands of patient care.'* I address 'Real Work' later in the study.[47]

The last decade has seen a significant change in the accountability and range of tasks undertaken by practice nurses, in that there are now nurse-led clinics, nurses can make preliminary diagnoses of disease and there is limited nurse prescribing of certain medicines (expanded roles). However, like other professions, nursing is becoming increasingly subject to both Government and managerial control. Research by Annandale (2002) indicated that nurses felt that they were increasingly working in a climate of risk and uncertainty, particularly in these newly defined roles that are supposed to increase their autonomy. In fact, the roles were seen as increasing their vulnerability and removed from how the traditional role of the nurse is perceived, taking them away from traditional pay and career structures. Nurses had raised concerns about their own personal accountability. Annandale (2002) recommends that the legal context of these roles are well thought through and that clear accountability guidelines exist for guidance, but notes that nurses viewed the documentation as excessive which, in turn, made them reluctant to take on new roles.

Nevertheless, it is clear that these developments arose due to events that happened outside nursing that supports the notions put forward by Dingwall; Rafferty and Webster (1988) and Rafferty (1996). These changes in the nursing division of labour were influenced by labour shortages. The up-skilling of nurses, for example, to undertake clinical doctors' tasks (extended roles), was seen as a solution to the reduction in junior hospital doctors' hours (Walsh 2000). Nurses, in a subordinate profession, are generally seen as solutions to the medical workforce problems, brought about by the 1990 GP contract, the publication of the Scope of Professional Practice (UKCC 1992b) and the skill mix review, which was related to the costs for the implementation of Project 2000 (Lankshear *et al.* 2005). Therefore, Government targets, doctor shortages and the requirements for the European Working Time Directive have all had influential effects on the nursing profession. These changes were identified as important for enhancing the equality of patient care and providing a satisfied workforce.

47 See Chapter 7:4 Real Work and 7:5 Clinical Governance and Bedside Care

There has also been a long history of class differences and gender issues that underlie the current challenges to collaborative teamwork in healthcare. Workforce planning was also seen as inhibiting interprofessional working (DH 2000b) and there were calls for more flexible working practices that depend on the skills of staff, rather than a job title. However, the extended and expanded roles taken on by nurses still indicate some sort of two-tier hierarchical structure and the benefits or advantages are yet to be identified. Qualitative work by Allen (2001) examined the division of nursing labour within a district general hospital and described the 'jurisdictional ambiguity' that was created by the introduction of new roles and blurred boundaries in nursing. The resulting strains were evident with the blurring of roles between staff nurses and support staff, yet Allen (2001) also identified that there was little conflict with other professions when they could not engage in such work, as nurses often took on roles without consulting them when it was seen to improve care.

Lankshear *et al. (*2005:1) in a health policy report (instigated to review whether the changes in the nursing role and skill mix were improving patient care) noted that there is still a lack of clarity within these new roles as to the exact nature and definition of the function and level of experience. They comment: *'Policy makers, practitioners, professional organisations, educationalists, administrators and the regulatory bodies have been unable or unwilling to define standards of nursing practice and determine the most appropriate and cost effective ways of delivering patient care.'* They also suggest that these roles *'are uncontrolled developments and that a large increase in nursing titles has occurred without systematic review or regulation, so creating confusion both within and outside the nursing profession.'* Therefore, although it argued that nursing autonomy has increased in practice areas, together with the specialised labour divisions within professional groups in the NHS, nurses are still dependent on other health care professionals, most notably doctors. As such, it appears that, whilst there is confusion and lack of standards within the roles created, nursing remains largely a subordinate occupation or profession. All professions however are ultimately dependent on the State for their licence to practice and State intervention and regulation of health care is considered in the following section.

3:5 State Intervention and Regulation of Health Care

Whilst the first part of this section focused specifically on the division of labour in health care, and the role of nursing within it, this section considers what some have described as; '*the bureaucratic burden in the NHS'* (NHS Confederation 2007), that is, the increasing regulation of healthcare. Whilst NHS regulation and inspection are necessary components of everyday healthcare practice, it would seem logical that they are balanced and based on the

principles for better regulation, as laid down by the Better Regulation Executive.[48] These principles are that regulation should be proportionate, accountable, consistent, transparent and targeted.[49] The ultimate aim should be that the assessment and information gained aids an organization to run more efficiently. With this in mind, the next section addresses some of the background and current regulatory processes involved in the regulation of healthcare.

There are three different components to the regulation of health care in the United Kingdom. These comprise the regulation of healthcare organizations, of individuals working as employees within these organizations and the regulation of persons as members of a profession. Regulation of healthcare and of healthcare professionals has experienced a rapid growth in the last few years (Walshe 2003), and evidence of major reform and profound change in the nature of the 'management revolution' can be identified in the literature. Walshe (2001) for example, found, in relation to the health service, that there was a wide diversity of approach in that some systems of external review had a mandatory or statutory basis in law, whilst others were voluntary. Some were undertaken by independent or professional organizations and others led by Government agencies. Some are confidential and others open to public scrutiny. A few make use of formal standards whilst others are based on subjective judgment, and sometimes there are financial incentives and sanctions. Whilst there have been various definitions of regulation, one, of a *'sustained and focused control exercised by a public agency over activities which are valued by a community'* (Selznick 1985:363), is relevant to healthcare. Nevertheless, regulation also has several different meanings and there is disagreement about what 'good' regulation is.

It appears that before 1980 the NHS relied on the traditional bureaucratic control from the Department of Health (Walshe 2003). Since 1980, the use of regulation in the private and public sectors of the UK has escalated. This has been identified as '*The New Public Management'* (Ferlie *et al.* 1996). It has become evident in such things as a compulsory five-yearly revalidation for General Medical Council registration for doctors and statutory governance in the appearance of a Council for the Regulation of Health Care Professionals (DH 2001b), established in April 2003 (now known as the Council for Healthcare Regulatory

48 http://www.cabinetoffice.gov.uk/regulation/The Better Regulation Taskforce (BRTF) have developed five principles of good regulation.

49 Proportionate: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed and costs identified and minimised.

Accountable: regulators must be able to justify decisions and be subject to public scrutiny.

Consistent: Government rules and standards must be joined up and implemented fairly.

Transparent: regulators should be open and keep regulations simple and user friendly.

Targeted: regulation should be focused on the problem and minimise side effects.

Excellence) (CHRE).[50] This is a statutory overarching body, covering all of the United Kingdom and separate from Government.

Other major changes in healthcare regulation have been apparent since 1997 when the Government abandoned the traditional bureaucratic mechanisms and created several new regulatory agencies and independent bodies. Harrison (2004) points out that the very nature of these changes implies a conflict between medical autonomy and managerial authority. The implication is that because so few managers are medically qualified they increasingly rely on enforcing rules and criteria developed outside their hierarchical control and have to emphasise the need to adhere to such rules and criteria. The drive to manage performance has resulted in a reduction of medical autonomy and, because of this; NHS organizations are required to generate substantial amounts of information for various performance purposes. In 2003, the NHS Confederation published the results from a small limited study within the NHS identified as *Smarter Reporting* (NHS Confederation 2003), which gathered information over a period of one month to establish the time spent on this activity and what use the information was for the organization concerned. It appeared that the Strategic Health Authority and the Department of Health were responsible for over 60% of the monthly information requests, but that 58% of the data collected was unusable by the organization for any worthwhile purpose. There was further review of the Whitehall bureaucracies in the Department of Health's 'Arm's Length Bodies'[51] (ALBs) (2004a) report.

Proposals from this review recommended merger, rationalisation or abolition of various bodies. This report stated *'we are confident that expenditure on ALBs can be reduced by at least 0.5 billion by 2007/8. Savings of this magnitude will be associated with a reduction in the number of posts in the ALBs sector of around 25%'* (DH 2004:29).

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50 CHRE is a statutory overarching body, covering all of the United Kingdom and separate from Government. It promotes best practice and consistency in the regulation of healthcare professionals by the following nine regulatory bodies: General Chiropractic Council; General Dental Council; General Medical Council; General Optical Council; General Osteopathic Council; Health Professions Council; Nursing and Midwifery Council; Pharmaceutical Society of Northern Ireland and the Royal Pharmaceutical Society of Great Britain.

51 Arm's Length Bodies (ALBs) are a key part of the health and social care system. As stand-alone national organizations sponsored by the Department of Health, they work closely with the local NHS, social care services, and other ALBs to regulate the system, improve standards, protect public welfare and support local services. ALBs vary in size but normally have boards, employ staff and publish accounts. They are accountable to the Department of Health and sometimes directly to Parliament. Most ALBs also receive substantial funding from the Department of Health. ALB-style agencies are an important feature of other major health systems around the world. ALBs regulate the health and social care system, establish national standards, protect patients and the public, and provide central services to the NHS. The Department of Health works with executive agencies, special health authorities and non-departmental public bodies.

Another study conducted by the Department of Health also reviewed information collection (DH 2006), with some focus on frontline staff. This study found that, although the number of data requests had decreased slightly, there were still, on average, 600 collections every year, mostly on behalf of the strategic health authorities. The Healthcare Commission introduced a voluntary Concordat between bodies that inspect the NHS. This work is still ongoing.

A recent study conducted by the NHS Confederation (2007) identified the many bodies that hold different status and power in the 'hierarchy' of regulators in the NHS. A substantive, but still incomplete, list compiled by the NHS Confederation[52] (2007) specified many different categories of inspection and gave examples of up to sixty-five various bodies that could review NHS Trusts. Bodies such as the Medicines and Healthcare Products Regulatory Agency, Health and Safety Executive, Healthcare Commission, National Patient Safety Agency (NPSA), Skills for Health, and Breast Cancer Quality Assurance Review all require different information from Healthcare Trusts.

A further list[53] of bodies that assess or monitor similar standards in relation to safety and patient experience gives many examples of overlap in the assessing and monitoring systems with different bodies asking for similar information presented in slightly different formats. For instance, the Annual Health Check has twenty-four core standards and thirteen developmental standards but still requires further evidence for 'safety' that is different from the Clinical Negligence Scheme for Trusts (CNST) information provided for the NHS Litigation Authority (NHSLA). The Health Commission does not accept Trust evidence of CNST achievement. The NHSLA is a special health authority set up under section 11 of the NHS Act 1977. The authority's principal task is to administer schemes under section 21 of the National Health Service and Community Care Act 1990. This enables the Secretary of State to produce one or more schemes to help NHS bodies pool the costs of any '*loss or damage to property and liabilities to third parties for loss, damage or injury arising out of the carrying out of (their) functions. The Secretary of State's overall aims for the Authority in*

52 There are four bodies which can review NHS Trusts
There are seven third parties with general statutory enforcement powers and that can visit hospitals
There are six third parties with a specific statutory role in healthcare but no enforcement powers
There are nine professional bodies
There are twenty-two third parties with no statutory role but with a legitimate interest in healthcare
There are eight Department of Health initiatives involving standards
There are two NHS developed review bodies
There are seven examples of voluntary bodies invited by hospitals to visit them

53 1 Standards for Better Health, 2 Health Commission Criteria, 3 Patient Environment Action Teams (PEAT)4 National Health Service Litigation Authority (NHSLA, responsible for CNST), 5 Audit Commission, 6 Health and Safety Executive, 7 Information Governance Toolkit.

administering the schemes are to promote the highest standards of patient care and to minimize the suffering resulting from adverse incidents, which do occur'

There are clear financial saving incentives for improving quality in this context and indications in the observation process within the NHS Trust appear to support this as the main driver to raise standards. I mention the financial saving incentive specifically, as the preparation in respect of gaining the clinical negligence scheme (CNST)[54] level two accreditation was particularly relevant in my observation of staff during the fieldwork period. For example, I observed in this study, that the clinical governance facilitators, having just completed the CNST validation requirements, were then withdrawn from their 'job description' roles again (in helping frontline staff implement clinical governance) in order to prepare the paperwork for inspection for the Annual Health Check[55] for the Healthcare Commission.

Together with the bodies of inspection, there are also several other organizational regulatory requirements such as the ten National Service Frameworks from the Department of Health.[56] By the end of 2006 (NICE)[57] had issued hundreds of sets of recommendations in the form of clinical guidelines, appraisals of technology and statements on the safety and efficacy of interventional procedures. The establishment of the Modernisation Agency[58] was intended to help staff implement the changes outlined in the NHS Plan (DH 2000a) and, as part of this, the Clinical Governance Support Team (CGST) offers practical support through its development programmes which are promoted as being highly successful. However, the National Programmes Review Panel of the Office of Strategic Health Authorities (OHSA) has recently decided that it is not necessary for the work of the Clinical Governance Support Team (CGST) to continue at a national level. It states that most of the functions currently undertaken by the CGST can be performed more appropriately at a local level. This is

54 See Chapter 5:7 Clinical Negligence Scheme for Trusts

55 The annual health check is far more wide-ranging and tougher than the old system of star ratings, which only looked at how the NHS was performing in relation to targets set by the Government. The annual health check goes much further. It scores NHS trusts on many aspects of their performance, including the quality of the services they provide to patients and the public and how well they manage their finances and other resources, such as their property and staff.

56 The NSF goals are *to 'set national standards and identify key interventions for a defined service or care group, put in place strategies to support implementation. Establish ways to ensure progress within an agreed time-scale from one of a range of measures to raise quality and decrease variations in service, introduced in The New NHS (DH1997) and A First Class Service'* (DH1998).

57 See also Footnote 9. NICE is an independent organization responsible for providing national guidance on promoting good health and preventing and treating ill health.

58 The NHS Modernization Agency established in April 2001 to support the NHS in England, and its partner organizations, in the task of modernizing services and improving experiences and outcomes for patients. The NHS Institute for Innovation and Improvement superseded it on 1st July 2005.

effective from 31st March 2008.[59]

3:6 The Regulation of Healthcare in Relation to Clinical Governance

The divisions of 'occupational' and 'organisational' professionalism[60] would appear to offer a useful way of understanding professionalism and the current occupational changes and challenges of work within the National Health Service, and to have particular relevance to clinical governance. NHS Trusts have had to change their internal organizational structures to meet reporting requirements for the various bodies identified in the last section. Organizational professionalism and regulation of healthcare, in the form of clinical governance, with the focus on systems and processes, increases the pressure on Trusts to report back yet again in a slightly different format to their Strategic Health Authorities. What is different in this instance is that there is a clear requirement for Trusts to conform to the '*legislative and regulatory initiatives, improvement programmes, new organizations and evaluation capabilities designed and implemented to improve quality in health care and performance of the health care delivery system' (*Leatherman and Sutherland 2003:1).

The current culture of governance in the NHS appears therefore to be one of regulatory frameworks, codes of practice, and sets of guidelines. The official policy is that the answer to NHS problems lies in having enough policies, frameworks and good practice guidelines to follow, and currently there are large amounts of money spent on developing and checking these guidelines. Ferlie and Geraghty (2005) identify this as the evidence-based knowledge movement, and comment on its contradictory nature. On one hand, there is an attempt at bureaucratization, codification and control, yet, on the other, there is an emphasis on research-based knowledge, where research proposals continue to attract large sums of money. This is an example of organizational professionalism and occupational professionalism working concurrently. One perspective devalues the normative pressures exerted by the dominant professionals within the health service, and the other encourages them. Nevertheless, if systematic institutional implementation and access to these policies is not seriously addressed[61] and the response merely seen by the organization as a 'ceremonial conformity,' this view could appear irrational and, in this case, the organizational professionalism of healthcare appears to be a naive means of restricting and imposing control on the behaviour of health care practitioners.

59 http://www.cgsupport.nhs.uk/

60 See Chapter 3:1 The Professions

61 See Chapter 5:5 Policies and Protocols

This section has given an overview of just some of the current requirements for documented evidence required by some of the regulatory bodies that have access to the NHS and of the confusion that exists in the process. It is evident that many of these requirements are duplicative in content. However, this information is still incomplete, and in the next section, I concentrate on the regulation of other healthcare professionals.

3:7 The Regulation of Health Care Professionals

A definition of professional regulation is of measures designed to *'ensure that healthcare professionals acquire and maintain professional competence'* (Bristol Inquiry Secretariat 2001). The economic, social and political changes of the Thatcher era resulted in a major re-organization of all public services. There was a *'civic awareness among the general public'* and increasing demands for *'coherence, accountability and transparency from service providers,'* with tight controls over public expenditure (Barrett *et al.* 2005:8). The regulation of organizations varies between the four countries within the UK, due to differences in the way health policy is made. However, the regulation of healthcare professionals is consistent and consists mainly of state-sanctioned council self-regulation. It is stated that *'the system of professional regulation in the United Kingdom is designed to ensure that if a patient is seen by a health care professional, the patient can trust that the care they receive will meet certain minimum standards of safety and quality'* (King's Fund 2007).

There are currently nine councils in total.[62] Professionals wishing to practise and use titles such as 'physiotherapist' or 'registered nurse' must reach accepted professional standards and be registered by their respective relevant councils. The functions of the councils are therefore to protect the public from unsafe or poor-quality practice. They do this by setting curricula for education and training, standards for good practice and policing by the investigation and prosecution of practitioners whose practice is in dispute.

Another council (currently identified as) the Council for Healthcare Regulatory Excellence (CHRE),[63] was set up in 2003 to oversee the nine councils. The remit of this council is to conduct annual reports of how the regulators carry out their functions; to recommend changes to the rules of regulators and sometimes to consider 'leniency' judgments made by regulators in disciplinary cases (Kings Fund 2007). There have been various criticisms of

62 The General Chiropractic Council (GCC), the General Dental Council (GDC), the General Medical Council (GMC), the General Osteopathic Council (GOsC), the Health Professions Council (HPC), the Nursing and Midwifery Council (NMC), the Pharmaceutical Society of Northern Ireland (PSNI), the General Optical Council (GOS) and the Royal Pharmaceutical Society of Great Britain (RPSGB)..

63 See Footnote 50

the current system and in February 2007 the Government White Paper, *Trust, Assurance and Safety: the regulation of healthcare professionals in the 21st century* made recommendations for a programme of reform. The proposed changes aim to address various inconsistencies and improve safety and quality assurance issues, but already there have been a number of criticisms of its intentions (King's Fund 2007), and the debate looks set to continue.

The traditional view of health care is a highly professionalized system with doctors working autonomously and with a high degree of control over practice. Freidson (1970a) displayed this in his classic theory of 'professional dominance.' He further pointed out (1970b) that physicians would not become better practitioners through educational reform, but only by changes in the contexts of their employment, in that the role of the professional is a dependent variable, dependent on the institutional environment within which it is exercised.
It would appear that the professional monopoly of medicine was based both on the physicians' expertise, together with their role as control agents. It is now evident that health care professionals are under increasing surveillance as their work is subject to greater control and monitoring. The situation of *'the poorly performing doctor, an out of date General Medical Council and a National Health Service that was managed in a way that has allowed the medical mandate to prevail'* has altered (Allsop and Saks 2002:90). The control of healthcare professionals is subject to increasing regulation as can be seen with the publication of the White Paper, *Trust Assurance and Safety – the Regulation of Health Professionals in the 21 Century* (DH 2007).

The creation of the internal market resulted in some agencies and professions being assigned to a purchaser role, with others designated as providers, although it appears fundamental that quality in healthcare is dependent upon how different professionals work together effectively. Developments in knowledge have also resulted in a high level of specialisation, so no one healthcare professional now has sufficient information to respond to the many complex situations that might arise. A consequence of these changes was the shift of control of service delivery away from the health care professionals to management bodies and managers in the form of organizational professionalism. Another result of the change was increased fragmentation in the organization of health care delivery so that 'normative' values or occupational professionalism decreased. In an attempt to provide a cohesive structure for health care delivery because of these changes, integration of services and interprofessional working was encouraged as a solution to any potential problem (Barrett *et al.* 2005).

Increasingly, under what is identified as a '*strategy of incorporation*,' (Ferlie and Geraghty 2005:429) health service managers who have a background within a professional field are being appointed to medical manager roles (for instance, that of a Clinical Director), in an attempt to link the managerial and clinical role. These have emerged '*as an important leadership group, often more influential than the managers in the 1980s,'* but collective forms of leadership characterize professionalized organizations, so the emphasis is still moving from a professional dominance perspective to that of managerialization (Ferlie and Geraghty 2005:429). The result of these changes is an emphasis on cost effective integrated services that meet the needs of, and actively involve, service users. Nevertheless, this has again also highlighted the tensions between occupational and organizational professionalism, in health service delivery on one hand and the edicts of central Governmental control of professional work on the other. Therefore, whilst some professionals, such as doctors, are still expected to make some independent autonomous decisions, they are becoming increasingly 'managed' to the extent of losing the autonomy that has always characterised their activities. For example, in 2007 doctors have experienced modernising medical careers (MMC),[64] the medical training application service (MTAS),[65] the NHS review,[66] the new GP contract,[67] contract re-negotiation, and, to a lesser extent, the continuing saga of the National Programme for IT.[68] As a profession, they also now have to face issues such as unemployment, revalidation, privatisation and targets.

It is evident then that although professionals are represented as expert advisers in central Government, they are also being increasingly managed. On one hand, it would appear that there is a challenge in professionalism as a governing principle, and on the other a dependence on professionals for subsequent implementation. Ultimately, *'the alignment or divergence between policy and professional interests and agendas may determine the outcome of current reform efforts*' (Ferlie and Geraghty, 2005:423).

64 http://www.mmc.nhs.uk/

65 http://www.nhsemployers.org/workforce/workforce-1326.cfm

66 http://www.number10.gov.uk/output/Page13406.asp

67 http://www.pulsetoday.co.uk/story.asp?storyCode=4000798&sectioncode=23

68 http://www.connectingforhealth.nhs.uk/

3:8 Professional Regulation of Nursing

The history of the regulation of nursing as a 'profession' has been well documented (Chiarella 2002; Maggs 2004) with Government reports recommending different initiatives, some of which will be mentioned here as having an impact on practice and the division of labour. The Briggs Committee, for example, established in 1970 considered issues concerned with the quality and nature of nurse training and the place of nursing within the NHS, rather than regulation in isolation. It reported in 1972 and recommended the replacement of the existing regulatory structure (involving nine separate bodies across the United Kingdom) with a unified central council and separate boards in each of the four countries, with specific responsibility for education. The modified Briggs proposals formed the basis of the Nurses, Midwives and Health Visitors Act in 1979.

The Judge Report (Commission on Nurse Education 1985) emphasized the need for nurse education to be placed into higher education, but it was not until the 1986 publication by the UKCC of *'Project 2000: A New Preparation for Practice'* that any fundamental changes were instigated. With the introduction of Project 2000 and the initiation of the 'knowledgeable doer,' it was advocated that nursing students would develop an ability to appraise theory and practice critically. It was stated '*Students of nursing should demonstrate an appreciation of research and use relevant literature and research as an aid to practice*' (UKCC 1986:41). Following the Judge Report of 1985 and the Peach Report (UKCC 1999), other reports began to make suggestions about the blurring of professional boundaries and the idea of substitution (DH 2000b). Arguments began to appear for a new generic healthcare worker who would be able to replace the traditional roles of doctors and nurses.

The Peach Report of 1999 produced a radical overhaul of nurse education. Commissioned by the UKCC and led by Sir Leonard Peach; the aim was to evaluate Project 2000. The resulting documentation, entitled *'Fitness for Practice'* (UKCC 1999), was included in the report '*Making a Difference*' (DH 1999a). The key recommendations in this report were for the practical skills of nursing to be moved to an agreed outcome competency-based approach to cover knowledge, understanding, skills values and abilities. The report therefore incorporated a set of competencies for inclusion within the curriculum of competency for entrance to the register. These included four domains, those of Professional and Ethical Practice, Care Delivery, Care Management and Personal and Professional Development (UKCC 1999). There was greater flexibility for entry to nursing programmes and accreditation given for prior (experiential) learning, aimed at health care assistants who could then be included into tailored programmes. Graduate training was to

be expanded and academic practice credit awarded to early leavers, together with students who take a short interruption of training (UKCC 1999; DH 1999b).

The Project 2000 strategy, in which a diploma programme replaced the traditional routes to registration as a nurse, represented a major reform of nursing education and had far-reaching implications for the structure of the nursing workforce and the care that nurses deliver. The policy agenda on workforce expansion, human resources initiatives, continuing professional development and career pathways as set out in *Working Together (*DH 1998c*); Making a Difference (*DH 1999a) and *Health service of all the talents (*DH 2000b) had been reinforced in *The NHS Plan (*DH 2000a).

In 2002, there was a takeover of the National Boards and UKCC's functions by a new Nursing and Midwifery Council (NMC) in England, instigated by an Act of Parliament. Other countries replaced their National Boards with other bodies. The function of The Nursing and Midwifery Council is to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients. In doing this, it maintains a register of qualified nurses, midwives and specialist community public health nurses and sets standards for conduct, performance and ethics. It provides advice for nurses and midwives and considers allegations of misconduct, lack of competence or unfitness to practise due to ill health (HMSO 2001).

The NMC revised the Code of Professional Conduct (UKCC 1992a) into the *'Nursing and Midwifery Code of Professional Conduct'* published by the Council in April 2002 and effective from June 2002. An addendum made in August 2004, included a new section on indemnity insurance, published again in an updated version in November 2004. The name of the document changed to: *The NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics* with the references to 'nurses, midwives and health visitors' replaced by 'nurses, midwives and specialist community public health nurses.' This code is important as it still clearly emphasises that registered practitioners should be *'accountable for practice and able and willing to take responsibility for personal and professional development*' (Davies 2002:99).

3:9 Summary on Professions, Division of Labour, Professional Regulation

This first section of Chapter Three, in addressing the professions and division of labour, healthcare regulation and the professional regulation of nursing*,* continued to set the theme, context and background for the study. It commenced with some general discussion on the debate about the professions and the division of labour in health care and noted some

change of opinion back to the professions as making a normative and value contribution to society. It continued by describing nursing as a subordinate profession and by emphasising the current situation resulting from the overwhelming and un-coordinated efforts of State intervention and regulation of healthcare and of healthcare professionals. I specifically mention some of the effects such regulation has on the division of labour in nursing. I note that nursing is considered a subordinate and managed labour force, with historical State intervention and blocking of actions that the General Nursing Council wished to take. Nevertheless, there appeared to be signs in the 'renewed strategy of professionalisation'[69] that this might be subject to change, with the vision of a 'professional practitioner' with the aid of higher levels of education. This, however, might be seen in conflict with increasing regulation.

Historically, there have been other challenges to professionalism such as the introduction of general managers after the Griffiths report of 1983. I was specifically interested if further evidence would emerge from my study that clinical governance was instrumental in affecting professional regulation, or in shifting the balance of power between professional groups. It would appear that the professions and professional power are under increasing threat from the explosion of regulatory influences (including clinical governance) and this needed further enquiry.

In the process of reviewing the different literatures on health service management, policy process and the sociology of professions, I became interested in two sociological perspectives of organizational functioning that I felt were helpful for my work. The new institutionalism theoretical work by Meyer and Rowan (1977), Powell and DiMaggio (1991) and Scott *et al.* (2000), was specifically related to that of the 'formal structure' as a 'legitimating myth' and the proposals voiced by Dingwall and Strong (1997). One concerns 'new institutionalism', the other the 'negotiated order' (Strauss 1978) perspective on organizations. The second section of Chapter Three addresses the theoretical context for the study with reference to new institutionalism theory and the perspective on organizational functioning. There is emphasis on the importance of organizational culture as the main driver in the use of new institutionalism theory, and the recognition that culture change is notoriously difficult to achieve within the NHS.

69 See Chapter 3:2 Nursing as a Subordinate Profession

Section B

New Institutionalism Theory

3.10 Introduction

Institutionalism is a social science approach that examines institutions in order to explain sequences of economic, political and social behaviour and transformation across time. It is a comparative approach to the study of human organizations and generally achieves this by utilising a case study methodology, although other methods might be used. New institutionalism theory describes a specific perspective on institutions, the way they interact and their effects on society. New institutionalists promoted the idea that institutions are socially rewarded if they gain legitimacy, which brings with it extra resources and survival. This was based on their passive acceptance of coercive, normative and mimetic institutional pressures and implied the transmission of background values, ceremonies and symbols into organizational structures, strategies and practices, thereby generating isomorphism. Ultimately, the theory argued that any organisation succumbing to institutional normative, mimetic and coercive pressures obtained the social support of stakeholders (Meyer and Rowan 1977; Scott 1987; DiMaggio and Powell 1991). New institutionalism theory provided an alternative to economic analyses, offering explanations as to how institutions, although created in different ways, end up having similar structures and how these institutions might shape the behaviour of the individuals within them. Recent work (Powell 2007), however, has acknowledged criticisms of the original idea that homogenizing pressures alone exert similar influences throughout organizational fields and this will be discussed in a later section.

There is a vast research literature on organizations, examining the way they function, prescribing managerial structures and reviewing the behaviour of groups and individuals in organizational settings. Much of this literature sees the implementation of policy as a separate issue, in that policy might be made, then the administrative system of an organization executes it (Barrett and Fudge 1981). The implementation of a policy is identified as being *'bound up'* with the structures and processes of the organization and *'refined and translated'* as it moves throughout the system. Policy comes 'from the top' and has been translated into operations by the time it reaches the 'bottom' of the hierarchy (Barrett and Fudge 1981:9).

Weberian ideas (as discussed in the next section), are firmly embedded in an assumption that if the attempts to improve the public sector *'management structures and processes,*

channels of communication and clarity of communication are 'right' (then) *effective action will be assured'* (Barrett and Fudge 1981:9). Fifty years ago, organizations were depicted as tightly bounded entities separate from any surrounding environment. Early institutionalism studies concentrated on efforts to discover the most efficient 'structures' of command and control for the achievement of the organization's goals. There was consideration of the way in which workers subverted rational economic models of their behaviour with the thinking that if ambiguity was removed from work design and control, it would shape a workforce into mature sober workers. Organizations were 'rational systems', social machines designed for the efficient transformation of material inputs into material outputs (Scott 1987).

In the last forty years, organizational researchers have increasingly recognized that organizations have both formal (governed by rationality) and informal (governed by culture) dimensions. New institutionalism theory focuses on the *'cultural basis of all organizational structures and action'* and views *'organizational boundaries as open and fluid so that the cultural foundation of action was not contained within the organization but reflected the organization's interactions with its environment'* (Dingwall and Strangleman 2005:248). This notion is particularly relevant to the National Health Service and clinical governance as the organizational boundaries are changing within the NHS and clinical governance highlights the importance of culture change.

The next section, following a brief introduction to the history of early and new institutionalism, will discuss how the theoretical lens of 'new institutionalism' can be used to help explain how one case study NHS Trust organization reacted to the policy implementation of clinical governance. It is significant in any study of policy implementation (such as clinical governance) to examine the various stages in this process, to recognize who is involved, examine the roles they play, discover any motives they might have and, ultimately, to identify how these policies are perceived. In this way, policy implementation can be scrutinised as it moves through the organization and this will be further discussed within the study.

3:11 Early Institutionalism Theory

The use of institution and institutionalism ideas was based on the concept of a social framework that influences human behaviour. It originated in three fields in the late 1800s and early 1900s: economics, political science and sociology. Apart from research in sociology, the concept largely died out in all three fields until revived in the early 1950s and then became popular in the late 1960s. Scott (1995) provides a review of early institutionalism theory in the three fields and recounts how institutional theory became

developed and connected to organizations, but comments on the many varying meanings and usages associated with the concept of institution.

New institutionalism theories emerged from the schools of thought that attempted to explain political, historical, economic and social institutions. They relate to the Chicago or Ecological Schools' 'economic imperialism.' This refers to the first major source of work that emerged during the 1920s and 1930s, specialising in urban environmental sociology. Theory and ethnomethodological fieldwork were combined in this work, which initially took place in Chicago, but is now applied elsewhere. The sociology department at the University of Chicago has a prestigious influence in this field, particularly in the study of symbolic interaction and human behaviour as determined by social and physical environmental structures. This early work influenced sociological theory about organizations. Sociological institutionalism is today the type most equated to institutional theory (Garson 2007). Herbert Spencer is often regarded as one of the first sociologists. Spencer compared organizations that operated in different societal settings in order to develop generalizations about how they worked. This work was firstly augmented by others (Sumner 1906), and then discarded by later generations, but Spencer's recognition of the centrality and functionally specialized arenas of institutions as a sociological focus is still reflected in sociological texts today (Scott 2001). There is therefore a long-standing tradition in some parts of the social sciences that focuses on structures and the ways in which they generate action. However, this has been in competition with other parts that focus on action and how this generates systems. Hughes focused on the institutional structures involving and supporting work performance, particularly in respect of occupations and professions, and how institutions reacted with the individual in respect of the provision of a licence to perform restricted professional work (Hughes 1958); he was also involved in the discussion of occupational licences and mandates (Hughes 1971). Sociological institutional theory is differentiated from historical institutionalism by a lesser emphasis on power and norms (as in group and structural-functionalism theories), but still overlaps with the socio-political-cultural embeddings of institutional decisions. It is in contrast to rational choice theory and does not emphasise that decision-makers are rational or self-interested.

Both economic and political perspectives on institutionalism faced challenges from the work of Simon (1945) on bounded rationality, although they proved to be highly resilient. Rational choice models (developed by economists and exported to political science and sociology) to explain the emergence and functioning of political institutions, include such theories as public choice, principal-agent or market theories and emphasise the pursuit of rational self-interest in decisions made. However, rational choice theorists did not seek to analyze decisions

affecting institutions, so this field is often seen as a contrast to, rather than an explicit part of, institutional theory (Garson 2007). Rational choice institutionalists focus more on the *'rules of the political game…the important question is not so much what institutions are but what they represent, an equilibrium'* (Lecours 2005:6). Rational choice models view institutions as governance or rule systems that represent persons seeking to endorse or guard their interests.

Historical institutionalism refers to the 1960s and 1970s era of group theories of politics and structural-functional theory (Garson 2007). Group institutionalism theorists questioned whether economics could be reduced to a set of universal laws and argued that economic processes operated within a social framework influenced by both cultural and historical forces. Sociological structural-functional theory in institutional change emphasized the importance of culture, values and norms. Work on the analysis of institutions was strongly influenced by Weber who wrote about ways in which bureaucracy and institutions dominated society. Weber was involved in major debates at the beginning of the twentieth century and his theoretical stance is difficult to characterize, but whilst he did not explicitly employ the concept of organization, he is acknowledged as a '*guiding genius'* in this field (Scott 2001:13). Weber was interested in understanding how cultural rules and rule systems defined social structures and governed social behaviour. He described three types of administrative authority systems, charismatic, traditional and rational-legal as legitimising the exercise of authority (Scott 2001). Weber's legacy to neo-institutionalism was his concern for legitimacy. He was interested in how power was turned into authority, charismatic power legitimated by faith, bureaucracy power legitimated by reason and traditional power legitimated by history.

The last twenty-five years have seen a major revival of institutional theories in the social sciences with the appearance of different perspectives. 'Old institutionalism' was criticized for being descriptive, a-theoretical and narrow-minded, and 'new institutionalism' society-centred approaches became more popular in the drive to generalise and enable comparisons (Lecours 2005).

3:12 New Institutionalism Theory

Meyer and Rowan (1977) and DiMaggio, and Powell (1983; 1991), are generally recognised as offering the most influential statement on new institutional theory (although the Chicago School is also acknowledged as a powerful influential source of reference, mainly in the

economic field of new institutionalism).[70] They wanted to establish new answers to questions of how social choices are shaped, mediated and channelled by institutional arrangements. They suggested that Weber's (1968) emphasis on the competitive market place, as the major environmental drive for organizational change was no longer valid. New institutionalism was a response to rational choice accounts of political behaviour and asocial accounts of the context in which behaviour occurs (DiMaggio and Powell 1991). DiMaggio and Powell viewed institutional environments demanding conformity as dominant, and, as a result, organizations increasingly become prisoners in a new 'iron cage' of 'institutional isomorphism.'[71]

Weber (1968) first proposed the importance of legitimacy in his work on definitional foundations of the types of social action (cited by Ruef and Scott 1998). Meyer and Rowan (1977) noted how organizations seek legitimacy and support by incorporating structures and procedures that match widely accepted cultural models with common belief and knowledge systems. This reliance on legitimating external institutions rather than internally initiated efficiencies is a strategy used by organizations to maintain stability and reduce turbulence (Meyer and Rowan, 1977). DiMaggio & Powell (1983) also emphasized the domination of the motive of organizational legitimation over the motive of organizational efficiency. When forced to choose, organizations will select options that preserve and enhance organizational legitimation. A point developed further in this Thesis is that 'legitimacy' may also be generated by the 'ceremonial' adoption actions of the organization. While they can manipulate resources, this 'ceremonial action' can remain divorced from the day-to-day activities and working practices of an organization.

Meyer and Rowan (1977:343) also described formal organizational structures as '*manifestations of powerful institutional rules which function as highly rationalized myths that are binding on particular organizations.'* They suggest that legitimacy is closely related to structure, as it is to any institutionalized practice and that societal devices exist for the translation of social into formal organizations by the use of building blocks, or, *'vocabularies of structure'* (Meyer and Rowan 1977:349). These provide prudent, rational, and legitimate accounts. DiMaggio and Powell (1983:148) have stated the institutional elements involved

70 http://sociology.uchicago.edu/department/history.shtml

71 Weber is best known for his work on bureaucracy and it is interesting that the original German term of 'stahlhartes gehause' that Weber used in 1905 was translated into 'iron cage' by Parsons (1958) in a rendition of Weber's (1934) book. Parson's (1958) translation of Weber's work has been criticised (Baehr 2001), in that the literal conversion of 'stahlhartes gehause' should have been 'A Steel Encasement.' Nevertheless, Weber's work (1952; 1968), is still mainly associated with the notion of an 'iron cage.'

in this as well in that organizations go through a process of 'structuration.' This consists of four parts, '*An Increase in the extent of interaction among organizations in the field. The emergence of sharply defined inter organizational structures of domination and patterns of coalition. An increase in the information load with which organizations in a field must contend and the development of a mutual awareness among participants in a set of organizations that they are involved in a common enterprise'*

Overall, new institutionalists gave fundamental questions new importance in classical debates and definitions as to what institutions were, what their impact had on action and how they were formed and transformed. New institutionalists proposed answers to these in some new and different ways. For the old political institutionalists, institutions were material structures, comprising constitutions, cabinets etc*. 'Institutions referred to the state or more exactly to 'Government'* (Lecours 2005:6). A distinction in definition between the old and the new institutionalism is therefore important in that it can be materialist or normative.

Historical institutionalists took the view that institutions are formal 'structures' and that norms and values are a function of these material institutions, which they imitate (Lecours 2005). Rational choice theorists are more interested in what institutions represent and not so much in what they are. March and Olsen (1989) contested and diverted from these materialist definitions and concentrated on the conceptualization of organizations in terms of norms, values and interrelated rules and routines. Sociological institutionalists therefore do not define institutions in materialist terms; they concentrate on beliefs, values and cognitive scripts (Scott 2001) and it is from here that a 'mythic' description arises, in that institutions internalize as they form, with cultural and normative contexts (Dingwall and Strong 1997). Sociological institutionalists conceptualize institutions with cognitive frameworks, detached from formal structures. New institutionalists believe that institutions therefore shape 'action' and this argument caused new questioning as to structure and agency. New institutionalists focus on the impact of institutions on action rather than the alternative way round. Their interest lies in the mechanisms that shape change, the influence of institutions on agents and on strategies and preferences (Lecours 2005).

March and Olsen's (1989) article appeared at the beginning of the revolution against the *'methodological individualism of both behavioralism and rational choice approaches'* (Peters 2000:1). They classified institutions as *'expressing norms of interrelated roles and routines that define appropriate actions in terms of relations between roles and situations'* (1989:21). Rules were said to be sustained by trust, and were sets of expected behaviours that institutions impose on their members. Rules were identified as formal and informal and

whilst formal rules might be changed, informal rules are difficult to change. These ideas take a holistic view in that action is not just the result of individual choice, but is also influenced by culture. Sanctions form part of this, in that institutions can make some courses of action possible and others not, if management reforms for instance, come 'top down.' This notion initially captured substantial interest amongst political theorists; nevertheless, it is evident that reforms can be interpreted and processed in different ways and institutions, whilst providing opportunities constrain action as will be discussed.

DiMaggio and Powell (1991) originally argued that the new institutionalism was more concerned with 'persistence' rather than change and that 'the legitimacy imperative' acts as a source of 'inertia' and that not only does new institutionalism emphasize the homogeneity of organizations, it also tends to stress the stability of institutional components (DiMaggio and Powell 1991:13/14). New institutionalism theory emphasised the convergence of organizations and their adoption of similar processes. DiMaggio and Powell (1983) proposed that organizations exist in the fields of other organizations that influenced their behaviour. When these organizational fields become 'structurated' (in other words, more mature and defined), they exerted influence on the behaviour of organizations within them. These fields then experienced increasing structuration and the organizations become homogeneous.

However, Oliver (1991:165) proposes that new institutional theory explains '*not only homogeneity and isomorphism in organizations but also heterogeneity and variability of generated profits.'* He links this with resource-based theory and suggests that where institutional and competitive pressures exert strong influences, competitive advantage might be gained through heterogeneity in resources and capability but still result in conformity to institutional pressures. This argument arises from the suggestion that if all organizations generated isomorphism (homogeneity and similarities) in the way they managed, no organization would have an advantage over another. Managers therefore had discretion by introducing agency, which allows them to manage how well they adapt to institutional pressures in order to gain a competitive advantage.

In recent work, Powell (2007:4) accepts the original proposal that homogenizing pressures exerted similar influences through an organizational field had raised concern. Citing work by Edelman (1992); Dobbin and Sutton (1998) and Edelman *et al.* (1999) he acknowledges the findings in that organizational fields are *'fragmented, contained multiple institutional influences and were thus subject to ambiguous requirements.'* There was also recognition that organizations *'helped construct the law and created the regulations that shaped 'best'*

practice' (Powell 2007:5). He states that the heterogeneity of response within organizations increased concern with the role of agency in institutionalization. This reflected on the political process of institutionalization and the power of the agents who steer the process. This is apparent in the changes and increases in rules, normative systems and cognitive beliefs which *'eroded the sovereignty'* of physicians and changed organizational fields as demonstrated by Scott *et al.* (1990). Powell (2007) notes that the original work had some limitations in the assumption that ideas and practices *'diffuse seamlessly'* and acknowledges the importance of political opportunity and cultural frames in shaping the diffusion process and that *'social movements are critical to the acceptance of ideas.'* He further states that further analysis of *'forces that account for institutional heterogeneity and homogeneity'* would *'bode well for the robustness of institutional analysis'* (Powell 2007:8).

Scott (1995) describes new institutionalism theory as continuing from the 'intellectual revolution' that commenced in the 1960s when the concept of 'open systems' was introduced into organizational studies. Open system theory stressed the importance of a much wider environmental context and the fact that institutions are affected by the nature of this environment. Scott (1995) suggests that over time, with some variation, *'organizations' gradually become 'institutions'* and that institutions are comprised of *'regulative, normative and cognitive elements and activities that provide meaning to social behavior'* (Scott 1995:33). He later provided a fuller definition of 'cognitive' as 'cultural-cognitive' (Scott 2001:52), with increased emphasis on the part that 'culture' paid.

Scott proposes that the regulative elements of an institution *'constrain and regularize behavior'* and regulatory processes involve *'the capacity to establish rules, inspect others' conformity to them.'* These are generally from an external source. Normative elements reflect and include both values and norms. '*Values are what might be preferred or desirable, together with the constructions of standards to which existing structures or behavior can be compared and assessed*' (Scott 2001:55). Norms '*define legitimate means to pursue valued ends.'* As identified with new institutionalism theory there is more of an emphasis on cultural-cognitive aspects as affected by the wider environmental context. Scott (2001:57) identifies these as the '*internalized symbolic representations of the world, shaped by external cultural frameworks.'* He is particularly interested in professional organizations in which '*professionals share in the determination of goals and standards.'* Scott (1995: x) describes professionals as exerting control on institutions by the following three mechanisms: cognitive (in that they alone are qualified to make decisions), normative (in deciding rights of authority and who should decide), and regulative (determining which

actions can and cannot be used). This work has special relevance to the NHS, which has a clear history of medical dominance.

Powell and DiMaggio (1991) suggest that institutional effects are diffused through regulative, normative and cultural-cognitive elements. Three mechanisms are identified: coercive, normative and mimetic. These are comparable to the regulative, normative and cultural-cognitive elements identified earlier, but have a slightly different construction. The application of these theories and ideas will assist in constructing an analytical framework for this study and are helpful when explaining the working processes and cultural dimensions of the Trust. As mentioned Powell and DiMaggio (1991) argued that organizations in the same field tend to adopt similar forms despite the consequences for the efficiency or effectiveness of that form for their own organization. For example, whilst there are differences and diversity in the early stages of any new market, ultimately 'modelling' occurs on their more successful peers, regardless of whether that strategy is right for them. This is the process organizations use in an attempt to be viewed as legitimate (Powell and DiMaggio 1991). Nevertheless, if organizations incorporate the external remit of suggested bureaucracy and formality, they become 'legitimate' in that they can survive in the environmental climate imposed on them. Without this externally acknowledged 'legitimacy,' they do not survive. However, it is suggested that 'legitimacy' may be obtained by the 'ceremonial' adoption of actions within the organization, in that they can manipulate resources, and this 'ceremonial' action can remain divorced from the day-to-day activities and working practices of an organization. Allen and Pilnick (2005) also point out studies that have paid attention to the mismatch between these formal organizational plans and workplace jurisdictions.

'Isomorphism' (Powell and DiMaggio 1991) is the constraining process that increasingly forces units to resemble others when confronted with the same sort of environmental conditions. New-Institutionalists state that the drive for isomorphic change is by the three control mechanisms identified earlier: coercive in that there is a legal requirement to conform; mimetic in that if there is uncertainty a 'role model' copying approach may be adopted, and normative, where professional interest is dominant, driven by the adoption of values and beliefs, for example, within a profession (Powell and DiMaggio 1991:67). Thus, Powell and DiMaggio (1991:67-72) suggest that organizations in the same field adopt similar forms despite the consequences on the efficiency or effectiveness of that form for their own organization. In this respect, a description of the control mechanisms of isomorphism and their relevance to the NHS follow.

In the NHS context, 'coercive isomorphism' might be identified as 'pressure from the state.' A clear example of the power of coercive isomorphism can be given where *'in the space of four years the NHS went from a situation where there were no hospital Trusts to one in which almost every provider had converted to the Trust format'* (Pollitt *et al.,* 1998:98-99). So in the NHS, these 'pressures' may be viewed as the external requirement for NHS Trusts to conform to processes, policies and protocols, in order to be viewed as being 'legitimate.' The key argument is however, that these changes are largely 'ceremonial' and ultimately act to shape organizations in similar ways, while, in this process, organizations are decreasingly held together by output controls, in that they form outputs to meet necessary targets that become unrelated to the real work of the organization. 'Mimetic isomorphism' arises when there is uncertainty and lack of understanding within an organization and the copying of another which is seen as successful occurs. Normative pressure arises from the process of professionalization (Powell and DiMaggio 1991), in that professional differences exist because of training and philosophical approaches that underpin the relevant professions. 'Normative isomorphism' encompasses both the normative and cultural-cognitive elements identified earlier in the Thesis.

3:13 Coercive Isomorphism

Coercive isomorphic change is said to occur from '*pressure from the state' or 'the formal and informal pressures exerted on organizations from other organizations upon which they are dependent and by cultural expectations in the society within which organizations function'* (Powell and DiMaggio 1991:67).

In relation to 'ceremonial conformity' Meyer and Rowan (1977) explain that it is a myth to believe that institutionalized products, services, techniques, policies and programmes are adopted and used by organizations, as in practice it is just a 'ceremonial' operation.' Very often, compliance to these would cause conflict with the reality and efficiency of everyday practice, but they have to exist, as the organization has to maintain its external legitimacy.

Meyer and Rowan (1977:342) make an observation that there is a large gap between the formal and informal organization; quoting March and Olsen (1976) and Weick (1976) in that: *'formal organizations are often loosely coupled: structural elements are only loosely connected to each other and to activities, rules are often violated, decisions are often unimplemented, or, if implemented have uncertain consequences, technologies are of problematic efficiency, and evaluation and inspection systems are subverted or rendered so vague as to provide little coordination.'* Interestingly, previous research studies (Strong and Robinson 1990) have consistently indicated that whatever the formal lines of authority and

accountability, what happens at working practice level is not determined by central diktat.

3:14 Mimetic Isomorphism

Powell and DiMaggio (1991) state that not all institutional isomorphism is derived from coercive authority, and that imitation, or 'mimetic' isomorphic change, also arises from uncertainty and lack of understanding within an organization. Uncertainty is a powerful force that encourages imitation. In the instance where organizational goals may be ambiguous or if the environment creates uncertainty, organizations model themselves on other organizations within the same field (with or without the model organizations' permission) but there may not be any evidence to indicate that the 'model' has been any more successful or is any more efficient than the first organization. Cyert and March (1963) advocate the advantages of mimetic behaviour in that when a solution is not clear, it is relatively inexpensive to search and copy elsewhere for a visible solution. It will be discussed in this study whether modelling and imitation of other organizations, as a response to uncertainty in relation to clinical governance implementation, is apparent within the case study organization. I shall identify at what level it occurs and discover if this leads to innovation and/or success, or whether circumstances limit understanding or accomplishment.[72]

3:15 Normative Isomorphism

A third subdivision of isomorphic change occurs through 'normative pressure' and is concerned with professionalization. Normative Isomorphism encompasses both the normative and cultural-cognitive elements identified earlier. Professionalization can be defined as '*the collective struggle of members of an occupation to define the conditions and methods of their work, to commit the production of producers and to establish a cognitive base and legitimation for their occupational autonomy*' (Powell and DiMaggio 1991:70) and professions as '*occupations based on advanced or complex or esoteric or arcane knowledge'* (MacDonald 1995:1). Powell and DiMaggio (1991) suggest that professions are subject to the same coercive and mimetic pressures as organizations and that those professionals must compromise with other *'non professionals, regulators, clients and bosses'* (Powell and DiMaggio 1991:70)

In this situation, isomorphism occurs by two processes: firstly, in the cognitive base that professions gain from the similar formal education produced by specialists, and secondly in the dissemination of these professionals throughout the professional network within different

72 See Chapter 5:4 Meeting Themes

organizations. This creates the dissemination of the normative rules about organizational and professional behaviour. I believe this is relevant, as within the health service there are large numbers of different professional groups, each with their own different professional normative pressures, adding more complications to the process of change; and it is important to remember that whilst some health care professionals wholeheartedly endorse clinical governance and modernisation changes, others just as wholeheartedly resist them.

3:16 Structure, Agency and Processes of Institutional Change

Social science faces the challenge of understanding the extent to which human behaviour is the result of voluntary and undetermined action (agency) or whether it is determined by system requirements (structure). The tension between structure and agency has historical philosophical overtones in the social sciences (Dolfsma and Verburg 2005) in that the social sciences are divided between supporters of the view that institutions or structures determine individual behaviour and those who argue that individual behaviour interplays with any outcome of social structure or institution. Ultimately, a compromise does not seem possible; nevertheless, the structure–agency debate continues.

Brief reference has already been made[73] to the concepts of 'structure and agency:' firstly in respect of Freidson's (1970a) view that physicians would not become better practitioners through educational reform, but through changes in the contexts of their employment, as the role of the professional is dependent on the institutional environment within which it is exercised. Secondly, with Herbert Spencer's recognition of the social sciences where he focuses on structure and the ways in which they generate action (Scott 2001) as well as the competition with other parts that focus on action and how this generates systems. Thirdly, in the changing belief of new institutionalists that institutions shape action, yet still allow agents to manage how they adapt to institutional pressures.

However, it is noted that new institutionalists tend to focus on the impact of institutions on action, rather than the alternative way round and the mechanisms that shape change, the influence of institutions on agents and on strategies and preferences (Lecours 2005). Currie and Suhomlinova (2006:3) also state *'As with any other organizational activity, knowledge sharing is subject to the constraining and enabling influence of institutions.'* However, it is accepted here that organizational members enact their membership in environments that are constituted by that membership; neither is prior to the other. Nevertheless, in order to address these viewpoints this Thesis, in studying social phenomena, elicits two contrasting

73 See Chapter 3:7 The Regulation of health Care Professionals, 3:11 Early Institutionalism Theory and 3:12 New institutionalism theory

methodological viewpoints. That of methodological individualism in that an explanation can be built from questioning the preferences expectations and behaviour of individuals and that of methodological collectivism, a study of the social system in which they occur.[74]

3:17 Rationale for the use of a New Institutionalism Theoretical Framework

The attraction of using new institutionalism theory in this study was influenced by Meyer and Rowan's (1977) work on how organizations incorporate structures and procedures that match widely accepted cultural models in order to become 'legitimate;' they indicate that this 'legitimacy' may also be obtained by the 'ceremonial' actions of the organization. I felt this to be highly relevant and appropriate when investigating the case study's Trust structures and processes, and I wished to investigate whether or not this was apparent in the case study. Powell and DiMaggio (1991) emphasise that new institutionalists go beyond the previous definitions of the formal and informal division of organizations and note the importance of a 'holistic' cultural aspect for the basis of any action and structure within an organization. They maintain that the external environment has an effect on the organization, so that flexible organizational boundaries have to be apparent, and that there is a 'cultural interaction' between the organization and the external environment. I was particularly interested in the use of this theory because of its emphasis on 'culture, in that clinical governance advocates state that clinical governance produces a 'cultural change'[75]

Whilst there is no lack of social science research on healthcare, there appear to be relatively few applications of new institutionalism theory in English NHS studies, although North American studies have utilised the new institutionalism approach in healthcare in quantitative studies. Scott *et al.* (2000), present a study on healthcare delivery systems, conducted during the 1990s, in a period described as one of great turbulence in US healthcare. In a study of the changes (which spanned a fifty-year period from the end of World War Two), an open systems approach was embraced to emphasise the effect of environmental factors on organizational forms and functions.

In one UK study of the impact of institutional forces upon knowledge sharing in the UK NHS, Currie and Suhomlinova (2006) stated that they 'ground' their investigation in neo-institutional organizational sociology. In order to analyse from a broader, open systems approach and *'highlighted the influence of regulatory normative and cultural-cognitive aspects of institutions operating in the health field on the boundaries that impede knowledge*

74 See Chapter Four 4:7 Methodological Individualism and Methodological Collectivism

75 See Chapter 2:17 Promotional Clinical Governance Literature and 2:23 Organizational and Organizational Culture Studies

sharing' (which is relevant to this study). They identified that managers do not always recognise the cultural and political dimensions of knowledge sharing and that knowledge sharing across boundaries will be difficult to realize. They also mention an opportunity for nurses to increase their power in the relative position of stakeholders. Using the example of nurses, under the 'old neo-institutional theory' template (in that *'Nurses are handmaidens to doctors'),* they suggest that a 'new neo-institutional' template might signify that: *'Nurses have significant influence in shaping services because of their frequent interaction with patients.'* They also noted under the old neo-institutional template *'Patients* (are) *subject to a professionally defined service'* whereas under the 'new neo-institutional' template *'Patients or advocates (nurses) have significant influence in shaping service.'* (Currie and Suhomlinova 2006:10). Some reference to this work occurs later in the Thesis.[76]

In another article, Allen and Pilnick (2005) mention new institutionalism in linking Abbott's (1988) system of professions and legitimacy, to Powell and DiMaggio's (1991) work on new-institutionalism in the sociology of organizations. It would seem desirable therefore to conduct an English case study, utilizing new institutionalism theory to address this neglected area, in order to examine the implementation of the Government policy initiative of clinical governance.

Whilst the choice of theory has mainly focused on Powell and DiMaggio, I did consider the work of various others that would also be useful to frame the analysis. Dingwall and Strong (1997) for example, in presenting a case for an alternative interpretation of organizational *'negotiated order'* (Hughes 1971), offered a *'programmatic statement'* (1997:153) for ethnographic studies. Building on work by Hughes's (1971) discussion of occupational licences and mandates, and Goffman's (1968:81) notion of official goals, they propose additional concepts of 'mission' and 'charter' for the analysis of social organizational action. This way echoes themes in neo-institutionalism but from a very different starting point.

A 'mission' is the organizational members' sense of 'what we are all here for,' an internal collective interpretation of an externally coercive obligation in order to avoid too much upset, disruption and more use of resources. A charter is '*the concept to which organization members orient in their dealings with one another and with non-members to establish the limits of legitimizable action*.' The suggestion is that a charter represents the constraints on a member's freedom of action from exterior objectives and given experiences (Dingwall and Strong 1997) and has the notion of a common language understood by all. Dingwall and

76 See Chapter 8:4 Imposing Control - Professional Regulation

Strong (1997) suggest that some conflict may arise with the mission when the charter of an organization reformulates, as for example in the requirement to implement clinical governance. Clinical governance, in this context, can be seen as the 'mission' and the coordination of new clinical governance systems as the reformulation of an organizational 'charter.' This work will be referred in order to illustrate points within the Thesis.

3:18 Summary and Concluding Comments

Chapter Three, *Professional Regulation and New Institutionalism Theory,* has continued to set the context for the study. **Section A**, *Professional Regulation,* outlined the importance of the professions, and the division of labour, together with current professional and health care regulation, in order to identify and explain some of the pressures that health care personnel have to contend with in their work. It reviewed the subordinate role nursing has always played in relation to the dominant medical profession. **Section B** introduced *New Institutionalism Theory* as a framework for the study. In describing institutionalism as a social science approach that examined institutions in order to explain sequences of economic, political and social behaviour, this section presented some historical landmarks within the field. It describes new institutionalism theory as being a specific perspective on institutions in the way that they are socially rewarded by legitimacy, resources and survival, subject to their acceptance of coercive, normative and mimetic institutional pressures. Mention is also made of the structure and agency debate. Traditionally differentiation has been linked with heterogeneity and conformity with isomorphism. While it is still evident that organizations do become isomorphic, I acknowledge recent work by Powell (2007), in that both heterogeneity and homogenizing pressures are present within organizations and that there are complexities and varieties of organizational responses, that exert similar influences throughout organizational fields and that powerful agents can still manage to gain competitive positions. With the many different professional groups in the NHS and the changes in professional regulation, it is anticipated that new institutionalism theory has clear relevance to this study and it is noted that its previous use in the NHS context has been limited.

The following Chapter will discuss the ethnographic methodological case study approach undertaken and discuss how data were obtained.

Chapter Four

Methodology and the Research Process

4:0 Introduction and Guiding Assumptions

The first three Chapters set the background and reviewed the political, theoretical and regulatory frameworks for this study. This Chapter will explain the rationale for the ethnographic methodological case study approach undertaken and discuss how data were obtained. The data comprise documents, field notes from periods of direct observation of everyday ward practice and audiotape recordings of semi-structured interviews with nurses and other key clinical governance stakeholders. The Chapter commences with the explanation of the methodological approach employed and gives a broad description of the ethical considerations and NHS Hospital Trust where the study took place.

4.1 The Methodological Approach

In my research proposal, I had defined the main objectives of the study to investigate the implementation of clinical governance in nursing practice and describe its effects on nurses' roles and the quality of nursing care and identify what practitioners and other stakeholders regard as good practice in clinical governance for improving the quality of direct nursing care. I envisaged that an observational study of a healthcare setting would be a complex activity, but as qualitative methodology is concerned with an in-depth study of human phenomena in order to understand the nature and the meaning they have for the individuals involved, an ethnographic case study approach was to me the clear methodological choice. I wished to engage as a participant observer in the daily life of a particular group in order to focus on one aspect: clinical governance. I was interested in how nurses and stakeholders made sense of the complex variables involved with clinical governance and search for patterns, which I envisaged, would have clear limitations in depth and be difficult to measure in any meaningful way if I employed a quantitative questionnaire or survey approach. I therefore needed to conduct fieldwork to observe behaviour in a particular setting and understand the actors' perspectives. An ethnographic study would allow me to gain an insider's depiction of the studied world, bearing in mind that an 'ironic outcome' might be the outsider's report from a research participant's perspective (Charmaz 2006). I therefore had to be careful in my objective analysis of the situation under study.

Ethnography can be described as a genre of research that presents varying degrees of qualitative and quantitative descriptions of human social phenomena based on fieldwork,

presenting an in depth, descriptive study of a culture. Ethnography presents the results of a holistic research method which has been founded on the idea that a system's properties cannot be understood independently of each other. Typically, ethnography involves the detailed study of a small group of people in their own environment. Rather than looking at a small set of variables and a large number of subjects Hammersley and Atkinson (1995) state that it is essential to understand both the small and the big picture. The ethnographer attempts to get a detailed understanding of the circumstances of the relatively few people studied. In its most characteristic form it involves the ethnographer participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact collecting whatever data are available to throw light on the issues that are the focus of the research. However, the difficulties of ethnographic research make it much less popular than questionnaires, interviews, or database analysis. I initially proposed studying three organizations but soon realised that I would not gain the depth of understanding that I wanted, so I decided to concentrate on one organization. Ethnographies characteristically include only one organization but I had to consider that my conclusions would not be easily generalizable. The absence of rigorous quantitative data is also problematic for organizational researchers who prefer statistical evidence. Qualitative research is not as popular or generally seen by some as being as academically pervasive as quantitative research; therefore, the choice of an ethnographic approach needed careful consideration.

I believed that ethnography allowed for the process and development of grounded theory[77] (an abstract theoretical understanding of the studied experience) throughout the research process. I was not sure what I would observe, so the ethnographic method sanctioned more flexibility in relation to this, allowing understanding, reflection and incorporation of any ideas in the social object under study. It was clear that quantitative methods alone would not allow for the in-depth analytic analysis and detailed description that would be required for such a setting, although it was useful in respect of attendance at corporate clinical governance meetings.[78] Miller, Dingwall and Murphy (2004) state that whilst quantitative research designs are useful for examining relationships between inputs and outputs in organizational work, they do not inform about how or why outcomes are effective or ineffective. They explain this by citing Seely Brown and Duguid's (2000) work; in these cases organizational work is viewed from the outside and too much faith is placed in the 'formal responses' of organizational problems. In contrasting quantitative, qualitative, outside, and inside approaches, Seely Brown and Duguid (2000) identify the advantages of

77 See Chapter 4:22 Grounded Theory

78 See Chapter 5:4 Terms of Reference and Minutes of Meetings

qualitative organizational research in that it focuses on the shared organizational knowledge and everyday action and interaction: the explanations answer questions about the *'how and why of organizational outcomes.'* The knowledge gained from such studies provides important information to stakeholders who *'might contemplate changing work practices'* and it indicates detailed unintended consequences of any implemented change (Miller; Dingwall and Murphy 2004:205). Having considered the alternatives, I believed that ethnography was appropriate for this study.

4.2 Participant Observation

Hammersley and Atkinson (1995:1) state that all social research takes the form of participant observation in that it involves participating in the social world, in a covert or overt manner, and reflecting on the results of that participation from the 'outside' as objects in the world (Hammersley and Atkinson (1995). In other words, the participant observer collects data by participating in the daily life of those he or she is studying. The advantage of this is that participant observation allows for the examination of everyday interaction or behaviour and not merely behaviour elicited from questionnaires and interviews. Ethnographic analysis is usually narrative but it can employ some statistical analysis. The ultimate aim of participant observation is to produce a 'thick description' of social interaction within natural settings by using participants' own language and everyday concepts to describe what is going on. In due course, by using this process, a picture emerges of the research setting as a social system, as described from a number of participants' perspectives enabling the observer to find some meaning in the encounters and situations (Geertz 1973; Burgess 1984).

In describing the variety of methods the participant observer role might employ, McCall and Simmons (1969:1) state that *"....participant observation is not a single method but rather a characteristic style of research which makes use of a number of methods and techniques - observation, informant interviewing, document analysis, respondent interviewing and participation with self-analysis."* Hammersley and Atkinson (1995:1), in citing Gold (1958) and Junkers (1960) in the way of describing or characterising the various participant roles those researchers take in situations; distinguish between the complete participant, the participant as observer; the observer as participant and the complete observer. I was not in this case a complete participant (obscured as an 'ordinary member' with the purpose of doing research). I was not a complete observer either (a researcher who has no contact at all with those they are studying). I was, in a way, part of a situation: the participant as observer. In this instance, I was an academic in practice within the Trust who then took up clinical governance as a research topic. It could be that I was, as Hammersley and Atkinson

(1995) describe, already implicated in existing social practices and expectations in a far more rigid manner than the known researcher would be in the one area of practice within which I was known (the elderly care directorate). My research activity could have been influenced by pre-existing social routines and realities. However, I did not, know the routines well enough for this to be a problem and it was not hard for me to optimize data collection possibilities when undertaking my fieldwork. I would also argue that I was an observer as participant in the neurosurgical directorate, where I had no prior connection, so as Hammersley and Atkinson (1995:108) explain, there may be problems with dimensions of variation in Junker's (1960) typology.

Although qualitative ethnographic case studies on clinical governance are limited, other qualitative studies into healthcare have utilised the ethnographic study approach. For example, Strong and Robinson (1990) conducted policy ethnography. Their study was an analysis of the massive wave of changes that took place following the Griffiths reorganization, dealing with *'dilemmas and solutions experience and opinions, hopes and fears tactics and strategies, and perspectives and ideologies*' in making sense of Griffiths. One of the aims was to catch *'a new culture in the making*' (Strong and Robinson, 1990:8), which is familiar territory in this study. A major study by Weiner (2000) on quality assessment in US hospitals also used a sociological, qualitative, grounded theory approach. Her work considered the quality accountability movement in the health service in the United States, the 'Elusive Quest,' again a topic near to this study. This work is important as it not only describes what happened in the accountability movement (there is detailed explanation of how hospitals prepared for quality inspections), but it also presents relevant data on *how* it happened and *why* it consequently failed. Similarly, Casper (1998), in an ethnographic study of the emergence of fetal surgery, approached her topic with a blank mind but ultimately utilised theory and observation in her analysis *'from the ground up'* (1998:18).

I had defined the main objectives of the study as follows: to investigate the implementation of clinical governance in nursing practice and describe its effects on nurses' roles and the quality of nursing care, and to identify what practitioners and other stakeholders regard as good practice in clinical governance for improving the quality of direct nursing care. The aim of the research was to present a systematic view of the phenomena examined, through a case study: '*A case study is not a methodological choice but a choice of object to be studied'* (Stake, 1994:237). In this research, the 'case' was that of clinical governance implementation in an acute hospital Trust and the original objective was to determine whether this implementation could demonstrate any improvement in bedside nursing care, the effect this had on nurses' roles and the quality of nursing care.

The purpose of a case study, as defined by Bryman (2001:55), is *'the intensive study by ethnography or qualitative interviewing of a single case, which may be an organization, life, family, or community.'* A case study can be qualitative or quantitative in nature, or a combination of the two. Yin (1994:13) identified a case study as '*an empirical inquiry that investigated a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not evident.'* The topic chosen, clinical governance, lacked the specificity and boundedness to be a case; but its local implementation in an NHS Trust was specific and constituted the case. Clinical governance therefore has relevance to the concept of organizational environment, in turn this links to new institutionalism theory in respect of healthcare internal and external boundaries that have eroded with the division of labour and fragmentation changes taking place within the NHS.

Stake (2000:237) identifies three types of case study depending on the purpose for studying the case. The first, an intrinsic case study, is undertaken not to build theory, but because of an intrinsic interest in a particular topic; for example, a child, clinic, conference or curriculum. The second is that of an instrumental case study, where the examination of a particular case is to provide an insight into an issue or to refine some theory. Here the case study is of secondary interest; it plays a supporting role to facilitate our understanding of something else. The third is a collective case study, extended to several cases, an enquiry into the phenomenon, population or general condition. Stake (2000:238) acknowledges that *'all authors and reports seldom fit neatly into such categories,'* but they do serve some useful purpose of explanation.

In this instance, I utilised an instrumental case study approach, as the aim was to provide insight into an issue. The research question therefore shaped the method used, as it was necessary to identify relationships between the many interrelated events in the study that I needed to observe, dissect and question, as a means of generating data. This formed part of the ongoing research process of a qualitative ethnographic study. The documents, working atmosphere, observation of formal and informal meetings, observation on wards and semi-structured interviews in this case study were all used to obtain an in-depth understanding of patterns of meaning that link manifestations together.

A strength of qualitative methodology is the study of human beings undertaking their everyday activities. In general, all research methods have advantages and disadvantages. *'Qualitative methods are helpful in providing rigorous descriptions of practice and the organizational context in which it occurs'* (Murphy and Dingwall 2003:35). However, all

research methodologies also have their limitations. It was important to consider that the credibility of a qualitative study, although providing depth and intimate knowledge of the case, is in fact a potential weakness, in that objectivity and generalisability may be particularly problematic. Hammersley and Atkinson (1995:42) state that one of the limitations of ethnographic work is in the lack of representativeness of the findings as they can only be related to the case studied. The results are highly valid in respect of the case in question but may lack credibility in that they lack generalisability to other subjects. However, in this case, generalization may be in a theoretical and analytical manner, pertinent to similar Trusts.

Therefore, a recurrent criticism of case study methodology is that its reliance on a single case renders it incapable of providing a generalizing conclusion. Yin (1993), offered some discussion that considered case methodology 'microscopic' because it 'lacked a sufficient number' of cases. Hamel (Hamel *et al.* 1993) and Yin (1984, 1989a, 1989b, 1993, 1994) convincingly argued that the relative size of the sample, whether two, ten, or one hundred cases are used, does not change a multiple case into a macroscopic study. The goal of the study should establish the parameters, and then should be applied to all research. By this method, even a single case could be considered acceptable, provided it met the established objective. However, in this case, generalization was not the principal concern, as the intention was to elicit characteristics of this particular situation. But whilst it is evident that this case study has a strong qualitative foundation, in order to increase its validity thick background data was collected to *'have ready recall and to understand and portray the full range of contexts of the study'* (Charmaz 2006:18).

Findings from qualitative case studies can also be rigorously evaluated, thus there was attention paid to the research design. Yin (1994:32) identifies criteria for judging the quality of research designs in stating concepts offered for logical testing such as trustworthiness, credibility, confirmability and data dependability. He further states four tests used in the instance of a case study, to establish the quality of its given design. These tests are for construct validity, internal validity, external validity and reliability, and these are considered below.

4:3 Construct Validity

Construct validity according to Yin (1994:33) is *'establishing correct operational measures for the concepts being studied.'* He further identifies three principles to establish construct validity: those of triangulation (the use of multiple methods to study the same phenomenon), the creation of a case study database and by maintaining a chain of evidence.

In order to utilise the information for construct validity, data were collected in a variety of ways: by the compilation of field notes, storage and analysis of formal and informal documentation electronically and by the recording, transcribing and storage of audio tapes from the semi-structured interviews. Storage of these on a secure database presented a chain of evidence for cross-referencing and re-checking. This method was used consistently in the gathering of observational field notes in the context within which they arose, in order to focus on key analytical ideas.

4:4 Internal Validity

The second test is that of internal validity, defined by Yin (1994:33) as *'establishing a causal relationship, whereby certain conditions are shown to lead to other conditions as distinguished from spurious relationships.'* In this case, all the interview responses were tape-recorded, transcribed, and coded to identify the themes that emerged. There is identification and examination of patterns and inconsistencies in relation to other sources of data. There was comparison with documentary and observational data at different stages of the fieldwork. Whilst transcribing in full all of the tape-recorded interviews, I considered the use of Nudist software in the analysis of the data obtained, but ultimately felt that it was practicable to display connections by the use of various comparison charts without the use of qualitative software. I also felt that the time required for loading and coding data would not be cost-effective or valuable for the effort involved.

4:5 External validity

'External validity is establishing the domain to which a study's findings can be generalised' (Yin 1994:33). The external validity aspect has been a major disadvantage in the use of the case study approach. However, in this instance, the methodology employed for the case study strove to define the process in a way that is meaningful in settings beyond that in which the study is being conducted. I am confident that the methodology applied could be utilised in other large acute hospital Trusts in the NHS in England.

4:6 Reliability

Reliability is '*Demonstrating that the operations of a study such as the data collection procedures can be repeated, with the same result'* (Yin 1994:33). There is a need in undertaking a case study to document all the procedures used, in that if there were repetition of a similar study the results would be the same. In this instance, reliability relates to repeating the same study using the methods described. In this research, there is a

description of both the data collection procedures and the documentation used, so that they might be rechecked for reliability if required.

4.7 Methodological Individualism and Methodological Collectivism

Explanation has been offered for the choice of utilising new institutional theory as a framework for analysis and two contrasting methodological viewpoints will be utilised:[79] that of methodological individualism, in that an explanation can be built from questioning the preferences, expectations and behaviour of individuals and methodological collectivism, a study of the social system in which they occur in order to elicit the whole picture. As each model pursues a different perspective on how agents act in a co-ordinated way, if viewed alone they still only provide a one-sided view of society.

4:8 The NHS Trust

Initially I had identified three sites as potential organizations for fieldwork, but soon realised that this had been far too ambitious. The amount of data generated for one meeting at one Trust was substantial and I concluded that, unfortunately, I did not have the resources to undertake an ethnographic study in more than one Trust, but, as an alternative, studied two directorates within that Trust. The selection of the chosen NHS Hospital Trust was through a process of 'purposive sampling,'[80] which followed a review of published documentation about its clinical governance process. I made this selection in order to observe a hospital working environment. The hospital Trust selected therefore became the 'case study.'

The NHS Trust was broadly typical of any large university teaching hospital in England, with wards structured within directorates and departments actively engaged in teaching and research. Approximate figures are given here to protect hospital anonymity. The Trust employs over four thousand two hundred staff and trains approximately three hundred medical students. Three hundred student nurses and therapy students undergo practice experience on placement in any one year. On a day-to-day basis, the Trust has the facility to see 1,000 outpatients and may treat up to 250 patients in the Accident & Emergency Department. There are in-patient facilities for over 900 patients and the day surgery unit

79 See Chapter 3:16 Rationale for the Use of a New Institutionalism Theoretical Framework

80 A purposive sample is one selected by the researcher subjectively. The researcher attempts to obtain a sample that appears to be representative of the population and will usually try to ensure that a range from one extreme to the other is included.

can treat over 70 patients on a day case basis. Daily departmental activity might include for example, over 600 radiology examinations, 14,500 pathology tests and the dispensing of over 1,200 prescriptions containing over 99,000 doses of medicine. The population served by the Trust is poorer than the national average and experiences a higher rate of illness. Almost 98% of the population in the region describe themselves as white.
Having outlined the general status of the day-to-day activities of the hospital, I now provide a brief description of the directorates and wards where the fieldwork took place.

4.9 The Directorates

The Trust had a number of service units separated into directorates. The elderly care and neurosurgical directorate both formed part of larger specialist directorates, but were separate units engaged in their own specialities. I visited both acute and rehabilitation wards within each directorate during the course of my fieldwork. Both directorates conducted their own clinical governance meetings, described in detail later.[81] Soon after I completed the fieldwork, the Trust obtained Foundation Status.

4.10 The Neurosurgical Directorate and Wards

The neurosurgical directorate provides care for a general population of over three million people. The directorate studied had eight wards and observation took place on the neurosurgical wards, as the acute and rehabilitation wards equated to the same type of wards within the elderly care directorate. More than eight neurosurgeons covered these wards. There were also support departments attached to the directorate, for example, those of neuro-physiology and a pain centre.

The nursing staff on the acute wards within the neurosurgical directorate cared for patients with conditions such as a head injury, subarachnoid haemorrhages, cerebral tumours, prolapsed discs, and epilepsy. The nursing model used was that of a modified Roper Logan and Tierney,[82] with the systematic planning of nursing care. The neurological specialist nursing experience on the wards related to nursing patients with these conditions, pre- and post-operative theatre care, neurological observations such as the Glasgow Coma Scale, care of the unconscious patient and tracheotomy care. The rehabilitation wards

81 See Chapter 6:2,Directorate Meetings 6:3 The Neurosurgical Directorate, 6:5 The Elderly Care Directorate

82 The Roper Logan and Tierney Model of Nursing(2000) is based on the main features of the highly complex Activities of Living, Communicating, Maintaining a Safe Environment, Breathing, Eating and Drinking, Eliminating, Personal Cleansing and Dressing, Controlling Body Temperature, Mobilizing, Working and Playing, Expressing Sexuality, Sleeping and Dying. It allows for an organization of nursing care based on any difficulty which occurs from one of the above activities that subsequently goes wrong, e.g. a breathing difficulty.

within the directorate cared for patients who required prolonged rehabilitation following neurological trauma.

4:11 The Elderly Care Directorate and Wards

The elderly care directorate consisted of eight wards, including both acute and rehabilitation wards. During the period of my research, the directorate became part of the larger medical directorate, although it still functioned separately in terms of its clinical governance meetings. The elderly care directorate at the time of the conduction of the research was a pilot area for a two-year project implementing electronic patient records. There was an Essence of Care 'focus' within this directorate and money had been obtained for implementation of the National Service Framework for Older People.[83]

The nursing staff on the wards within the elderly care directorate cared for patients suffering from medical conditions such as respiratory disease, cardiac disease, diabetes, renal disease, bone disease, neurological conditions and acute and chronic confusion. Again, a modified Roper Logan and Tierney model (2000)[84] was used to plan and deliver nursing care. The wards were extremely busy, and the specialist nursing skills required related to nursing patients with multiple medical problems.

4.12 Arranging Access to the Trust

For many years, I have had professional educational links with the elderly care directorate at the studied Trust. This involved monthly ward visits to each of the eight wards I covered to ensure that the trained staff were updated on educational issues relating to the student nurses they had on clinical placement. I also attended the monthly professional development meetings chaired by the senior nurse or Modern Matron[85] of the directorate. Before my fieldwork began, I asked if I might use some of the data obtained from the meetings in my research. I received initial permission to do this from the Matron of the directorate,[86] but soon after requested this formally in writing.

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83 The National Service Framework sets out standards that aim to provide person-centred care, remove age discrimination, and promote older people's health and independence and to 'fit the services around people's needs.' http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066

84 See Footnote 82.

85 The Government made a commitment in 'The NHS Plan' to introduce modern matrons - senior sisters and charge nurses who are easily identifiable to patients and who have the authority and support they need to make sure the fundamentals of care are right.

86 See 4:13 Ethical Considerations

I had informal talks with the Trust Executive Medical Director and the Trust Executive Nurse, outlining my research idea and seeking permission to become a participant observer at clinical governance meetings. At this stage, I felt it important to become orientated with the day-to-day organization within the Trust so I sought further advice from the Trust clinical governance co-ordinator who recommended that I attend the corporate clinical governance committee meetings and clinical governance executive sub-group meetings.[87] I also requested access to relevant documentation concerning clinical governance and the Essence of Care project at the hospital and became included on appropriate mailing lists. After some discussion about which directorates to incorporate in the study, the Medical Director suggested that I included the neurosurgical directorate as well as the elderly care directorate, as he considered that this directorate was an example of 'good practice.' Whilst I knew some of the staff within the elderly care directorate, I had no prior knowledge of the neurosurgical directorate and thought that it would be a useful association, as both directorates had acute and rehabilitation wards.

In February 2003, I wrote formally to both the Trust Medical Director and the Executive Nurse requesting to observe at corporate, directorate and other relevant clinical governance meetings and received written confirmation to do so from both. I already attended nursing meetings due to my educational links with the elderly care directorate, but also asked in my formal letter if I could use any information generated from these meetings for my research. At this stage I believe that I had the naïve assumption that I could consider nursing in isolation, but soon realised that I had to study the organization as a whole, as nursing was very much influenced by, and part of, that organization and could not be considered separately from it.

Between February 2003 and October 2005, I observed corporate Trust level clinical governance meetings, described in detail later.[88] This stage of the research, for a variety of reasons, took longer than anticipated, but there were no difficulties encountered with the observation of meetings. In fact, I attended more meetings that any other member of personnel employed by the Trust at that time. At this stage, whilst I had gained initial written agreement to attend meetings, I felt it both necessary and appropriate to commence the formal ethical approval procedures before I could start observation on the wards or interviewing staff members.

87 See Chapter 5:1 Corporate Clinical Governance Committee Trust Meetings and 6:1 The Executive Sub-group Meetings

88 See Chapter 5 Corporate Documentation and the Organizational Process of Clinical Governance

4.13 Ethical Considerations

In November 2003, I completed the appropriate forms for both university (University Research Governance and Ethics Committee) and the NHS Local Research Ethics Committee (LREC) approval. Completion of the university ethical approval request procedures were on-line and final approval was given on 15 January 2004; I obtained LREC approval on 26 January 2004. It was also necessary to apply for and obtain an Honorary Research Contract from the Trust; this commenced on 18 February 2004 and ran until the end of December 2006.

Whilst the university requested minor grammatical amendments to my application, which was then approved, it was interesting that a member of the NHS LREC committee phoned me to state that the ethics committee had requested that I obtain written permission from every patient on the wards where I was observing nurses. This to me would have been impossible to achieve for a variety of practical reasons. When I pointed out that the focus of my interest was not on patients, but on nurses in the giving of care as influenced by clinical governance, a compromise was reached. It was agreed that a notice for patients and staff would be put up in each ward on which I observed practice and that any patient or nurse could object, if they so wished. I complied with this request, but on several occasions had to retrieve the notices on the wards to make them visible as others had obscured them. No patient or any member of staff ever objected to my presence on the wards, all being more than co-operative. A year later, I was contacted by the LREC committee and asked to complete a progress report, which, I was told, had been considered and in February 2007, I was sent a letter from the same committee asking for an update about *'a pilot study investigating abnormalities in tight junction proteins in patients with benign gastrointestinal disorders.'* When I phoned to say this was not my study, I received no further communication. The Ethics Committee did not request any details of what I had done, or ask to see any results. In this respect, I considered the completion of ethical paperwork to be 'ceremonial conformity' but this is not under discussion here.

I left an explanation form about the study and my contact details on the wards for nursing staff to read. When I spent time on the wards, interested nurse interviewees approached me, or, having spent some time with a nurse on duty, I asked if he/she would be willing to be an interviewee. Nobody refused. Interviews took place either in an office, or in a quiet area on the ward. An interesting situation and dilemma for me arose in respect of the honorary research contract agreed with the Trust. In my role as academic educational link with another employer, I am able to visit wards and observe any direct nursing care given,

with no clinical contract of any sort, yet I had to obtain an honorary contract to do the same thing for my research. Whilst I agree with the principle of this when conducting research, it did make me reconsider my professional role as an academic educational link because, when I enquired, the Trust informed me that the process of issuing clinical contracts for all academics in practice would not be viable. I pondered, then, that if the true priority was for the protection of the patients, how are they and I 'protected' in this situation? I did wonder at the logic of this. Nevertheless, in relation to the research undertaken, I did consider that the patient was 'protected.'

I approached members of the Trust management and the key clinical governance personnel individually in respect of taking part in a recorded semi-structured interview. In line with the ethical approval given, when I arranged the interviews, I gave each interviewee a letter[89] and a form[90] explaining about the study and my contact details in case they wanted to withdraw before the interview took place. There was always some time (at least a week) between my initial request and the interview. All interviews took place at the allocated period apart from one senior manager who rescheduled twice due to other commitments. I requested that all interviewees sign a consent form[91] (previously approved by the NHS LREC) before the interview took place. On the consent form, I stated that I would maintain the interviewee's confidentiality. Nobody objected to the recording of the interview. There was an option on the form for the transcribed interview to be given to the interviewee, if they so wished, but no interviewee requested this. The Clinical Director added a sentence to his consent form requesting me not to identify the Trust when transcribing the interviews.

4:14 Collection of Data

Stake (1995) and Yin (1994) identified at least six sources of evidence in case studies: those of documents, archival records, interviews, direct observation, participant observation and physical artefacts. This study employed a multi-method and multi-stage approach. There were three main methods of data collection: those of documentary analysis, observation and semi-structured interviews.

4:15 Documentary Analysis

The analysis of documents in qualitative research is useful in presenting insights into the ways in which the work of an organization is represented. Records construct a

89 See Appendix A3 Letter to Participants

90 See Appendix A4 Information Sheet for Participants

91 See Appendix A 5 Consent Form

'documentary reality' of 'objective factual statements' rather than *'mere personal belief'* (Hammersley and Atkinson 1995:173). Documentation, Atkinson and Coffey (1997) state, forms the basis for organizational features, that are created and sustained through 'documentary realities.'

I obtained documentary materials from the corporate Trust level meetings (such as annual reviews, reports, strategies and action plans) and analysed these using established conventions for qualitative data analysis (Bryman and Burgess 1994). Scott (1990) proposes four criteria for assessing documents for their quality: those of authenticity, credibility, representativeness, and meaning. May (2001) also notes the four criteria above and adds that documents have the potential to inform and structure the decisions that people make on a daily and long-term basis. Prior (2003:152) calls the documents that people produce or use in their everyday work, '*naturally occurring forms of documentation'* and states that it is documentation *'that underpins the organizational presence*' (Prior 2003:60). He also suggests that there are good reasons for selecting samples of documentation, as the sheer volume of results could overwhelm the researcher. Documents were analysed bearing in mind the drawbacks of relying solely on these alone, as they may be subject to misinterpretation and are only relevant to a specific time.

Whilst different categorisations of types of documentary material exist, Hammersley and Atkinson's (1995) definition of official, formal, and informal sources was utilised in this research. Official documents were those such as public records, and the compilation of official data and statistics. I identified formal documentation as those circulated to committee members within the Trust, which included:

The terms of reference for the Trust corporate clinical governance meeting (September 2004)
The Trust annual report (2003-04)
The Trust clinical governance development plans (2004-05; 2005-06)
The document control policy (Issued 06/02, revised 10/04)
The clinical governance reporting mechanism (2002-03)
The Essence of Care annual report (2004)

I considered informal documentation to be my own field notes and recordings taken during meetings and periods of observation. It is clear that clinical governance systems have produced a huge proliferation of documentation in terms of agendas, minutes of meetings, reports, action plans, guidelines etc, and, in this instance, I identified a number of

documentary records as a source of data in order to relate their use to everyday practice. I subsequently analysed and tracked action in the official documentation related to the content of these meetings. For the purposes of this research, there is consideration of key Trust documentation, as it is the general storage, dissemination, retrieval and use of this information in everyday practice that is of interest to me.

4:16 Observation of Meetings

In order to orientate myself and to obtain documents relevant to my study, the first stage of the research commenced with attendance and observation at clinical governance meetings taking place at various levels within the Trust. The purpose of this observation was to consider the process of the clinical governance meetings that had been initiated to implement and disseminate information about clinical governance. Since the study commenced in February 2003, I attended and had been included in the circulation of the official minutes from the following meetings:

- Twenty-seven corporate clinical governance meetings (monthly from March 2003)
- Eleven sub-executive corporate clinical governance meetings (fortnightly, until June 2004, after which these meetings were discontinued due to lack of action and poor
- attendance)
- Two clinical governance facilitators' meetings (replaced above meetings, commenced November 2004)
- Thirteen neurosurgical clinical governance meetings (monthly)
- Seven elderly care 'protected time' meetings (quarterly)
- Twelve nursing professional development meetings, elderly care directorate
- (monthly, until elderly care directorate was incorporated in the larger medical
- directorate)
- Three critical incidents meetings elderly directorate (monthly, until discontinued with the appointment of a new clinical governance lead)
- Two senior nurse meetings, neurosurgical directorate
- Two Trust matrons meetings (three attended erratic organization – abandoned after three attempts for access and cancelled meetings).

These meetings generally lasted for about two hours. Attendees came and went due to a variety of commitments throughout. As well as attending formal meetings I met informally at various times with different Trust staff either through my role as an academic-in-practice, or whilst conducting my fieldwork. I was careful to keep my academic in practice role and

responsibility for student nurses a separate issue from my research, but, at times, this blurring of role did produce data in respect of the day-to-day events in the Trust that provided useful background knowledge for the research.

4:17 Field Notes

I made contemporaneous extensive notes of the formal and informal progress of the meetings. Following the meetings, my field notes were typed and I tried to identify any emerging themes and kept a record of these. My main difficulties were the constant production of new reports and the dynamic environment of change within the Trust together with shifting deadlines and topics discussed. This led me to focus on organizational theories[92] as discussed earlier, in an attempt to understand the processes concerned. From my detailed notes, I identified themes emerging from the data from the meetings I attended.

4:18 Ward Observation

The choice of wards for my observation of day-to-day nursing practice was purposive in the sense that I wanted to match acute and rehabilitation wards on both the elderly care and neuroscience units. In accordance with the ethical approval, I placed brief details of my research intentions of that time[93] on all the notice boards of the observation wards, but, commonly, new information obscured them. Therefore, many nurses on these wards were still not aware of what I was doing, so I spoke to some informally as I observed practice and asked if they would be willing to be interviewees.

Whilst not detailing this observation to nurses, I was particularly interested in observing practise concerned with the Essence of Care[94] benchmarks whilst on the wards, which, in turn, linked to an evidence-base (for the Essence of Care) under the remit of best practice. I was paying attention to how nurses translated available evidence into their daily nursing care practise, what opportunities there were for this and, how they saw their responsibilities in making a difference to the quality of patient care, using the Essence of Care benchmarks.

In explanation of how I could 'see' evidence-based, or good practice, I felt this would be variable. For example, it is easy to see if a hand hygiene dispenser at the entrance of a ward is present, in working order, empty, full, or broken (Staniland 2008). If empty, broken

92 See Chapter 3 Section B New Institutionalism Theory

93 See Appendix A 1 Notice to patients on Ward

94 See Chapter 2:15 The Nursing Component of Clinical Governance – The Essence of Care and Appendix B2a and B2b The Essence of Care

or not available for some reason, I would take more interest in hand washing during that period of observation (Essence of Care Benchmark Two; Personal and Oral Hygiene). There is research-based evidence available to support the need for hand washing.[95] Ward notices and screen savers on all of the wards in the Trust also reinforced this. I could relate this principle to other nursing activities, such as protected meal times, in relation to the best practice guidelines in the Essence of Care Benchmarks.[96] During, or following observation, I also naively and diplomatically questioned nurses as to what they were doing or asked why they were doing it. Although I obtained extensive data of ward observation during these periods of observation, I chose two examples of observed practice to include in this Thesis, that I would describe as 'typical' of ward activity.

I subsequently carried out participant observation in the selected directorates by visiting a number of wards to observe nursing practice. This involved being present at ward handovers and observing how nursing care was organised and delivered at ward level. The observations comprised short stages of four or five hours at any one time over a period of eighteen months (within the total period of two-and-a-half years fieldwork) in the two chosen directorates within the Trust. Whilst on ward observation I attached myself to various members of the nursing staff as they were on duty, accompanied doctors on medical rounds with nurses and sat in on ward reports.

I made extensive field notes during (if appropriate) and at the end of each period of ward observation and analysed these using the same grounded theory analytical process as the semi-structured interviews. In total, I undertook sixteen periods of ward observation, totalling a period of approximately sixty-five hours. These first two phases (documentary analysis and observation, both at meetings and on the wards) facilitated the design of semi-structured interview questions.[97]

4:19 Semi-structured Interviews

Based on my observation at meetings and on the wards, I formulated nine questions to guide the semi-structured interviews[98] in the 'Nurses' category. I used these as reference points throughout the interviews, although I sometimes pursued other topics raised by me, or the interviewees. On the basis of the comments that I had received from nurses in that

95 See http://www.jr2.ox.ac.uk/bandolier/booth/booths/hand.html for hand washing evidence and the Essence of Care Personal and Oral Hygiene.

96 See Appendix B2b The Essence of Care

97 See Appendix A 2 Nurses' Questions

98 See Appendix A 2 Nurses' Questions

managers did not visit the wards, I added a question in the 'Stakeholders' interviews asking if they managed by 'walking about'[99] and omitted the ward category of how clinical governance had affected their own practice. Most interviews lasted for approximately forty-five minutes. In total, I conducted thirteen semi-structured interviews within the 'Nurses' category and fifteen within the 'Stakeholders' category.

Whilst direct observation of the day-to-day nursing practice on the wards continued, the next stage of the research was to carry out semi-structured interviews with a purposive sample of relevant nursing personnel and stakeholders in the Trust. Although ethical approval for the interviews was based on informed consent, in the process of ward observation 'natural occurring talk' also happened, as opposed to what Silverman (2001:159) describes as '*researcher provoked data'* and this also provided some questions for the semi structured interviews. The semi structured interviews with the various, at that time, 'grades' (now known as bands)[100] of nursing staff within the two directorates formed a significant part of my data collection. I had developed an understanding of what members of the corporate clinical governance committee had 'assumed' was happening in the delivery of the service and I was collecting data from observation of practice. A logical concurrent step therefore was to interview these stakeholders and, more specifically, the nursing staff who were engaged in experiencing the implementation of change at ward level.

From my orientation and analysis about the organization of clinical governance, two categories of personnel emerged from the different professional groups within the Trust. These mainly comprised what I initially described as a 'management' category and a 'practice' category. These categories subsequently for convenience became 'Stakeholders' and 'Nurses' (although I recognise that nurses are also stakeholders, in this case study they fall into the 'Nurses' group). I selected various 'professional groups' to consider within each category for interview, as will be explained. I conducted semi-structured recorded interviews with the various members of hospital staff at mutually convenient times in their own working environment.

4:20 Interview Arrangements

All the interviews took place in the interviewees' own offices or wards, in quiet private areas where there was access to a power point for the tape recorder. I recorded and transcribed

99 See Appendix A 6 Stakeholders' Questions

100 For grading and bands see Agenda for Change (2004) the new pay structure and careers modification package covering the employees who work for the NHS http://www.NHSemployers.org/pay-conditions/agenda-for-change.cfm

all interviews. I retained the letter of consent that I asked each interviewee to sign. The interviewees kept a copy of the information relating to the study and my contact details.

4:21 Categories

For the purpose and nursing focus of this Thesis, the 'Nurses' category comprised thirteen nurses. Most of the nurses interviewed were recruited while I was observing, two, a G grade and E grade nurse telephoned me volunteering to be interviewed. (At the time of the research, the 'grades' of nurses were being changed into 'bands,' so reference is made to both grades and bands). Nobody approached refused to take part in the interviews, although one band five staff member could not meet at the arranged time due to work pressures and I had to wait several times for staff to become available when I arrived at the agreed times. One interviewee was a senior nurse within nursing services and the rest of the interviewees were matrons and the nursing staff within the two identified directorates in the Trust. I consequently grouped the responses from a senior nurse in the matron response category. The rest of the interviewees comprised two band eight (a) matrons, four band seven G grade sisters, two acting band seven G grade sisters, two band six F grade sisters and two band five E and D grade registered nurses. For classification purposes, the interview responses were identified by the following method:

N = Neurosurgical, EC = Elderly Care, 8a – 5 = band or grade, then number of respondent
Therefore N 5 1 indicated a band 5 staff nurse working on a neurosurgical ward, respondent number 1.
EC 7 2 was a band 7 G grade sister working on an elderly care ward, respondent number 2. More detail of this identification can be located on the Nurses' Analysis Grid.[101]

The numbers and identification for the Nurses' Group follow:

Matrons/Senior Nurses Band 8a Neurosurgical (N) Elderly Care (EC) Senior Nurse (SN)	G Grade Ward Sisters Band 7 Neurosurgical (N) Elderly Care (EC)	F Grade Ward Sisters Band 6 Neurosurgical (N) Elderly Care (EC)	E and D Grade Staff Nurses Band 5 Neurosurgical (N) Elderly Care (EC)
N 8a 1	N 7 1	N 6 1	EC 5 1
EC 8a 2	EC 7 2	EC 6 2	N 5 2
SN 8a 3	EC 7 3	N 6 3	
	N 7 4		
	EC 7 5		

101 See Appendix A 7 Nurses' Analysis Grid

Effectively, the interviewees comprised a purposive sample. I argue that they appropriately reflect the range of expertise and experience relevant to obtain practitioners' insights into the processes of clinical governance.

In the initially named 'Management' category, I divided the interviewees into three professional groups, those of Managers, Professions Allied to Health, and Consultants. All these stakeholders held positions of authority within the Trust. The Manager category included two directorate General Managers (GM 2 and GM 3), the Associate Director of Quality for the Trust (GM 4), and the Director of Operations within the Trust (GM 1). The Professions Allied to Health group included the two Clinical Governance Co-ordinators; I chose to place these personnel within this group due to their previous background. The first had practised as a dietician (AP5); the second had worked as a porter (AP6). Other interviewees included a Senior Occupational Therapist (AP4), a Physiotherapist (AP3), a Pharmacist (AP2) and a Neuro-psychologist (AP1). The Consultant Group included five Consultants: the Clinical Governance Lead for the Neurosurgical (C3) and Elderly Care directorates (C1), The Trust Executive Clinical Governance Lead (C2) and another Clinical Director who had been the Chair of the clinical sub-executive group (C4).[102] Another consultant from Neurosurgical was included as an active attendee of the clinical governance management group (C5).

These personnel were a 'convenience' sample as they either were members of clinical governance sub groups, or had a responsibility for the dissemination of information within their own professional fields. All but three (the Neuro-psychologist and the two Clinical Governance Facilitators), were previously unknown to me. As responsibility for the implementation of clinical governance largely lay within this category, I re-labelled it a 'Stakeholders' category as I felt that they were not all in management and the term was less restrictive.

The numbers and identification for the Stakeholder Group follow:

Managers		
General Managers	GM 2	GM 3
Associate Director of Quality for the Trust	GM 3	
Director of Operations within the Trust	GM 1	

102 See Chapter 6:1 The Executive Sub-Group Meetings

Professions Allied to Health		
Clinical Governance Co-ordinators	AP 5	AP 6
Senior Occupational Therapist	AP 4	
Physiotherapist	AP 3	
Pharmacist	AP 2	
Neuro-psychologist	AP 1	

Consultants	
Clinical Governance Lead for the Neurosurgical Directorate	C 3
Clinical Governance Lead for the Elderly Care directorate	C 1
Trust Executive Clinical Governance Lead	C 2
Clinical Director	C 4
Neurosurgical Consultant	C 5

4:22 Grounded Theory

I utilized the process of grounded theory to inform the analysis of data from the semi-structured interviews and periods of ward observation. Grounded theory is an approach to the analysis of qualitative data that aims to generate theory out of research data by achieving a close fit between the two (Strauss and Corbin 1998; Denzin and Lincoln 2000). It therefore acquires its name from the generation of theory from research that is 'grounded' in the data. The endeavour of this approach is to develop some explanatory theory about common social patterns. Glaser and Strauss (1967:3) describe the usefulness in the grounded theory approach as providing understanding and some control of situations and a stance to be taken towards data and to provide modes of conceptualization for describing and explaining. When the grounded theory approach is utilised, data collection is linked to analysis from the start of the research.

Grounded theory methodology emerged from Glaser and Strauss's work for the production of theoretical analyses in the social organization and temporal order of dying in hospitals (Glaser and Strauss 1965; 1967; 1968). This work enabled systematic methodological strategies, which could be further utilised by other social scientists. The basis for this methodological approach is the belief that systematic observation, replicable experiments and operational definitions of concepts with logically deduced hypotheses can form the basis for upholding quantitative methods. Glaser and Strauss (1967) defined components of grounded theory as including concurrent participation in data collection and analysis, the

construction of analytic codes and categories from the data obtained (with no preconceptions), using a constant comparative method during each stage of the analysis. The development of grounded theory during the various steps of data collection and analysis arises from the sampling of this data. The review of the literature generally takes place after the analysis of data.

4:23 Analysis of Data

Having transcribed the interview data for each interviewee, in order to begin to ask analytic questions of the data I had generated, I followed guidelines for the process of grounded theory coding as explained by Charmaz (2006). Charmaz (2006:43) recommends '*categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data.'* To do this, I prepared two grids, one for the nurses[103] (which I have included in the appendices), and one for the Stakeholders (which I have not included as the interview data collected ran in excess of fifty pages), using the same principles. For both groups, I displayed the interviewees' bands and responses to each question on the charts, also identifying each band and interviewee to allow for any further comparisons. I initially identified the 'right,' 'wrong' and 'uncertain' answers (as based on the understood 'official' or suggested definitions of clinical governance) as Y, N, U (yes, no, uncertain). I highlighted pieces of 'wrong' data in yellow, 'right' answers in green and 'do not know' answers in red.

I re-examined the answers in different ways, for example using grading, grouping, response and directorate. In selecting, sorting and separating data and asking questions such as *'what is this data a study of?'* and *'what does this data suggest?'* (Charmaz 2006:47), I initially found some patterns. I could group and discuss the emerging themes under 'Quality;' 'Clinical Governance Terms;' 'Professional Personal Development;' 'Practice Issues;' 'Essence of Care;' 'Dissemination of Information;' 'Increased Documentation' and 'Protected Time.' In respect of the answers given, some useful identification of *in vivo* coding helped to preserve participants' meaning of their views and actions. I use these at the beginning of some Chapters. *In vivo* coding was valuable in this instance in that participants' innovative term catches a meaning or experience.[104] Using these themes, I established focused coding to make decisions about the most analytic sense in which to categorize the data.

103 See Appendix A 7 Nurses' Analysis Grid

104 In vivo coding enabled assigning the text to a code, whose label is the text itself

In asking *'which theoretical categories might these statements indicate?'* (Charmaz 2006:45), I was able to regroup the themes into an analytical framework, under three broad theoretical categories, those of 'Making Sense' 'Somebody Else's Job' and 'Real Work.' However, within these three broad categories, I used axial coding in order to relate categories to sub-categories. Axial coding specifies the properties and dimensions of a category, the purpose being to arrange, synthesize and sort out large amounts of data and assemble them in new ways so that the when, how, where, why, who and with what consequence questions are answered (Charmaz 2006). Within the first category of 'Making Sense' a further sub-category was identified, that of 'Knowledge Construction' covering how the interviewees perceived the organization, dissemination and provision of information and whether they felt clinical governance connected with professional development.

I did not use new institutionalism theory in the analysis of the interviews, as the purpose was to generate theory in respect of the answers given. I did, however, map the grounded theory generated key themes with the concept of Mission and Charter[105] in order to explain the data, identify any links and make it more 'understandable' to an audience (tenHave 2004:138). Whilst I did not use this extensively in the interview results in Chapter Seven, I occasionally refer to it in order to make a point. The important aspect here was the linking of individuals' description of the situation, and their own analysis of it with the rhetoric of the written official documentation of what was stated to be happening, or thought to be happening, within the Trust.

In respect of the periods of ward observation, I utilized a slightly different approach. I made extensive field notes and chose two typical ward observations from these. I therefore decided to change the presentation of the grounded theory by presenting two chosen narratives of observational practice to illustrate everyday practice and to demonstrate how the theoretical categories emerged. The data from the analysis of documents, attending corporate Trust meetings, observing practice and interviewing staff members within the two directorates in the hospital generated a case study of the phenomena of interest and an exploration of the factors that might link them.

In summary, I commenced observation at the relevant Trust by attending clinical governance meetings, elderly directorate clinical governance and nursing meetings in March 2003. In April 2004, I also started to attend the neurosurgical clinical governance meetings and, from September 2004, commenced short periods of observation on the day-to-day nursing

105 See Appendix A 8 Link with Mission and Charter

activities on wards in the two directorates. I began to interview staff in October 2005 and completed all interviews by April 2006. Compilation of the interview data and analysis took place between May and September 2006.

4:24 Summary and Concluding Comments

This Chapter has described and discussed the methodological approach undertaken during this study. I wanted to gain an understanding of Stakeholders and Nurses' experience of the implementation of clinical governance and I perceived that an ethnographic case-study research design was an appropriate methodological strategy for gaining an insider's depiction of the studied world. The Chapter also covered the ethical considerations and gave a broad description of the NHS Hospital Trust in which the study took place. I provide detail of the setting and arrangements for the analysis of documents, observation of meetings, ward observations and semi-structured interviews.

Having described the methodological process of the study, the next Chapter will address the corporate management process of clinical governance in the Trust and relate this to my own findings. I focus on key examples gained from the analysis of the corporate clinical governance meeting documentation and from my own observation at these meetings, in order to recount the *reality* of these in helping to improve quality and patient care. Whilst the various committees produced the appropriate paperwork, I found that an analysis of this same documentation produced some interesting results. In Chapter Five, I concentrate specifically on the paperwork that arose at the corporate level committee meetings. In my analysis, I pick out some examples, which I feel, warrant further discussion.

Chapter Five

Corporate Documentation and the Organizational Process of Clinical Governance

"What it doesn't do is make you do it" (Consultant comment at a Trust Corporate Clinical Governance Meeting)

5:0 Introduction

This Chapter will begin by describing what is 'stated' to be happening in the Trust, according to its formal documentation. This will be followed by my analysis of the same paperwork in the light of my observations from attendance at the corporate clinical governance meetings. The background account of the structure and organization of the Trust will provide evidence of the formal and symbolic aspects of the clinical governance systems and sketch the context within which nursing and other health care staff work. The purpose of the corporate clinical governance meeting will first be explained in terms of its 'official' published terms of reference. This explanation is necessary before we can explore how these formal terms were enacted in practice through an analysis of the documentation in use. In so doing it will become evident that clinical governance systems have generated a proliferation of both externally and internally generated paperwork in the form of guidelines, protocols, terms of reference and minutes of meetings.

In 2001, just prior to this research, the Trust had undergone a Commission for Healthcare Improvement (CHI) clinical governance review. The results were published in November 2001. In this report, CHI criticised the ineffective use of a model previously adopted by the Trust to support continuous quality improvement. Specifically, they considered that its implementation had become too focused on process rather than delivery of improvements. A staff survey had also indicated extensive dissatisfaction. Together with a survey of 2000 patients discharged in September 2001, their review had revealed significant concerns about communication, staffing, environment and internal waiting times.

In the same month, the Trust clinical governance committee agreed the development of a new structure to carry clinical governance forward to the next CHI review in 2005. It was stated in the Trust's official response that the vision for clinical governance would focus on three areas: continuous improvements in patient-centred, safe, effective, timely, efficient and equitable care; clinical governance that would be open and accessible to all staff and

patients; and clinical governance that would be understood by, and continuously inform the actions of, all Trust employees.

In December 2001 the Chief Executive, Executive Medical Director and Executive Nurse commissioned a new strategy. This document was intended to guide the development and management of clinical governance during the period April 2002–March 2005. Because of this, the corporate clinical governance committee, the executive sub-committee, directorate clinical governance management committees and directorate clinical governance committees convened, together with their accompanying terms of reference. A clinical governance co-ordinator was appointed and administrative and secretarial support provided. The formal designated organizational structure of clinical governance focused on holding designated committee meetings at various levels throughout the Trust, ranging from corporate to directorate level.

At the beginning of my fieldwork, I was able to use the Trust clinical governance intranet site to gain access to the documents that set the remit for the Trust meetings, such as the strategy, terms of reference, and the document control policy. Some Trust public documents, such as annual reports, were already available on the hospital Trust website. The Trust vision stated that the focus for these committees would be on patient experience, clinical effectiveness, risk management effectiveness, communication effectiveness, resource effectiveness, strategic effectiveness and learning effectiveness. It was acknowledged that the Trust staff were its most important resource and must be trained and supported in order to deliver its precepts: every three months, the Trust provided designated half-day 'protected time,' with routine operating lists and outpatient clinics cancelled to enable staff to attend clinical governance directorate meetings. The elderly care directorate utilised these 'protected time' allocations to hold their clinical governance meetings, the neurosurgical directorate used the time to conduct individual interest meetings, e.g., interest in stroke, multiple sclerosis, nursing meetings, etc.

The following observations on the management of clinical governance and document analysis are based on my observation of corporate clinical governance and other meetings and other field notes collected over a two-and-a-half-year period. I was included on the circulation list for all necessary documentation related to most meetings and I was present at all but two.

As discussed earlier,[106] in the process of reviewing the different literature available on health service management, policy process and the sociology of professions, I became particularly interested in two sociological perspectives on organizational functioning that seemed useful for this work. One is the new institutionalism approach founded in the work of Meyer and Rowan (1977), specifically that of the formal structure as a 'legitimating myth.' The second involves the complementary proposals voiced by Dingwall and Strong (1997) about 'negotiated order.' Both provide useful tools for explaining and understanding the political process that currently pervades the NHS. These theories are useful in constructing an analytical framework and in explaining the working processes and cultural dimensions of the Trust in relation to the documentation and format of the clinical governance meetings.

5.1 Corporate Clinical Governance Committee Trust Meetings

In the Trust, the corporate clinical governance committee was established as a formal sub-committee of the Trust Board under schedules 4 and 5 of the Trust's Standing Orders. The committee's purposes were laid out in the official terms of reference. It is useful to relate some of these in detail in order to explain the committee's formal remit:

- To develop and promote the visions, value and culture of clinical governance across the Trust
- To develop, review and implement the Trust Clinical Governance Strategy
- To determine the structures and processes of clinical governance and their effective functioning
- To ensure that the requirements of all the pillars of good clinical governance and Standards for Better Health are practised by all staff throughout the Trust
- To monitor and evaluate clinical governance implementation and performance at group and directorate level

Although the terms of reference stated the purpose of the committee, it appeared that responsibility for all decisions relating to clinical governance activities still lay entirely with the Trust Board (and, on a statutory basis, with the Chief Executive). As such, the corporate clinical governance committee had 'delegated' powers from the Trust Board on a practical basis, to oversee, coordinate, review and assess the effectiveness of clinical governance arrangements and activities within the Trust. The principal devolution of the Board's responsibilities related to the establishment of structures and processes, which would ensure that effective clinical governance was practised across the Trust. In effect, the committee was responsible for the monitoring and evaluation of clinical governance performance, for the

106 See New institutionalism theory Chapter 3:B

approval of policies and procedures required for effective clinical governance and clinical practice and the management of the clinical governance budget and the deployment of clinical governance resources. In the course of my fieldwork, I established that there was actually no designated budget for clinical governance implementation.

I began to attend the corporate meetings in March 2003. This committee was large,[107] and the meetings were held monthly. The corporate clinical governance committee reported to the Trust board, through executive, bi-monthly meetings; an annual report was produced and an annual implementation plan, stated as being published on the Trust website (I mention this, because it was not). The formal documentation also stated that other clinical governance reports would be available via the hospital intranet (but this facility was very erratic, with only one or two reports ever appearing). I attended corporate clinical governance meetings for some considerable time. Towards the end of my fieldwork, in preparation to meet the requirements for 'Standards for Better Practice,'[108] the committee ceased to exist and reconvened as a Clinical Effectiveness Committee with a new designated membership. I considered this would be an appropriate time to withdraw.

5.2 Documents and Clinical Governance

Normally, documentation has a comparatively low profile in any organizational structure and it is only when things go wrong that it may be subject to some detailed critical scrutiny. Nevertheless, the 'routinization' of this documentation interested me. I had established that in 'official documentation' (in this context, 'official documentation' was formal Trust documentation circulated throughout the Trust and placed on the intranet and at times, the internet) there was clear information in the terms of reference for the corporate clinical governance meetings. This was consistent with Murphy and Dingwall's (2003:66) suggestion that documents '*can provide valuable evidence about what people and organizations would like to be thought to be doing.'* I argue here, however, that, although there was an overwhelming production of documentation, its actual relevance and practical use was not evident. For example, I started noticing small discrepancies in the attendance

107 Members of this committee are drawn from senior staff within the Trust and are stated in the formal documentation as being: Executive Medical Director (Chair), Executive Nurse Director, Medical Director Clinical Effectiveness, Deputy Director of Nursing & Clinical Governance, Associate Director Corporate Governance, Associate Director of Patient and Corporate Services, Director of Infection Control, Medical Directors, Associate Nursing Directors (Medicine, Surgery), Allied Health Professional Lead, Chair Drugs & Therapeutics Committee, Director of Pharmacy, Director Clinical Informatics, Director R & D & Education, General Managers, Head of Midwifery, Trust Board Non-Executive, Two Patient representatives, PCT representatives, Clinical Claims and Litigation Manager, Risk and Health and Safety Manager, Clinical Risk Manager, Governance Facilitators, another Executive Director chosen from Chief Executive, Director of Finance, Director of Operations or Director of Human Resources.

108 The Department of Health's Core Standards set out the standard of care all healthcare providers should meet covering a wide range of areas including safety, cleanliness, patient information, treating patients with dignity and respect and good clinical practice.

list at the meeting soon after I began my fieldwork. At one meeting, I observed that the minutes of the previous meeting had indicated that a consultant had given his apologies. Yet this same person was a keynote speaker at that meeting and an active participant, as also stated in the minutes. An obvious mistake, but one not corrected, or perhaps even noticed, by any of the participants at the following meeting.

Documentation may appear an uninteresting topic, but it provided me with a rich source of data for analysis. While documents may be thought of as a mere representation of a social reality, that representation has real consequences. How are these documents written? Who reads them? How should they be read? What purpose do they serve? Hammersley and Atkinson (1995:172) recall a remark, by Garfinkel that records should be viewed as 'contractual' rather than 'actuarial': they are not literal accounts but evidence that the appropriate personnel went about their business in a competent way, a point which will be referred to later.[109]

Documentation presented to the committee at the meetings included paperwork in the form of terms of reference, annual reports, quarterly reports, clinical governance development plans, clinical audit reports, the framework for clinical groups' clinical governance reviews, policies, standards, protocols and guidelines, to mention but a few. Documentation produced by the business of the meeting (sometimes two millimetres or more high when printed out), was overwhelming and frequently changed with the announcement of new initiatives, such as the NHS Improvement Plan (2004c),[110] Standards for Better Health (2004b),[111] the work of the National Patient Safety Agency[112] and the move towards Integrated Governance.[113] The detail in each document can be further broken down into

109 See Chapter 8

110 The NHS Improvement Plan set out the priorities for the NHS between 2004 and 2008. It supported the ongoing commitment to a 10-year process of reform first set out in The NHS Plan

111 Standards for Better Health replaced the former 'seven pillars of clinical governance' and constituted a number of new domains for 'Core' and 'Developmental' standards. Their aim is to improve quality assurance across the whole of the NHS and they were set to be implemented in stages starting from late 2004 and leading up to 2006/7. All NHS services are required to meet the 24 core standards set out by the Department of Health to establish a certain 'level of care' and 10 developmental standards 'designed to enable the overall quality of healthcare to rise' in the longer term.

112 The National Patient Safety Agency (NPSA) is a Special Health Authority created to co-ordinate the efforts of all those involved in healthcare, and more importantly to learn from patient safety incidents occurring in the NHS.

113 In 2004, the concept of integrated governance systems was developed in the NHS; a common framework with the following elements developed in 2005 to bring together the various strands of governance. This included the following: Finance, efficiency and economy, effectiveness and efficacy, compliance with authorizations, compliance with the healthcare standards and national targets,

various component parts and took up considerable discussion time at the meetings. Whilst I collected a considerable amount of this documentation, it is only possible to give summarised examples here.

Committee meetings took place monthly, on alternate Monday mornings and Thursday afternoons. At this time, there was a clinical governance facilitator in post and we usually met up before the meeting. The designated meeting rooms varied, but were always large and formal and never set up beforehand, so the hour before the meeting involved the manual handling of tables and chairs in preparation. After a couple of meetings, I began to help with this. It was supposed to be a job for porters, but they generally arrived minutes before the meeting when the room was already set up (if indeed somebody had remembered to order the job) and the clinical governance facilitator just accepted the situation. The room was arranged around a large table, positioned to view any formal presentation scheduled. There were generally problems with the technical support and many presentations were delayed by non-functioning equipment. Meetings were due to commence at 10:00 and 14:00 but committee members arrived and left throughout. The three patient representatives on the committee usually arrived first.

At the first meeting, I sat slightly behind the main table on my own. I was introduced as an observer undertaking a PhD on clinical governance. At the second meeting, I sat beside the clinical governance facilitator and thereafter sat at the main table, but I did not participate in any discussions. Initially this was extremely difficult for me, particularly if there was an item under discussion that I knew the answer to, as it was not a role I was used to, but, as my experience grew, I found it easier to remain detached. Before and after the meeting I spent time chatting with the patient representatives, who, I noted, frequently experienced problems in receiving the minutes of the meetings and having points they raised included in these minutes. I believe I became known as a person who was sympathetic when minutes were not received and one who always asked how they were feeling (these patient representatives generally suffered with long-term conditions requiring either admission or outpatient appointments).[114] Periodically I was included in the round of introductions if there was a visitor to the committee. I became part of the group and known to be very reliable in having all the appropriate documentation, which I sometimes had to lend to other committee

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the duty of quality (as reflected in clinical governance), the duty of partnership, the duty of patient and public involvement, developing the board membership

114 I was very sad when one representative became seriously ill during the course of my fieldwork and was glad I was able to visit her on the ward shortly before she died, so in a way I was not wholly detached.

members. One neurosurgical consultant clinical governance lead stated that he liked to sit beside me, as he knew I would always have everything that was required.

5.3 Terms of Reference and Minutes of Meetings

I analysed the documents from the corporate clinical governance meetings from February 2003 until October 2005. I found that the terms of reference and minutes of the corporate clinical governance committee were logically constructed and had a numbered items column, a title, discussion column, and a designated action column. The corporate clinical governance medical director's secretary took the minutes, subsequently emailed to committee members. There were three changes of personnel in this role over the period of observation. In order to gain some understanding of the workings of the committee, I firstly looked carefully at the terms of reference for the meeting and noticed that these terms clearly set the agenda format. I then compared this agenda format with the standard agenda produced for every meeting. This comparison is below.

I noted that the terms of reference set the agenda format for the corporate meetings as:

Conduct of Meetings

The meeting will follow the following format:

- Minutes
- Matters arising
- Safety
- Clinical and cost effectiveness
- Governance
- Patient focus
- Accessible and responsive care
- Care environment and amenities
- Public health
- Progress against corporate clinical governance strategy
- Any other business

I observed that the committee had approved the terms of reference for setting the agenda in March 2004, but as demonstrated, there was a variation in subsequent set meeting agendas, with an example given of the July 2005 agenda:

1. Minutes from previous meeting

2. Matters Arising
3a. NCEPOD – An Acute Problem – (name of presenter)
3b. Confidential Enquiry terms of reference – (name of presenter)
4. Oxygen prescription and Therapy – (name of presenter)
5. Blood Transfusion – EU Directive – (name of presenter)
6. NICE Guidelines implementation – (name of presenter)
7a. Clinical Audit Strategy – (name of presenter)
7b. Briefing paper on the transfer of clinical audit to clinical governance team
8. Infection Control Report - (name of presenter)
9. Nutritional Steering Group terms of reference - (name of presenter)
10. Child Protection Strategy – (name of presenter)
11. Annual Clinical Governance Report – (name of presenter)
12. Any other business
13. Time and date of next meeting

Therefore, I suggest that even though the committee had approved the terms of reference, it is apparent from this given example, and in all the other agendas I collected, that their use was not evident in the day-to-day running of the meeting. The used agenda was designed in an information-giving format. For example, I did not ever hear the *'progress against corporate clinical governance strategy'* discussed. Whilst the agendas did appear to follow a month-by-month structure, the terms of reference were not utilised at any meeting that I attended. I argue therefore that the terms of reference demonstrated correct procedural work, but the day-to-day reality of content bore little relationship to these and cannot be reconciled with the routine way in which the minutes were generated. The ultimate meaning of documents is understood in the social context in which they were produced and discovered. TenHave (2004), for instance, comments that a central concern in documentary analysis is establishing the factuality of claims through the authenticity, credibility, and representativeness of artefacts. He reminds us that even when documents are factually established as credible representatives; we still must struggle with the problem of establishing their 'social meaning.' I would suggest therefore that this is an example of 'ceremonial conformity,' in that the Trust was obliged to produce relevant paperwork and to hold these meetings to maintain their 'external legitimacy.' I did not hear any committee member ever question the format of the meeting, ask for any clarification of the order of the meeting, or query what the meeting was supposed to accomplish.

I noted from the June 2003 minutes that because of the increasing workload it had been decided that the committee should meet on a monthly basis during 2004, with the exception

of August when a large proportion of staff took annual leave. There was also a suggestion that thought be given to the time of the meetings, as certain clinical governance leads were unable to attend the Monday morning meetings due to clinical commitments. There was agreement to survey members to ascertain their availability with regard to times and days of the week. At the July 2003 meeting, the committee approved the suggestion that the meetings would alternate monthly between Monday mornings and Thursday afternoons. Following this decision, the meetings continued for another two years until it was raised by a member of the committee group in April 2005 that the Thursday afternoon meeting appeared to be persistently under-attended:

'Attendance at CCGC Meetings
Due to the high volume of apologies it was suggested that attendance figures are compared between the Monday and Thursday dates.' (Extract from April 2005 minutes).

It was again, agreed by the committee that attendance should be reviewed. I thought that this would be a useful exercise to undertake myself as well and decided to complete my own analysis of attendance. Firstly, I consulted the Trust intranet clinical governance website to obtain a list of committee members. There had been no updating of this site since March 2003 and most of the information there, including the list of committee members' names, was completely out of date. I next observed that, whilst there were listed job titles in the terms of reference, there were no names cited, so I contacted a senior member of the committee (a Trust Board member) to ask if there was an up-to-date-list of names kept anywhere. He stated that he did not have the time to respond to my request, but, after some further searching, I now believe that no such list existed. I eventually used the email list for the circulation of minutes to identify members of the committee, as this appeared to be the only resource of committee members within the Trust.

This may seem an irrelevant point, which might have been merely overlooked, but Trust staff may have found it useful to know who their representatives were on the committee. As such, no public list was evident, which is contradictory to the notion in the terms of reference: '*To develop and promote the visions, value and culture of clinical governance across the Trust'* as there was no clear way in which a staff member could identify who the members of the committee were.

I analysed the minutes for attendees at the meetings between February 2003 and March 2005, and on applying some simple quantitative statistical data such as dividing attendees into groups - for example, doctors, allied healthcare representatives, managers, nurses, clinical governance facilitators - I established that, on average, only 33% of committee

members attended Monday meetings whilst 28% attended Thursday afternoon meetings. 26% sent apologies for Thursday afternoon meetings in comparison to 11% on Monday mornings, with a non-response from the remaining members. The evidence therefore showed that there was not much difference in turnout, but the absences may have appeared more visible because of the greater number of apologies.

Following this analysis, out of a possible attendance total at 23 meetings, the key points that emerged from my own analysis of the written minutes were:

- Almost all groups had representation at each meeting.
- Eight committee members had attended 14 or more meetings
- Six committee members had not attended any meetings
- In respect of these six members, from 138 invitations (6x23), only twelve apologies were received in advance.

Yet in June 2005, the minutes stated that:

'(Name) had asked for attendance figures between Monday and Thursday meetings to be checked due to high volume of apologies. There was no relevance to the day the meeting was held.'

This clearly conflicted with my own detailed findings made from the same official documentation. This could have been due to a number of reasons. Either the analysis was inadequate, had not been done, nobody cared, or there was no intention of changing the meeting time anyway. I would argue, based on this finding, notes of the meeting and on the comments made to me in informal discussion such as:

"*There is no corporate response – nothing happens"* (consultant),
"Clinicians are not going to co-operate – more work – unless resources are going to be put into it" (consultant)

that overworked committee members became disillusioned and attendance was not seen as their 'real work,' their priority being patient care. An anaesthetist, in another informal comment before one of the meetings, complained to me that he had to attend the meeting, yet had a list of patients waiting to go to theatre. I suggest, too, in this instance, that because of the constraints of the 'charter,'[115] it was difficult for members to translate their own

115 See Chapter 3:16 Rationale for the use of a New Institutionalism Theoretical Framework

goals into organizational goals within the context of the meeting. Whilst there was discussion and debate, the chances of legitimating alternative actions were small and members' choices were limited, so there would appear to be little motivation to attend and contributes *'to a mode of discourse framed by a charter that constitutes the limits of what is thinkable*' (Dingwall and Strong 1997:149). In other word, members could not raise their own agendas and, when they realised this, the attendance decreased.

5.4 Meeting Themes

I made field notes of the formal and informal progress of the meetings. I dated and transcribed these notes following the meetings. I sorted into broad areas items that had arisen at discussion from this data identifying and listing any recurring themes that had evoked discussion. Having acknowledged the numerous themes that arose at the meetings, with no subsequent action taken, I began to wonder whether the committee did serve any actual purpose, apart from maintaining 'ceremonial conformity' and helping to keep the 'organizational legitimacy' of the Trust.

I noted that the committee's terms of reference were clear, with development plans written and presented, but, as demonstrated, these bore little correlation to the recurring agenda items. I then looked closely at the year-by-year clinical governance development plans. I found that some of the activities allocated as *'in progress'* had disappeared or been given another forward target date on the next plan (Clinical Governance Development Plan, 2004, Clinical Governance Development Plan 2005).[116] (See for example under the action point on the Oct 04 Plan: *Ensure that all clinical staff are competent to perform the duties they undertake* and *'review current systems, which assess the competency of medical staff in training.'* Although listed as *'in progress'* this action had disappeared from the Oct 05 plan although a similar one *'Develop and implement competency policy/system for all staff*' was there. One might assume from this that the action from October 2004 had been completed and had progressed to include 'all members of staff', but this is not stated. There are also examples where more detail is presented in, for instance, *'The Trust needs to establish a consistent approach to non medical Staff Appraisals and Personal Development Plans.'* Whilst it is difficult to see, the Oct 2005 Plan states that *'Since April 2005 181 members of staff have received an appraisal training update and 50 new appraisers have been trained, overall in excess of 400 members of staff have been trained.'* There is evidence here of some organizational progress. I present other examples as well in the comparison of plans

116 See Appendix B3 for examples of content from the 2004 and 2005 Clinical Governance Development Plans.

in appendix B3. The Trust was commended on its 2005 development plan, as an example of good practice, as stated in the August 2005 minutes:

'The Clinical Governance Report had been submitted to the Strategic Health Authority which considered the format and presentation to be so good that they had asked permission for them to send it to other Trusts as a template for future reports.'

However, whilst the presentation and format were identified as good, I would argue that this documentation had been scrutinised on a superficial basis, as a detailed analysis indicates that there was a lack of progression in some areas, with some actions omitted and similarity in the content with previous plans.

During my collection of documentation, I observed that there appeared to be a problem with the dissemination of information from these meetings, in that the Trust clinical governance website was not being updated. From my questioning of committee members, it appeared that nobody in the Trust had delegated responsibility for doing this following the departure of the clinical governance facilitator. This was contrary to the clinical governance strategy and Trust vision for having information available for all staff. The last documentation on the site related to March 2003. During the period of my observation, nobody raised this out-of-date information as an issue. When I asked a senior manager in April 2006 why the site had not been updated for three years the intranet site on clinical governance information for Trust personnel disappeared.

I would suggest therefore that these examples illustrate the explanation offered by Dingwall and Strong (1997:148), that whilst there appeared to be one mission, this was in fact reliant on several different charters and it would seem that there was a conflict between the mission of the organization and the charters. For example, the plans, terms of reference, agenda and minutes of the meeting served only to *'provide evidence that certain types of phenomena are admitted to constitute evidence for particular assertions.'* Dingwall and Strong (1997:148) also suggest that when there is a gap between a charter and action it is breached by the production of *'reconciliatory documents,'* in this case the minutes of the meetings. This provided the definition for a '*range of legitimizable accounts'* identified in the necessary production of paperwork, but the actions of members were constrained, in that reports of their activities at the meeting were not always recorded. The significance of this indicates that the minutes of the meeting do not accurately represent the record of the meeting, but stipulate and mediate it. I argue therefore that this explanation, in turn, supports the 'ceremonial conformity' and 'external legitimacy' suggestion (Meyer and Rowan 1977) in that

the Trust had to have these meetings, but the day-to-day reality of content and action bore little relationship to the representation in the documentation.

5:5 Policies and Protocols

I had noted that one of the functions of the corporate clinical governance committee was to approve Trust documentation pertaining to clinical governance in the form of policies and procedures as stated in the terms of reference:

'Approval of policies and procedures required for effective clinical governance and clinical practice across the Trust.'

I established that various members of specialist staff within the Trust wrote these policies and procedures (guided by the Document Control Policy), then presented them to the committee for approval. Following approval, staff were 'generally' informed by email that they had been placed on the hospital intranet as I had elicited in my semi-structured interviews.

KS "How did you know that the guidelines had changed?"

"Because I sometimes get the new policies coming through off email, so I spread it back down to the ward level by the staff information files"

KS "You 'sometimes' get?"

"Yes. I don't know whether I get them all" (EC 7 2).

"I probably consult guidelines and policies in situations where I am aware that they have been updated recently. For example, we had a presentation at governance that the antibiotic policy had been updated recently. I'm prescribing intravenous antibiotics in the next few months; I will probably check the policy to make sure that what I think is the right thing is now the policy" (C 1).

KS "If you hadn't had the presentation, how would you know that there was a new policy on the intranet?"

"Well I wouldn't necessarily, unless it is flagged up on the ( ) home page to say and I can't remember if it has been actually, but then I would. Sometimes I know I am trying to think if I have seen any examples on the intranet recently on policy. There have been some alerts on there but most common alerts I am aware of are related to IT actually, rather than clinical things, you know warnings about bugs" (C 1).

I found the classification of this type of documentation in the Document Control Policy (approved by the corporate clinical governance committee in December 2004) as:

Policy *- documents setting out the organization's position on a particular topic*

Standards *- documents setting out the level of performance that must be achieved*
Protocols *- documents, which specify a sequence of action with which the user must comply*
Guidelines *- documents which specify a sequence of actions with which the user may wish to comply but allows for the use of professional judgment when the use of the guidelines would be inappropriate*

Over the period of my fieldwork, I did see a clear improvement in the conformity of documents presented for approval, in that a document control policy made a difference in the quality of the format and content of the documents produced, but noted that insertion onto the Trust intranet was on an ad hoc basis.[117] I noted comments from members of the committee in respect of these policies.

"Its obvious common sense, we are doing it anyway. I don't know why we need a policy, but it is important that we have one and the means to implement it" (medical consultant).

*"We need secure, appropriate focused effective documentation" (*medical consultant).

I would suggest that it would appear entirely logical to disseminate good practice throughout the NHS by the formation of authoritative sources of national guidelines for standard practice, based on evidence of both clinical and cost effectiveness. The reason is that this demonstrates improvements in quality, because organizations need to be seen to have good information and information systems and it purports to decrease the variation in practice in a move towards 'evidence-based medicine' (Pope 2002). Inevitably, an industry of professional support documentation is emerging, which could be compared to the accountability movement in North America (Wiener 2000). I observed that up to March 2005, two hundred and six of these types of documents had been produced within the Trust. However, in reality, my observations indicated that the approval for the content of this documentation presented a different picture.

I established that there was emailing of the necessary meeting documentation to committee members either a couple of days before, the day before, or even on the morning of the meeting. Sometimes this could include up to ten new policies or protocols for approval by the committee. When I commenced observation in 2003, the discussion of the approval of new documentation was always at the end of meetings, but I noticed that many of the committee members appeared to leave at this point. In November 2003, I asked the clinical

117 See Appendix B1 List of Intranet Policies

governance facilitator why such an important discussion took place at the end of the meetings and was informed that there was no specific reason. She appeared to take the point because at the next meeting, in January 2004, the approval of policies and protocols was the first item on the agenda. However, I observed over a period that the length of the discussion of these policies did depend on the personnel attending the meeting. Sometimes, the approval appeared merely to be a token; for example at the following meeting, giving approval for ten new policies took nine minutes (February 2004):

'Management of Infection Control - Policy approved
Change of Tracheostomy Tube - Policy approved
Notification of Infectious Diseases - Policy approved
Guideline Prevention on Infection in Patients with an Absent or Dysfunctional Spleen - Policy approved
Management of Portable Bench Top bowl/instrument sterilisers - Policy approved
Policy for Management of Transmissible Spongiform Encephalopathies including CJD - Policy approved
Pandemic Influenza Plan - Policy approved subject to amending the policy from 'named individual' to 'title'
Assessment of Patient with Suspected Viral Haemorrhagic Fever - Policy approved
NCEPOD policy - Policy approved'

I wondered in this instance if anybody present had read any of the circulated policies. At other times, however, when different members attended the committee, the debate became lively and policies were referred back to the authors for clarification or further work as indicated by the March 2005 minutes:

'Internal Transfer Document via the Trust Electronic Patient Record (EPR) and Transfer Assessment Document - approved in principle subject to:

- being reissued in the current Trust format.
- Amendment to the procedure's first sentence to include the phrase 'will ensure complete transfer of documentation and all relevant fields completed in the EPR system.'
- A clearer specification as to who is responsible for monitoring, evaluation and review of compliance with the policy.'

I noted that whilst there were numerous discussions about dissemination of these policies to staff, there was not a clear strategy in respect of this, apart from inserting a paragraph about dissemination into the policy. Policies once approved were placed on the Trust intranet in an erratic fashion, but as one member commented in discussion:

"What it doesn't do is make you do it"

Sanderson (2000) advocated the need for information in the form of guidelines, protocols and policies to be available to staff on a hospital intranet in order to support the implementation of clinical governance. Under the remit of clinical governance, policies should meet some basic characteristics in that they should be scientifically sound, written by various stakeholders, and be focused on the applicability of the recommendations. Various authors have produced guideline production cycles to this end (Nicholls and Halligan 2000). In this instance, I would argue that whilst the document control policy addressed the content of policies and protocols submitted to the committee, there was inconsistent approval and at times inadequate discussion at the committee meetings. There was also an unaddressed criticism by members within the committee regarding the continuing lack of any implementation strategy for the dissemination and use of these documents throughout the Trust. This was still an ongoing problem when I completed my fieldwork. I believe therefore that the organization was more concerned with producing the evidence that they had the documentation rather than ensuring a 'culture' within which staff would, or could, use it. Whilst legitimacy is the pre-condition of organizational success rather than its consequence, neo-institutionalism says that 'culture' does matter, both externally and internally. These problems therefore gave rise to another question that I would subsequently ask nurses and stakeholders as to their use of protocols and policies.[118]

As well as identifying themes that developed through the official minutes and informal notes taken at the meetings, I feel that two further examples are pertinent to my argument as to the ceremonial conformity function of this committee. The first involves an aspect raised by a patient representative in October 2003 in relation to the provision of fold-up patient seating in the long main corridor of the hospital in that it would *"provide respite for elderly and infirm patients."* I felt that this was an example of a clear, practical quality improvement initiative for patient care. The minutes stated that the executive nurse supported the idea and would discuss the matter with the General Manager of Facilities.

The minutes from the October 2003 meeting stated:

'Patient Seating in Corridor
(Patient representative) felt that fold-up seating was required along the main corridor between the Red and Purple areas. This would provide respite for elderly and infirm patients. (senior nurse) supported the idea and agreed to discuss the issue with (name), General Manager Facilities.'

118 See Chapter 6:6 Knowledge Management – The Clinical Governance Trust Intranet

One year later in November 2004, the patient representative raised this matter again, as stated in the minutes:

'(Patient representative) *advised that the Patient Focus Group were promised seating on the main corridor and near maternity at a meeting some time ago. The maternity seating has been provided, however there is still no seating available on the main corridor. (name) to bring this matter to the attention of (name – general manager)*.'

At the December 2004 meeting, the minutes stated:

'Seating on the Main Corridor
(name) had agreed a few areas with (name) and these would be in place by mid January.'

Seating was finally evident in April 2005, but not at the sites agreed and it was felt by the patient representative that there were still too few seats, as stated in the minutes:

'Seating on the Main Corridor
(Patient representative) *suggested signs are fitted above the exiting seats as they can easily be missed if there is an obstruction in front of the seats and that another set of seats are fitted further along the corridor.'*

User involvement is a relatively new arena in the health care field. I believe that if this patient representative had not persistently brought this matter up, there would still be no available seating for patients in the hospital corridor. In this case, it would appear that the institution provides opportunities, but the narrow remit of the charter definition imposes constraints on mission action. Institutional rules may be formal, but are also informal. In fact, the important rules are the informal ones, as formal rules can change overnight, but informal rules are very hard to change. Nevertheless, under the 'charter' of improving the quality of care for patients, this was definitely a tangible quality improvement initiative, which would appear to be in conflict with the 'mission,' the members' notion of 'what we are here for.' There was also omission of this initiative in the annual clinical governance report.

The second example presented in detail concerns the 'Do not attempt resuscitation' (DNAR) 'policy.' I was present at the meeting in October 2003, when it was reported that a small team of clinical staff had recently visited five wards specifically to audit compliance with the Trust wide DNAR 'policy.' The following entry appeared in the minutes of the meeting:

'DNAR Orders

Dr ( ) informed the Committee that a small team of clinical staff had recently visited five wards specifically to audit compliance with the Trust wide DNAR ***policy*** (my emphasis)*. The team found that the DNAR* ***orders*** *had been appropriately issued and nursing staff were aware of which patients were not for active resuscitation. However, it was difficult to find the*

DNAR order in the case notes and documentation was poor with no review date stated in any of the notes and in 10 out of 14 cases the DNAR order had not been confirmed by the Consultant.
Dr ( ) proposed the Trust introduce a standard ***proforma*** *for recording DNAR orders which would be printed on the inside cover of every case note. This approach would mean that the DNAR* ***order*** *could be easily located and it would prompt medical staff to document correctly. Dr ( ) supported the form but felt guidance was needed in cases where relatives/carers had obtained Power of Attorney. (Patient representative) stated, that thought needed to be given to address the issue of living wills. Dr ( ) agreed that a patient/carer information leaflet should be provided giving guidance to patients/relatives/carers around Power of Attorney and Living Wills.*
The Committee approved the proposal to introduce DNAR ***proforma****. Dr ( ) to pursue this matter.'*

I noted that whilst the terms 'policy' and 'orders' and subsequently 'proforma' were used in the minutes of the meeting, there was no written Trust policy at this time in relation to DNAR and neither the term 'order' or 'proforma' is defined under the Trust's own document control policy. However, the committee approved the proposal to introduce a DNAR 'proforma.' At the same meeting, an example of 'good practice' in the use of a DNAR policy had been obtained from another Trust and shared with the committee (a case of mimetic isomorphism), but there was no note of this or where the policy had come from in the minutes. Although the medical director had agreed the provision of a patient/carer information leaflet giving guidance to patients/relatives/carers around power of attorney and living wills, at the end of my fieldwork this had not occurred. In November 2003, the medical director reported:

'DNAR
*DNAR Orders Dr ( ) reported that following the last CCGC meeting he had discussed the issue with Dr ( ) who felt that is might be possible to achieve all that had been previously agreed (the introduction of a DNAR proforma) using the EPR (*Electronic patient record). *The CCGC sanctioned implementation via the EPR if it proved feasible.'*

In January 2004, the minutes stated:

'DNAR Orders
Dr ( ) informed members that following the last meeting, he and Dr ( ) had developed a draft DNAR proforma for inclusion in the EPR in order to ascertain if this was a feasible option. The Committee agreed that this item be discussed again after the proforma had been piloted in 2 ward areas.'

In March 2004, the minutes stated:

DNAR Policy
'An EPR pilot solution to the need to ensure DNAR information is properly communicated is to be piloted for a month on a medical, surgical and elderly care ward. Dr ( ) and Mr (resuscitation expert) are to review the proposed system with Mr (a general manager) prior to the start of this pilot. There is a need for a DNAR Advance Directives Policy similar to the

one used by ( ) NHS Trust. Mrs (general manager) is to review this document and discuss its applicability to the Trust at the next Clinical Governance Committee meeting.'

The minutes stated in April 2004:

'DNAR progress: Pilot EPR information on DNAR about to start. DNAR Advance Directives Policy to be discussed at the next meeting and led by Ms ( ) and Dr ( )'

At the following May meeting, the minutes stated:

'DNAR/ Advanced Directives Policy
An Audit on DNAR had been carried out and a second audit was being carried out.
(name) informed the Committee that a pilot electronic system was being piloted in elderly care and if successful, it would be rolled out to the whole of the Trust.
(Name) made a presentation on the Advanced Directives policy, which outlined the good practice that was required. PB advised the Committee that adopting the (another named NHS Trust's) system may be the way forward. In addition, a group was to be set up to formulate the policy and its implementation. The group would consist of (doctors). (Doctor) was concerned as to how do we reliably know in emergency situations that a Directive exists.'

In analysis, I noted that whilst the minutes in April indicated that a 'pilot' was taking place, the minutes in May 2004 indicated that there had been a completed 'audit' on DNAR and a second audit commenced. The minutes stated in May that a pilot had commenced and in June 2004, the minutes stated that:

*'The DNAR Advanced Directives Pilot in Elderly Care had a delayed start but is now underway. A meeting on developing the **DNAR policy** was being convened by (name).'*

There now appeared to be some discrepancies as to the 'function' of the meeting, stated previously as having been set up to discuss the Advanced Directives Policy.

Reports in the minutes in December 2004 stated:

'DNAR Pilot

(Name) reported the system was piloted on the elderly care ward and was very successful, junior staff felt more confident and the outcome of the pilot was positive.
Dr ( ) asked ( ) to describe to the Committee the DNAR electronic process for their information.'

Following this, there was agreement for the pilot to be rolled out. A DNAR **'order form'** is now on the EPR system within the Trust, with the option to print the page out and attach it to the inside of a patient's notes by a doctor.

On scrutiny of the minutes, I observed that there were many discrepancies between what was reported verbally and what was done. From the written minutes, it was clear that information given to committee members varied in detail. However, a change did take

place, in that DNAR electronic 'orders' now exist, but under the terms of the Trust's own document control policy there is no definition of what an 'order' is. The practical implication of this has yet to be tested. It appears that nobody has disputed a dominant medical opinion in the issuing of DNAR 'orders.' No protocol or guideline in this respect has ever materialized, which was the initial function of the DNAR audit. The purpose of the committee was also to set up policies and guidelines for all staff. I would argue in this case that the formal procedure has been '*worked around to deal with situation exigencies'* (Gasser 1986, cited by Berg, 2004:46). Normative isomorphic pressure can describe the DNAR order of events. The medical director at the meeting firstly raised the subject and I have described the process. The difference here is that a DNAR 'policy' did not materialise and the more complicated guidelines concerning living wills have not progressed. An 'order' now exists. This can only be completed by doctors and printed off from the electronic patient record with the reasons for the DNAR, but whilst the importance of policies and protocols for guidance has been endorsed by the committee, nobody has raised the question as to why a Trust-wide 'policy' has not been developed in this instance. There was also discussion of 'adopting' another Trust's policy' that was seen as being successful. I suggest this as an example of mimetic isomorphism.

The following section identifies other common themes that emerged from the discussions at the meetings. Whilst it is impossible to list all the discussions that took place (although identified in my field notes), I was able to group together major topics and illustrate these with some examples.

5:6 Education and Training – Organizational Learning

Education (viewed as continuous professional development) and training (viewed as mandatory updating for fire procedures etc) of staff was a frequent discussion point at the committee meetings and clearly a problem within the Trust. During the course of my fieldwork, mandatory training was running at a 43% attendance rate; nevertheless, the Trust did not have the resources to allow every member of staff to undertake this training. This was often a point of criticism at the neurosurgical unit directorate meetings, as they had many staff on the waiting list and were also listed at corporate level as having high numbers of staff who needed updating.

I have previously referred to knowledge management[119] as *'involving the transformation of unconnected data or information into meaningful and connected knowledge. Knowledge*

[119] See Chapter 2:4 Knowledge Management, Organizational Learning , the Learning Organization and Organizational Knowledge and 2:14 Knowledge Management and Clinical Governance

management could be viewed as the creation of an environment, of infrastructures and processes that enable the achievement of organizational objectives.' Under the terms of reference for this committee, it should have been their responsibility to enable the process but, whilst there was frequent discussion of this topic, no clear strategy ever emerged at the committee meetings to rectify the problem.

The May 2004 minutes stated that:

'All Governance Reports should contain a section on Continual Professional Development as well as training'

However, it was evident that there was priority given to the training of staff in relation to obtaining the necessary litigation authorisation (CNST) in respect of medical equipment.
The June 2004 minutes stated:

'(Name) reported progress training of staff on the use of medical equipment. All wards now have medical equipment coordinators and are completing an inventory of medical equipment held on the wards. This should be completed by the end of July. A corporate database of medical equipment is also being developed together with a record of staff training. Practice Educators are identifying medical equipment training packages. Changes will be needed to the appraisal procedures so that they include a review of staff equipment skills. Job descriptions are also to be amended to include maintenance of medical equipment competence. There are also issues related to medical staff training which are to be discussed at group medical directors meetings. Dr (name) suggested that there was a need for a unified protocol on the taking of basic measurements such as temperature, blood pressure and respirations as there were wide variations in performance.'

This last comment related to a retrospective audit on patients who had deteriorated and been transferred to intensive care, in that the undertaking and reporting of basic observations on patients had become a major issue. More importantly, data indicated that these observations were either lacking, or that inappropriate action had been taken in the reporting of abnormal findings. This, when discussed at the meetings, was felt to be due to the lack of updating or training of nursing staff and health care assistants. In response there was an introduction of an early warning system tool (the Minimum Observation Standard, used elsewhere) in certain areas (in, for instance, the elderly care assessment unit). At the end of my fieldwork period, the dissemination of this tool throughout the Trust was still very erratic. An example given to me by a ward sister was that, with the merger of the elderly care assessment unit with the medical assessment unit, the new documentation (e.g. the early warning system tool) used previously in the elderly assessment unit was no longer being filled in. For some reason, the medical assessment unit felt this to be a retrograde

step in the assessment of patients. It had been suggested that a 'corporate approach to training packages' should be adopted, but the Trust did not pursue this during the course of my fieldwork.

The November 2004 minutes indicated that little progress had been made with the Minimum Observation Standard:

'(Name) commented that observations on patients are carried out largely by nursing staff and that the Minimum Observations Standard should be being used, but it was found that they were not being used properly and this policy was therefore prepared.'

'(Name) advised that the policy should be communicated and ensured that it is implemented fully.'

The January 2005 minutes stated:

'Competence forms are now starting to come in. Prof ( ) stated the problem is there as there is no one in the Directorate for education/training of junior staff, so problems will occur.'

The committee did not follow this through, there was no indication given as to who would be responsible, or what action the Committee would take in respect of lack of training. Nevertheless, one link I found related to the clinical governance development plan, with the ultimate responsibility designated to the Director of Human Resources, the Executive Nurse and Executive Medical Director, with an achievement date of July 2005. This issue was not raised at the Corporate Clinical Governance meetings again.

The July 2005 meeting raised another issue of staff training in respect of blood transfusion:

'(Name) presented Transfusion Update, a new legislation which has been out for two years which sets standards of quality and safety for the collection, testing, processing, storage and distribution of blood and products across the EU. The Trust must be compliant by November 2005.
Non-compliance could lead to large fines, two years in prison or the hospital being closed down. The legislation is aimed at the National Blood Service but there are implications for hospitals.'

It is a CNST requirement to demonstrate training for medical staff at induction.

'(Names) expressed concern that the induction agenda was already full and queried whether training could be given on ½ day Governance Protected Time Sessions. (Name) stated that the whole question of mandatory training for junior doctors and the pressure it brought to their timetables needed to be reviewed.'

No decision or action was agreed at the meeting. This matter was not raised again and in October 2005, the Committee was disbanded. I would suggest therefore, based on my

observation at these meetings and the discussions that took place, that there was no co-ordinated Trust knowledge management system in relation to the points raised.

I argue that this yet again reflects the 'ceremonial conformity' of having a corporate clinical governance committee in order for the Trust to be viewed as legitimate but, as there was no clear delegation in respect of intended action points, it was ineffective. The clinical governance action plan referred to above was not discussed at the meeting but was one of the previously described 'official documents' available on the internet as it was presented to the Trust Board. From these data, although some progress is evident, it is argued that the Trust did not proactively co-ordinate the vision of a learning organization or knowledge management [120] in the education and training of their staff.

5:7 Clinical Negligence Scheme for Trusts (CNST)

From my discussions with members of staff and observation at this meeting, it was clear to me that the topic of CNST overwhelmingly influenced the reality of the day-to-day working in the Trust. Obtaining CNST level one and level two[121] had financial implications for the Trust and affected its application for Foundation status. There was detailed discussion about CNST at almost every corporate clinical governance committee meeting I attended, as noted by some extracts from the minutes:

March 2004 minutes:

'Progress reported. CNST assessment planned for 27th May 2004. Progress on all key areas required have been made. There is now better and clearer integration and coordination with the Trust's risk management systems. Learning from incidents can be demonstrated. The key areas of concern are the lack of up to date records of training. This is particularly of concern for records of SPR's (specialist registrars) *attendance at mandatory training such as induction and records of the competence of staff to use medical equipment*.'

April 2004 minutes:

120 See Chapter 2:4 Knowledge Management, Organizational Learning, Learning Organization, Organizational Knowledge and 2:14 Knowledge Management and Clinical Governance

121 The Clinical Negligence Scheme for Trusts handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) and Primary Care Trusts (PCTs) in England currently belong to the scheme. Individual member contribution levels are influenced by a range of factors, including the type of Trust, the specialties it provides and the number of "whole time equivalent" clinical staff it employs. Discounts are available to those Trusts which achieve the relevant NHSLA risk management standards (applied at different levels against given criteria) and to those with a good claims history. http://www.NHSla.com/Claims/Schemes/CNST/

'Review of CNST/RPST (attached) presented.
The recommendations presented

1. *Proceed with the planned Level 1 assessment against the new Maternity Services standards in May 2004. A detailed Action Plan has been developed by the Service Manager, Children, Women and Sexual Health Head of Midwifery.*
2. *Review whether it is wise at this stage to be assessed at level two in March 2005.*
3. *At a minimum work towards 90% compliance with the CNST Level one standard and this requires that all documentary evidence is available no later than November 2005.*
4. *Are assessed for RPST Level 2 in March 2006*

were accepted. Members were asked to feedback any comments or amendments to the review which they felt needed to be made to (name).
(Name) was concerned that the Trust had not invested enough in the people resources needed to support the facilitation of the achievement of the standards in CNST. (Name) reported that she and (name) would be reviewing the current action plan for achieving CNST level 1 and 2 standards and the resources required to achieve these standards.'
January 2005 minutes:

'(Name) reported the Trust has had to defer Level II Assessment.
There will be a re-assessment of Level I in March.

(Name) reported the Trust has to achieve 95% on five assessments and will then be able to go through to Level II early in the new financial year.'
The September 2005 minutes stated:

'(Name) congratulated the Governance Leads in achieving Level 2 in CNST and achieving 100% in 5 out of 7 standards. (Trust) have requested to be a pilot for the new standards and will be assessed against the amalgamated RPST/CNST standards in 2006.'

Work however continued, as at this time there had been an amalgamation of CNST with yet another set of standards. The final October 2005 meeting minutes stated:

CNST

'(Name) presented to the meeting and gave an update on CNST and the amalgamation of CNST and RPST.
The Trust is being assessed for Level 2 CNST and Maternity Standards in January 2006. An early draft of the revised NHSLA Standards and Assessment for Acute & Specialist Trusts was circulated. Work is in progress at the moment in working towards a higher level of compliance, but (names) both emphasised the importance of maintaining the enthusiasm towards CNST and reminded the committee that a number of the current criteria still required immediate management and it could not afford to wait until nearer the next assessment!'

During the period of my fieldwork, the Trust was involved with applying for both level one and level two CNST statuses. Over this period, the responsibility for CNST shifted from a designated senior nurse manager (who left the Trust) to the associate nurse executive (who became sick) to the ex-resuscitation officer (when he became responsible for risk) and the newly appointed clinical governance facilitators.[122] This was especially noticeable in 2005 with much of the Trust clinical governance facilitators' time devoted to the preparation of

122 Following the departure of the Trust Clinical Governance Facilitator due to pressure of work and the appointment of the new Executive Nurse, Clinical Governance Facilitators were appointed to directorates within the Trust

documentation for the CNST inspection. Frequent updates were given to the committee members and all directorates were repeatedly urged to collect 'evidence' in the form of paperwork relating to examples of good practice, to be included in the portfolio of 'evidence' to be presented to the inspectors. The collection of this data, however, ultimately fell within the responsibilities of the newly appointed clinical governance facilitators, who informed me that they spent much of their time and effort visiting wards, identifying the necessary documentation for inclusion while rejecting other documentation. (One of these facilitators told me that, even when the inspection had taken place and the Trust were asked to produce four sets of correctly completed patient notes, these had taken the full team five hours to find, with hundreds rejected). This added pressure to provide increased documentation and was another issue I subsequently included in my semi-structured interview questioning with nurses and stakeholders.

5:8 Presentations of Audit Findings

My data and observations also revealed information concerning the various reports of snapshot audits carried out on an ad hoc basis in the Trust. These provoked much discussion, but no apparent action. One particular instance seems relevant to mention. In this case, a limited Trust pharmacy audit had found 600 illegible prescriptions on patients' drug charts on one day, in one part of the hospital. This number was reported verbally to the committee, but was not in the written March 2005 minutes that stated:

'Prescription Audit

(Name) briefly outlined the paper. Some of the issues he brought members attention to were:

i) Incorrect ward on prescription
ii) Medicines prescription signatures illegible
iii) Antibiotics with no review date
iv) Prescription entries altered but not signed and dated by Doctor
v) Missed doses of medication no reason given

(Name) reported there would be a time-tabled audit for next year to continue this work.'

There were problems in this instance with limited resources in the auditing of more prescriptions, so one could only wonder what would have been identified if a whole Trust audit had been carried out. In relation to this partial audit, the committee expressed concern and took no further action other than to agree that the situation required improvement. Nevertheless, if the idea of the committee was to improve the quality of care, one can only speculate as to why resources were not made available to address this major

issue. The committee had the stated authority '*To manage the clinical governance budget and the deployment of clinical governance resources,'* but in reality had no allocated budget. This supports the argument that the committee existed to function merely as a 'ceremonial conformity' within the Trust, with the collection of official minutes, and that it did not 'enable' any required change in practice.

5:9 Clinical Care

Interestingly, I noted that there was little discussion about clinical care at the meetings in comparison to agenda items such as CNST in that there were few examples that could be tracked. There was highlighting of the infection control for MRSA (methicillin resistant staphylococcus aureus)[123] only with the appointment of an infection control consultant. This then became a monthly agendum. Nevertheless, committee action was restricted, in that there were no directorate MRSA reporting statistics available for staff, due to 'lack of personnel resources,' as identified by the Infection Control Consultant. This issue was a cause of concern and a frequent discussion point at directorate meetings as remits were given constantly in respect of the action necessary for the prevention of MRSA, but no explicit information was offered as to the extent of the problem; neither were affected wards identified.[124] Infection control and the rise of MRSA clearly became an increasing problem during my period of observation, with the Trust in 2005 displaying the highest number of MRSA cases in the region. (Minutes June 2005):

'(Name) updated the Group on MRSA figures released last week from October 04 – March 05. The Trust has regionally the highest rate in the (region) and is the sixth highest nationally. The Infection Control Team is drawing up an Action Plan to help reduce blood stream infection rates. A new programme is being delivered to reduce health care acquired infections. The Trust to implement a group with clinical leads asking for regular audits by all wards, planning a structured way to cascade information in aseptic techniques and competency testing doctors. Discussions took place around high rate areas and how to reduce risks. It was stated other Trusts will not transfer a patient until MRSA is proven negative; (Trust) has no such policy. Awaiting National Guidelines.'

This report also resulted in a declaration by the committee that each MRSA case had to be identified as an adverse incident. I would argue that resources should have been identified

123 The term MRSA or methicillin resistant staphylococcus aureus is used to describe those examples of this organism that are resistant to commonly used antibiotics. Methicillin was an antibiotic used many years ago to treat patients with staphylococcus aureus infections. It is no longer used except as a means of identifying this particular type of antibiotic resistance. MRSA organisms are often associated with patients in hospitals, but can also be found on patients not in a hospital. Usually it is not necessary to do anything about MRSA organisms. However if MRSA organisms are passed on to someone who is already ill, then a more serious infection may occur in that individual. http://www.link.med.ed.ac.uk/ridu/Mrsa.htm#one

124 This was ultimately resolved when MRSA cases were reported as adverse incidents some months later

earlier if the intention of the committee was to improve systems for the quality of patient care, and to handle this matter proactively before the adverse situation arose. As might be expected, issues relating to nursing were not discussed other than the Essence of Care Project group reporting progress on the implementation of the best practice benchmarks within the Trust. The first time this happened was at the November 2003 meeting:

'Essence of Care Steering Group – Update.

(Two named nurses) joined the meeting and gave an informative presentation to CCGC to present progress to date.

(Consultant) thanked (Names) for their presentation and asked that they provide an update to the CCGC in March 2004.

(Consultant) asked is Essence of Care just for nursing staff. It was clarified that it is not just for nurses but for any group or member of staff involved in patient care.'

I subsequently noted that the group were not recalled at their allocated time. There was no further progress report given until the January 2005 meeting and at this stage, it was identified as an annual report:

Essence of Care – Annual Report (January 2005)

'(Name of nurse) presented and a copy of the presentation will be sent out, to supplement the roles of this meeting.

(Patient representative) commented that the patient that was involved with this project had not been mentioned by name and that it would be a nice gesture to include her name at the start of the document.

(Name of nurse) reported that this had not been intentional and it would be rectified immediately.
(Senior nurse) reiterated that this had definitely been an oversight.

(Name of nurse) was thanked for her presentation.'

This presentation was not sent out with the minutes of the meeting - sending out presentations with the minutes was usual procedure but nobody appeared to notice that it had not been attached. The next presentation was at the October 2005 meeting. The minutes stated:

'Essence of Care

(Nurses' names) gave an update on the 2nd year of the Essence of Care Project. The Project is a rolling programme identifying areas of good practice. All wards have link nurses. Audits have been completed revealing improvements in nursing practice. Campaigns include the Dignity and Respect programme and Protected Meal Times. The Group was awarded a National Award in November 2004.

Plans for the 3rd year include new group members, Essence of Care Awareness Day and the introduction of the 10th benchmark on Infection Control.'

I noted from this presentation that there appeared to be evidence of improvement in the quality of nursing care that I should be able to observe on the wards. I also decided to ask a question in my interviews about the link between the quality of care and clinical governance in respect of these campaigns.

In October 2005, at the end of the committee meeting, the following announcement was made:

'(Name) explained to the CCGC that due to the Trust's application for Foundation Trust status there needs to be a more robust organisational structure to comply with Corporate Assurance. This will be the final meeting of the Corporate Clinical Governance Committee as it stands. A Clinical Effectiveness Committee will be formed instead and (name) thanked the members of the CCGC who will not be part of the Clinical Effectiveness Committee for their time and contribution over the years.'

The committee then abruptly disbanded.

5:10 Summary and Concluding Comments

This Chapter has examined the Trust corporate clinical governance committee meetings, and tracked samples of documents produced by the business of these meetings, using guidelines described by Prior (2003). I examined documents for their authenticity, credibility, representativeness, and meaning (Scott 1990) identified how this documentation informed and structured the decisions made at the corporate clinical governance meetings (May 2001). I observed that there was no reference to the designated terms of reference and set agendas. Using evidence from the analysis of documents considered by the committee, I identified a 'ceremonial' management of clinical governance within the Trust.

I would therefore argue that if viewed with reference to new institutionalism theory, whilst these meetings met the 'coercive' external criteria requiring a relevant corporate committee in order to be recognized as legitimate, in reality the meetings were diverse, appeared ineffective and did not comply with the terms of reference. From my evidence, I would argue that considerable organizational effort was invested in something that few insiders appeared to take very seriously. A corporate committee was set up but attendance was patchy and not monitored. The committee approved policies with little or no debate. Organizational time and resources were consumed, and a stack of paper generated, but, ultimately, actions did not follow. It could be that the basic problem is that any committee has on it people who

have different preferences, but must come to an agreement by voting in accordance with how they rank particular issues. Virtually any coalition is unstable and can be unseated in a new vote. This is particularly the case if decision-making extends over several time-periods: minor changes in committee personnel can lead to dramatic shifts, which then shift again, as shown in the recorded attendance at these meetings.

This supports the argument that the Trust used documents as a means to achieve 'organizational legitimacy.' Whilst some protocols were proactively discussed (depending on the attendance at meetings), approval of protocols and policies seemed at other times to be just a paper exercise (ten protocols in nine minutes being one such example) and then published on the intranet, but without any attention to securing compliance. More importantly, the dissemination, implementation and embedding of these protocols in working practice was obscure.

By using these three detailed examples, I tracked official meeting minutes and compared these with my own observations. Whilst there were issues identified for action, many more simply did not appear in the documentation again. Nevertheless, there was no reflection of this in the displayed minutes, which simply portrayed the 'ceremonial purpose' of this committee. This evidence corresponds with the model of 'mission' and 'charter' as described by Dingwall and Strong (1997).[125] I would therefore question the function of this committee and argue that it did not add to quality improvement, but merely existed as a symbolic demonstration of conformity with clinical governance.

My conclusion is that although from a quality improvement perspective the committee was ineffective, from a new institutionalism viewpoint it was highly effective in that it did accomplish external legitimacy (Meyer and Rowan 1977) for the Trust in that it could produce the right sort of documentation to meet its external commitments. The minutes of the meetings appeared in a format suitable for publication, in what the organization would like to be thought to be doing, but did not display a literal account of the meetings.

Having described the main Trust meeting concerned with the implementation of clinical governance within the Trust, the next Chapter will give an account of the other meetings that took place at the various levels throughout the Trust including meetings within the two directorates: neurosurgical and elderly care. Subsequent comments made in respect of issues raised at these meetings by staff are included where relevant.

125 See Chapter 3:16 Rationale for the use of a New Institutionalism Theoretical Framework

Chapter Six

Meetings and the Organizational Process of Clinical Governance

6:0 Introduction

The last Chapter discussed the analysis that had arisen from the corporate clinical governance meeting. I argued that the documents I observed portrayed the 'official' version of the conduct of the meetings, and reflected what the organization would like to be thought to be doing. When examined in depth, however, these same documents indicated that the records were at times inaccurate and had many inconsistencies. However, viewed through the lens of new institutionalism theory, the Trust could be identified as being highly effective, in that it had produced the right documentation for the accomplishment of external legitimacy. This Chapter considers other clinical governance meetings taking place at other levels within the Trust, which were intended to implement and disseminate information about clinical governance: in effect the 'knowledge management' and 'organizational knowledge' systems that the Trust had implemented for the clinical governance process. To illustrate some of these knowledge-management processes, quotations from the interviews are also presented and analysed.

6.1 The Executive Sub-group Meetings

When I first commenced my fieldwork, I attended meetings held by a Trust executive sub-group. This was the next group down, described to me as the 'implementation group for the Trust corporate clinical governance committee.' Members included the Clinical Governance Medical Lead, the Executive Nurse, a General Manager, the Director of Quality and the Trust Clinical Governance Facilitator. Other Trust personnel, for example the Complaints Manager, were invited to submit reports if issues arose. The hospital Clinical Governance Facilitator was responsible for the writing up and circulation of the minutes and action plans from the meeting.

This smaller sub-group met every two weeks in an operational capacity, with a remit to drive clinical governance implementation forward within the Trust. The formal documentation stated that this group was responsible for preparing the clinical governance implementation plan and ensuring its delivery in alignment with concurrent Trust plans and policies:

- Creating the environment for clinical governance
- Monitoring the implementation

- Reporting on progress to the corporate clinical governance committee at each meeting
- Placing issues for resolution before the corporate clinical governance committee

I established that, whilst this group reported to the corporate level meeting, it also dealt with any day-to-day problems brought to its attention by the directorates or by the Clinical Governance Coordinator. The specific designated action of the group was through an updated two-weekly action plan. It also monitored Trust risk and adverse incident reporting. The first meeting I attended in April 2003 started at 17:05 and took place in the Nurse Executive's office. Introduced as 'a nurse doing a PhD on nurses and clinical governance,' nobody asked me to elaborate on this. Present at the meeting was the Executive Nurse, Assistant Executive Nurse, a Consultant and Clinical Governance Co-ordinator. I established that the executive sub-group of the corporate clinical governance committee comprised the Medical Director Clinical Effectiveness, Executive Nurse, and Director of Operations, supported by the Clinical Audit Co-ordinators, the Risk Management Manager and the Clinical Governance Co-ordinator.

I had been provided with an action list dated 9:01:03 by the clinical governance facilitator. At the time I did not question the date of this document, but the delay of the progress of the actions it contained became evident later. The Consultant took the lead at the meeting, going through each action point with a brief discussion on each. The Clinical Governance Facilitator clarified various points for me. The Assistant Executive Nurse complained that she kept receiving emails from a professor in elderly care concerning adverse incidents in the elderly care directorate and she did not know why. (As a participant observer in these elderly adverse incident meetings, I was already aware that he had taken the lead with adverse incidents in elderly care, which was why he was contacting her, but she appeared to be unaware of this).

The next meeting took place in the formal hospital boardroom. I was introduced to a senior general manager who commented that I must be there to 'check up on them.' He left the meeting after fifteen minutes. I noticed that this formed the basis for his attendance at most meetings, leaving early or frequently throughout, or not attending at all. I brought this up in his semi-structured interview conducted some considerable time later and was given a contradictory response:

KS "Do you think attending meetings is an important thing for clinical governance?"

GM 1 *"I think it's important, for people to discuss their own clinical issues and around clinical documentation and about everybody understanding that, what that one thing in the notes must mean the same to everybody, so yes I think it is."*

KS "One of the things that I've actually done is analyse the attendance at corporate level meetings and quite frankly you're one of the ones noticeable by your absence."

GM1 *"That's right, it was agreed about a year or eighteen months ago that not all the executives needed to go to clinical governance and so there was an agreement and directorate members, and I think we don't necessarily have to come. Now that, so that's, that was what was decided, that was actually instrumental of the governance committee in the first place in agreement. With us moving from governance to effectiveness, I'd certainly make a conscious effort to try and go to them."*

In July 2003, membership of the group widened to include the Patient Advisory Liaison Officer and the Complaints Manager, who then attended on a regular basis to give feedback on the progress of any serious complaint. Other designated members of the group continued to give apologies, including the personnel manager and hospital general manager, on a regular basis. It became increasingly evident that there were many decisions taken outside and independently of the meeting, so I began to wonder what the actual function of the committee was (Appendix B5). In late July 2003, it was also apparent that the clinical governance facilitator was becoming increasingly frustrated with her role, lack of progress and workload. A carefully worded document written by her, but tabled in her absence (ironically, as she had not been present at the meeting, no minutes were produced), requesting more resources, resulted in the appointment of two management trainees to help her, but both had specific designated managerial project work, so these extra resources were, in practice, little use to her. This proved to be an element in her subsequent decision to leave the Trust, in January 2004.

Apart from the CNST action plan progress, the issues raised in the meeting continued to focus on subjects such as pedal bins on the ward, cleanliness, culture change priorities, 'changing the system' and education and training. However, despite this discussion, the varying attendance at the meetings meant that hardly any issues on the action plan progressed, as people either sent apologies or omitted to send any feedback on progress. In November 2003, it became obvious to me that other conflicting working groups had been set up. For instance, a personnel group had been identified within the Trust to address communication issues, while a nursing group were simultaneously gathering information on the same topic in the context of The Essence of Care initiative, but these were not co-ordinated, although I knew that other members of the committee had knowledge of both. Comments made by various members that 'everyone is doing their own thing at the moment' were very pertinent, but the issue was not resolved.

In May 2004, I observed that the members at the meeting became heavily involved in the progress of the clinical negligence scheme for Trusts assessment at level two. I observed that there was discussion of little else and the action plans changed and became focused on meeting the standards required in the time allowed, as demonstrated by the May 2004 minutes.[126]

I concluded that the terms of reference for this committee had been abandoned. The overriding organizational goal at the time was the completion of the CNST paperwork and that became the committee's real work. Due to the frequent non-availability of various staff members, many action points could not progress;[127] consequently, this led to actions being held over for weeks, and the plans becoming longer at each meeting.

The May 2004 meeting was the last meeting of this committee. The meetings suddenly ceased without warning and the committee disbanded. It had become apparent to me that few members felt inclined to attend the meetings or do the work involved. Again, I suggest that the committee was initially constructed mainly for 'ceremonial conformity' purposes that contributed to the Trust's perceived legitimacy. Many months later I was informed that the new executive nurse felt that the meetings were unproductive, which concurred with my own observation. This decision did, however, correspond with the appointment of directorate clinical governance facilitators who became responsible for the clinical governance collection of evidence for CNST, which had become the 'real work' of the committee.

6.2 Directorate Meetings

I established that the directorate committees[128] were designated, by their terms of reference, to meet every two months, and report formally every six months, when their clinical governance leads (all doctors) gave the progress report on their behalf to the Trust corporate clinical governance committee. The clinical governance leads for both the neurosurgical and elderly care directorates were members of the corporate clinical governance committee. Nevertheless, I noted that, due to fixed clinical commitments, one was rarely able to attend and the other attended infrequently, although their responsibility was to disseminate any information from this meeting back to their respective directorates. There were, again, very

126 See Appendix B4 CNST Action Plan

127 See Appendix B5 Extract from the May 2003 CG Sub-Committee Meeting

128 Each management group clinical governance committee usually comprised the Medical Director, Associate Director of Nursing (or equivalent), General Manager, Risk Management co-ordinator for Group, Clinical Audit Co-ordinator for Group and Corporate Clinical Governance Co-ordinator. Others (e.g. Group Clinical Governance Medical, Nursing or Management Leads) were co-opted as required.

specific detailed formal remits[129] for these committees. It became evident, whilst undertaking fieldwork, that the neurosurgical and elderly care directorates had different approaches to convening their directorate meetings, as will be explained.

6.3 The Neurosurgical Directorate

A senior multidisciplinary management group met monthly within this directorate. Members included the Clinical Governance Coordinator for the directorate (at the time the fieldwork commenced, the neurosurgical directorate was the only directorate to employ a specific person to manage clinical governance, paid out of directorate funds), consultants, senior nurse managers and senior members of the professions allied to health, together with the general manager for the directorate. The structure of the meetings was based on a standard agenda, prepared by the Clinical Governance Coordinator, informed by the terms of reference from the clinical governance strategy and by the precursor documentation for Standards for Better Health (Assurance, the Trust Agenda DH 2002). The meetings were held in a seminar room on one of the neurosurgical wards.

I began to attend these meetings in May 2004. Although supposedly an observer, I was frequently included in the conversation or asked to comment if, for example issues were discussed concerning education or training and student nurses. This (occasionally) incurred a blurring with my research role. As previously outlined, the protected time facility within this directorate was utilised at a local level, with interest groups (for example for those concerned with multiple sclerosis) and specific professions (such as nurses) convening meetings. However, during the course of my fieldwork I was not able to meet with any ward nurse who had attended such a meeting within the directorate.[130]

Minutes of this meeting were initially available through a local neurosurgical directorate clinical governance website. The neurosurgical unit had also invested in and appointed a specific person for, the dissemination of information concerning clinical governance to staff within the directorate. Various sources were utilised in gaining information for staff to display on their neuroscience intranet site.

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129 Ensure that national specialty level priorities are implemented appropriately, review minutes / action notes from their group directorate clinical governance committees. Review reports from their group on patient experience, clinical effectiveness and risk management effectiveness and ensure appropriate actions are being taken. Consider and advise on trends arising from adverse incident reports and complaints. Advise on and support appraisal, education, training and development across the group and facilitate the sharing of best practice across their directorate

130 See Chapter 6:4 Organizational Knowledge Protected Time Meetings

At one of the early meetings, it was noted that there were several inconsistencies between what they were being asked to do and what they were able to do, because of the restricted resources and the nature of the software provided by the Trust. For example, mandatory training figures for the directorate were low, as had been identified in a report submitted to the corporate clinical governance committee. However, when the directorate attempted to give names in for training, they found that there was a seven-month waiting list for Trust training provision. The Trust stated that Education and Training were priority issues, but at the end of my fieldwork, this was still an ongoing concern as no extra resources had been provided.

Another issue was MRSA, previously mentioned.[131] I noted that the adverse incident reporting figures were inconsistent with the number of incidents because of a software problem and because the inclusion of protocols and policies on the Trust intranet was so disorganised they were impossible to work with. Nevertheless, when members of the committee tried to discuss these issues at corporate level, no action was forthcoming as indicated by the February 2005 minutes:

'(Name) tabled that he still needs to liaise with the infection control team to look at acquiring the MRSA swabbing information that is routinely collected by the Trust so it can be fed back down and actioned within the governance group'

'(Name) tabled again the idea to look at obtaining the national clinical indicator and infection control information that is routinely collected by the Trust as this information was readily available and so not requiring any additional audit or work.'

(September 2005):

'There have been 2 MRSA bacteraemia recently.
Unfortunately, there have been no reports produced recently. (Consultant) asked whether it will be possible to have some reports for (name) for the next Clinical Governance protected time. (Manager) advised that we can get and we were hoping to set up standard reports for each area that the leads can pull off themselves.
The importance of providing reports on trends was noted and it will be one of the first jobs of the new (clinical governance) appointee to set up the standard reports.'

The lack of response supported the notion of 'ceremonial conformity', and, to some extent, even organizational hypocrisy, as I observed comments from corporate level that the directorate was rebellious and difficult to manage because its members complained about the support systems not working (November 2004 minutes):

131 See Footnote 123

'Concerns were raised across the table as there has been no standardised approach across the Trust and no systems in place for the collecting of evidence for the requirements of CNST; this together with the associated timescale and the work being carried out, was considered to be a reactive rather than proactive approach.'

and questioned the point of supplying data when the results were not fed back. Based on my observations, I would argue here that the neurosurgical directorate did take these issues seriously and their concerns were that, when they did try to use the designated systems as advised, they did not work. It could also be that the more specific issues arose because the neurosurgical unit was the only directorate to invest in the appointment of a clinical governance facilitator, a person specifically responsible for the dissemination of information about clinical governance to staff within the directorate.

This person highlighted most of the difficulties encountered when using the systems to record the requested data and, due to his own frustration, had also set up a directorate clinical governance information intranet site. At one of the meetings, he gave a demonstration of the intranet site to the directorate committee. This site was specifically designed to disseminate information to staff about clinical governance and was, at the time, viewed as an example of good practice. It was evident that certain protocols formulated by different hospital Trusts were being placed on this site. Powell and DiMaggio (1991) argue that the greater extent to which technologies are uncertain or goals are ambiguous within a field, the greater the rate of mimetic isomorphic change, but in this instance it could also be seen as the development of best practice. However, when the role of the clinical governance co-ordinator changed and he moved out of the directorate, nobody had continuing responsibilities for following through this initiative. Eventually both the neurosurgical and the Trust clinical governance intranet sites disappeared, but, as I found in my interviews, and will discuss later,[132] their presence had made no difference to staff knowledge anyway.

6.4 Organizational Knowledge – Protected Time Meetings

I was therefore interested in how staff did gain appropriate knowledge to inform their practice. Sometimes the hospital newsletter contained general information about clinical governance. There was occasional information in oral updates for staff as part of the monthly managers' briefing,[133] and in the resulting newssheet circulated to each ward in an email format. The third source of shared information was to be found in the policies and

132 See Chapter 6:6 Knowledge Management – The Clinical Governance Trust Intranet

133 Monthly Managers Briefing meetings were held for senior nursing managers on general management matters

protocols placed on the hospital intranet. Fourthly, from my observations at the Trust, I had established that quarterly 'protected time meetings' for all members of staff had been initiated by the Trust Board for clinical governance activities. Each directorate's clinical governance lead was supposed to convene these within his or her directorate four times a year. Outpatient clinics and elective surgery theatre lists did not take place during these designated half-day protected times in order to allow staff to attend the meetings.

The elderly care directorate held a large multidisciplinary meeting with all members of staff invited. The neurosurgical directorate had smaller delegated meetings in areas of medical interest for staff, for example, illnesses such as multiple sclerosis or stroke. Nurses were invited to attend these meetings if they wished or had the option to arrange their own. Although fairly well attended by other disciplines, it was evident from my observation that attendance of nurses at these meetings in both directorates was infrequent, and noticeably lower in the neurosurgical directorate where some meetings commonly failed to take place on protected time days, with no records formally kept of staff attendance (although it was a Trust requirement). By contrast, other meetings in neurosurgical (such as the stroke meetings) had a reputation for a dynamic leader, a proactive approach and higher attendance. Despite these arrangements, when questioned in interviews, many nurses had no knowledge of any of these meetings, and those who did commonly did not attend. An F grade sister commented:

"Talking about the protected time, now that you mention it, I do remember we were told the X-ray dept, once. I remember them saying we've got protected time this morning so we're not doing any, and I remember thinking well, if they can get it, but we're never going to get protected time because who's going to be left on the ward if that happened? It's the same as everything, we're busy on the ward, the shift's busy it comes to the end of the day you think do I want to go to a meeting or do I want to go home and it's bad, you choose you want to go home I mean…" (N 6 2).

However, attending meetings did not appear to be a specific area of concern to nurses. I would argue that attending meetings was seen as being intrusive on their real work, which was looking after patients on the ward. Matrons, and sometime G grades, could go to meetings, ward staff did not. Issues such as meetings, paperwork and even clinical governance requirements intruded upon the routine of this real work. Meetings were not a priority and there was no coherent system noticeable of any advance planning on the wards to allow different staff to attend meetings. It was evident therefore that staff were at a disadvantage in making sense of clinical governance and that any change in practice in relation to clinical governance did not occur from attending meetings. Nevertheless, managers believed that change took place by personnel attending meetings:

"In terms of medical services, the links are there through our coordinating meetings for governance, so we have regular coordinating meetings" GM3).

Managers did not appear to recognise the difficulty that nurses experienced in trying to attend meetings:

"I think that ward managers, they can do something about that themselves, the dates are known for the next twelve months. I agreed that six weeks ago, so they were available from October 2005 to the whole of 2006, throughout the whole of the organization. If people then sit down with the rosters, then it's complicated but it, it is do able if people have got a will to make sure that they use that time" (GM1).

However, nurses were not always in a position to know what staff they would have a year (sometimes even a day) in advance, or how busy the wards would be on the days the meetings were arranged. These work pressures were evident within the elderly care directorate:

"I don't know, it sounds as if I am whinging, but it is time constraints, staffing levels, although the Trust will say, have remained consistent, they haven't, trained staff have been reduced and reduced and reduced, replaced by people like assistant practitioners, who are not trained nurses at the end of the day. So that puts more and more pressure on qualified nurses, paperwork has quadrupled, the number of meetings that are mandatory has gone through the roof and it all adds to time constraints that previously were not there" (EC 7 1).

6.5 The Elderly Care Directorate Protected Time Meetings

The elderly care directorate utilised their six half-days a year 'Trust designated Protected Time' for large clinical governance directorate meetings. No outpatient clinics took place on protected time half-days. I began to attend these formal meetings in May 2004 as a participant observer. The last meeting I attended took place in January 2006. The meetings took place in different large rooms within the directorate and had a formal character. Attendance at this meeting was generally good by doctors and professions allied to health, but as previously mentioned, extremely poor in the case of nurses. The matron often spent time phoning the wards at the start of the meetings to remind them to attend. This generally resulted in a delayed start and one or two more nurses appearing. I knew many members of this directorate (which again led to a slight blurring of my role), but was able to remain detached from discussion within the meetings, as the members respected my research role in this context. I describe some points from a typical meeting that took place in September 2004.

An invitation had been extended to all wards by email to attend the meetings. It was apparent in my later questioning of nurses, however, that this invitation was not widely known:

"I've not attended any meetings" (EC 7 5)
KS Are you aware of the Trust protected time?
"No" (EC 5 1)
KS OK. So, you have never been under protected time within the directorate?
"No" (EC 5 1)
KS Half study day?
"No" (EC 5 1).

In this instance, all the medical elderly care consultants attended the meeting, together with junior doctors and other health care professionals. Lack of nursing representation from six of the eight directorate wards was, as usual, noticeable, although the matron of the directorate attended. It was evident that there were knowledge management technological attempts to circulate information about clinical governance within the directorate in that minutes of the most recent corporate clinical governance meetings were emailed to all the elderly care wards. The clinical governance lead (a doctor) also gave verbal feedback from the minutes of the most recent corporate clinical governance meeting to all staff who attended.

The 'set remit' under the terms of reference for the meeting was to enable directorate staff to discuss and review the records of their clinical governance activities. There was a six-monthly presentation of these activities to the corporate clinical governance committee. As part of the remit for the six-monthly reports to the corporate Trust board, the elderly care directorate had to produce evidence of progress made in the availability of national and local policies and guidelines for staff use within the directorate. To this end, the clinical governance lead for the directorate had produced a brief report for the committee under the headings Policies, Pathways and Guidelines, listing national, professional, Trust and older-person related services and policies available. The report listed these relevant policies and gave their location as 'Care of the Elderly' or the Trust Intranet. There was provision of a self-assessment form by the Trust in order that the directorate could rate themselves on any progress made. Following the meeting, the minutes stated:

'Dr (name) commenced the meeting by presenting to the group the report that he has been concentrating on for the past 2-3 weeks. The report is to be presented to the Trust Management Committee by Dr (name).'

The actual discussion of this report took two hours at the meeting. It incorporated concerns with the design of the assessment form and what was being asked, but eventually the directorate awarded themselves (based on the paper evidence) a rating of '3' for policies pathways and guidelines. This equated to the given criteria for measurement: *'cause for concern, more weaknesses than strengths, several areas require urgent improvement, credible, appropriate changes planned.'* The rationale for this was in *'getting extra resources if we mark ourselves down'* (comment by a professor). The complete self-assessment report was forwarded to the medical management committee for presentation at the corporate clinical governance committee meeting. As previously stated, the elderly care directorate was part of a larger directorate and the medical management committee was responsible for reporting to the corporate clinical governance committee.

It was interesting to note that the rating scale for the self-assessment appraisal was unclear, and, unknown to the elderly care directorate, the medical management committee had changed this to yet another format. The elderly care directorate, in ignorance of this, had produced a report using the first rating scale (although they gave an explanation). The medical management committee, subsequently corrected this rating using their tool, but in doing so inadvertently changed the rating for the directorate to *'acceptable, strengths exceed weaknesses, several areas for improvement identified and changes planned.'* It appeared that nobody apart from me noticed this or, if they did, ignored it.

After the elderly care directorate meeting, I attempted to locate the directorate-listed policies, but this proved to be difficult. Despite the report that they existed, nobody knew where they were. National policies are available via the web, but these were listed as being within the directorate and the directorate general manager told me, 'presumed' to be in 'somebody's office.' When enquiring about the local directorate policies it appeared that a secretary was in the process of putting them on the intranet, but this exercise was not complete. To date I still have not located these documents or the secretary and doubt that they have are within the directorate.

Although the terms of reference were not used to guide the meetings, at the beginning of my fieldwork they were quite lively, with a variety of topics discussed. However, with the continued absence of nurses, the last meeting I attended in January 2006, mainly consisted of, and was dominated by, doctors and focused completely on medical matters: for example, reports of medical audits undertaken. At this meeting, nobody questioned the focus, or raised any general issues concerning clinical governance within the directorate

6.6 Knowledge Management – The Trust Clinical Governance Intranet

Reference has been made to knowledge management[134] that *'adopts a technical approach aimed at creating ways of disseminating and leveraging knowledge in order to enhance organizational performance'* (Easterby-Smith and Lyles 2003:3). I have also mentioned the considerable number of policies and protocols[135] that appeared on this intranet over the period of my fieldwork. Following the meeting, I spent some considerable time in looking at the Trust intranet, which I can only describe as cumbersome and slow. There appeared to be no logic or order (at that time) to the one-hundred-and-fifty Trust policies relating to various local guidelines, twenty-one infection control and seventy-six patient group directives. A search for 'clinical governance' located hundreds of documents, many untitled, again in no obvious order. Following the search, it appeared that if one needed to find the 'clinical governance' intranet site the word 'clinical' was the search word to go for, as it was not listed under 'clinical governance.' 'Clinical' would bring up the designated site, which, when found; only contained six out-of-date documents relating to clinical governance.

From my own difficulties, and the time I spent in trying to find documents, I questioned the extent to which policies are utilised in practice on a day-to-day basis for knowledge management purposes. I was still interested in establishing if these policies were acting to 'improve quality,' 'regulate professionals,' or, more importantly, if the information provided was in fact used and beneficial in practice. Based on my own experience, I am sure there would not be the time for any busy ward-based nurse to find them, which would not be a surprising finding. I identified this as a further point for investigation in the questioning of stakeholders and nurses and subsequently asked if matrons could give an example of a situation, in which they, or a colleague, might consult a protocol, guideline or a policy:

(Long pause).
KS "Do you want me to come back to that one?"
"Yes please"

(Some time later)

"OK adult protection. If you had somebody that you suspected was being abused then I would refer to guidelines how a referral should be made and what should be done."
KS "And these are the guidelines on the intranet?"
"Yes."
KS "OK. Do you find them easy to use?"
"No they're very difficult to find, even the simplest thing like the work wear policy,

134 See Chapter 2:4 Knowledge Management, Organizational Learning, The Learning Organization and Organizational Knowledge
135 See Appendix B1 List of Intranet Policies

you have to trawl through things and you can't immediately put your hands on it."
KS "Have you ever complained about it at all?"
"I think we have complained as a directorate, particularly the medical staff find it very difficult to find policies and protocols on there" (EC 8a 2).

These were surprising examples, as the rate of adult abuse is relatively low in terms of other occurring policy events and if work wear policy is regarded as 'the simplest thing' one might wonder why it was being referred to. The comment: "I *think* we have complained as a directorate" is significant as an indication that despite her own concern, the matron had not pursued this issue any further, leaving it to 'the directorate' which reflects the notion of hierarchy and nursing still as a subordinate profession. It is, however, also an indication that the matron would look at policies when she was not sure of how to proceed. Other matrons were more explicit:

"Whenever I was unsure about an area of practice" (N 8a 1)

"I think we do, well I look at protocols and guidelines quite regularly, one because I'm involved in the development of some of them even though I'm not in clinical practice such things would be like last offices, pulses and things like that. But investigating a complaint or an adverse incident we look at all the protocols that are in place for that, so we would look at them and see where we had, where we didn't follow protocol procedures, or if we did where it went wrong and if the protocol needs reviewing" (SN 8a 3).

There was a point made here that there was a use for policies and protocols to check practice in the event of a complaint or adverse incident. However, the assumption was, in this instance, that protocols and policies were there to provide an evidence-base for working practice. I pursued this with ward-based nursing staff, as to whether they could give me an example of a situation in which they or a colleague might consult a protocol, guideline or a policy. I found, as might be expected, the examples given related more to the issues apparent within everyday practice, as in a G grade ward sister's response:

"Yep, NG (nasal-gastric) tube feeding, they've just changed the indicator. Levels of NG feeding and how you establish that it's in the right place or not" (EC 7 3).

Another G grade used this example:

"Tracheostomy care, we have a lot of 'traches' through here so that's one guideline that's quite regularly consulted by the junior staff if they are not sure…" (N 7 1)

However, none of the junior nurses questioned could give me a specific example of any one situation in which they would consult a guideline or protocol, although an E grade nurse contradicted herself:

"I always look at nursing skills; I haven't done for a while" (EC 5 1).
"We have printed off a lot of policies recently" (N 5 2).

Three issues arose from these answers; the first is that, of all the protocols placed on the intranet specifically under the remit of clinical governance, there was only one practical example (tracheostomy care) mentioned by any grade of nursing staff. The rest of the protocols mentioned were already on the intranet, located there outside the remit of clinical governance. The second issue is the practical difficulty nurses have in finding relevant documentation on the intranet. The third, that there is 'a hit and miss system' within the Trust for notifying staff about new policies on the intranet in that 'sometimes'[136] they are informed via the email system, sometimes they are not informed. Whilst these were 'flagged up' as 'new' on the site, the knowledge management system of keeping staff informed about new policies is clearly unreliable. These findings are consistent with other studies: for example, Berti and Grilli (2003) found that guideline developers do not pay sufficient attention to the issues of implementation and that practice guidelines do not change professional behaviour. Therefore, the issue of the auditing of practice as to whether personnel are following relevant guidelines becomes apparent.

I then raised this aspect with all of the stakeholders, in order to establish their knowledge and use of these documents. It became evident that managers were concerned with 'legitimacy' and 'regulation' in the approval of protocols, but tended to avoid the implementation issues:

"I am more involved in making sure that the right levels of approval have been achieved…I basically control the final stage of the authorisation process. If I say that you haven't got the right authorisation or endorsement then obviously it does not go through" (GM 4).

*"If there are complaints coming in and I see the complaint is about our chief executive, then we'd refer to a protocol there, and obviously want to just check the protocol beyond clinical issues regularly " (*GM 1).

As these senior managers were both instrumental in the implementation of clinical governance, supported by an evidence-base placed on the hospital intranet, the situation was confused as to whose responsibility it was to ensure that the right knowledge management systems were in place for dissemination of these policies. If the managers avoided this, then implementation and dissemination of these policies appeared to me to be an unaddressed issue, so in essence, there was no effective Trust 'learning organization.'

Consultants did appear to consult guidelines

136 See Chapter 5.5 Policies and Protocols

"I consult protocols, guidelines, policies fairly frequently as a result of a failing memory….I take part in acute general medical take; I frequently encounter problems that are not part of my day-to-day practice" (C 2).

Overall, senior members of the medical staff in identifying that the systems did not work nevertheless appeared unconcerned, using expressions such as *"in situations where I am aware' 'unless it was flagged up."*

The professions allied to health indicated that where there was an established body of knowledge, as in for instance drugs, national protocols were frequently utilised as part of everyday working practice but that this also related to tangible types of effectiveness:

"On an almost daily basis pretty much" (AP 2).

A frequent complaint made by nursing staff was that policies and protocols were difficult to locate on the intranet.[137] In order to ascertain whether other health care professionals encountered this issue, I asked a senior physiotherapist if the policies were easy to find on the intranet:

"Now I know where they are on the system, yes. I am not saying everybody would, but I have had quite a lot of time practising using them so it…..some of them are easier to find than others….." (AP 4).

As identified from the nursing responses similar issues arose from these answers; there were few practical examples mentioned by any health care professional about clinical governance protocols. Again, there was identification of the difficulty in finding relevant protocols quickly and that finding relevant protocols required practice. There was not a robust system for notifying staff about new policies on the intranet within the organization.

Managers had a slightly different perspective on the use of policies, as indicated in responses to my question as to whether they found the intranet site easy to use:

"No it's often quite hard, because some protocols. I suppose clinical protocols, most of those are there and they actually are quite easy if you are looking for something if you know what you are looking for, it's knowing what you are looking for and what heading it's been put under or someone will say, it's pasted on the website, so you will go and look. I think the search engine could probably be better" (GM 2).

KS I'm thinking about a busy D grade or band 5 (nurse).

137 See Appendix B 1 List of Intranet Policies

" I don't think it's that easy to follow, when I go in to look for things, because we've had a complaint or a coroners report and we say, where's your policy and that sort of thing and it isn't that easy to find things" (GM 2).

Interestingly, the focus of the use of a protocol changed here from the manager's perspective, with a hint of a regulatory function (which will be discussed later), but he missed the point of my comment:

"Again it depends I think, I don't think, I don't think the way its presented its always clear that new policies and new protocols are there. I think that I've had recent examples of that…. I find the front page cluttered really, and I think there must be a better way of presenting….. I think it, some of it, when you do get in can actually get to new policies relatively easily but I think then It is quite variable getting, getting into other elements of the sign ups and the finding things. And I don't think it's you know that easy to get around for people" (GM 3).

KS: Taking an example like that, how would you express concern, what would be the system that you would express concern about - the front page of protocols?

"I think I would go to the web master, but also maybe to our own governance. Depending on how urgent or what it was" (GM 3).

Yet this site structure and appearance remained unchanged throughout my fieldwork.

Another Manager responded by informing me about a recent written protocol:

"We've recently written for external clinics referring into us. Within neurosurgical we have peripheral clinics within general hospitals and unless their admin processes are robust and ours are robust, patients can get missed….so recently we've written a little protocol which is in line with our Trust waiting list processes, which we've been sending out to all the other Trusts to try and adhere to. It's got some safety nets built in to ensure that if they don't hear from us within seven days they've got ownership to phone us ….so that's something we've gone down recently around communication improving pathway" (GM 2).

Despite the fact that all groups had identified different uses and difficulties with the intranet system, it was evident from these responses that no manager had been proactive in changing the appearance of the intranet to enable easier use, the view being that it was 'Somebody Else's Job,'[138] a theme I will pick up later. I would argue, then, that if Trust staff were dependent on a system that did not function efficiently in their everyday practice this would appear to be a highly significant issue. If, however, they were not dependent on this system, in that it did not influence their working practice, it would be insignificant if it failed to operate, apart from time wasting, which was highly significant. This is further evidence of the 'ceremonial conformity,' in that a system was there in order to show that the organization was legitimate. There was acknowledgement that it did not work but this did not appear to matter. The culture of the organization, to use an evidence-base for practice, had not been changed by the introduction of the system.

138 See Chapter 7:3 Somebody Else's Job Roles and Responsibilities in relation to Clinical Governance

I established that, whilst meetings took place at all levels of the organization, the major dissemination of written information about clinical governance activities to all Trust staff was (at the start of my fieldwork) by the clinical governance intranet website. Part of the clinical governance facilitator's role was to keep the site updated. It contained information about members of the corporate clinical governance committee,[139] the terms of reference for this meeting, protected time dates and some minutes of meetings. However, when the clinical governance facilitator left and the clinical governance activities were delegated within the Trust, with new facilitators appointed, nobody appeared to be responsible for updating this site and it still contained outdated, inaccurate information from March 2003, visible to all members of staff at the time the semi-structured interviews took place two years later. Yet at the Trust induction for new members of staff, the clinical governance facilitators still urged staff members to use the clinical governance intranet website. I was interested, therefore, to know how staff identified with this out-of-date information. It soon became clear. The greatest consensus of agreement in the semi-structured interviews was in relation to the Trust clinical governance website. Nobody used it as a working resource, but, more significantly, nobody could use it as a working or information resource because the content was so out of date. Indeed, the answers from two senior nurses were casual:

*"I look at it thinking we must do something about it" (*8a 2).

From another:

*"It's not been updated for 3 years, it's not accurate" (*8a 1).

Before my interviews took place, the clinical governance facilitator for the neurosurgical directorate was so concerned about this poor Trust resource that he had developed another very comprehensive detailed neurosurgical intranet website for all neuroscience staff to use. He informed me that he had spent considerable time visiting the wards and orientating nursing staff to the neurosurgical clinical governance website. I was therefore interested to learn from the neurosurgical interviewee respondents whether this had specifically made a difference to the nursing staff knowledge of clinical governance. One neuroscience ward sister did give an indication that she used it:

"It's quite clear and concise, quite informative. I've not been on it for a few, if I'm honest, I've not been on it for a few weeks, but I just click on it now and again just to see what's going and just get the general updates. I don't think that's been updated either for a while, I think we've got the same general information for the last couple of months. It's quite good" (N 7 1).

139 See Chapter 5:1 Corporate Clinical Governance Committee Trust Meetings

Nevertheless, when I asked her to show it to me, this interviewee could not find, or had forgotten how to access, the relevant site. The grades below F within the neurosurgical directorate did not use or display any knowledge of what was on the intranet yet the Clinical Governance Coordinator had spent a great deal of effort developing this site:

"No, no it's on the list" (N 6 3).
"No" (N 5 2).

Elderly care nurses gave similar responses:

"I've looked at it, but not had time to read it" (E C 7 2)
"No, I can't say I knew there was one" (EC 5 1)
"To be honest I haven't looked at it for a while" (EC 6 2)

However, the neurosurgical unit's own clinical governance website had clearly made a difference to their manager when I asked if she looked at it:

"Not the Trust one, I look at ours, well our website, we've set up, I'm the chair for it, and so our minutes are posted on there" (GM 2).
KS Do you put those on.
"( ), the secretary does. So, I if I'm looking for a minute, I will go onto there and we have an operational governance website that will enable me to get into our complaints report, adverse incidents reports any adverse incident. I will find an action plan, so there's quite a few, that's why I use the operational governance one more than the clinical governance one" (GM 2).

KS Who has access to that one, just the managers or..?
"No all the ward, down to ward sister level, we're encouraging them to access and get the information, so the minutes are posted on there as well" (GM 2).
KS Is it an easy to follow website?
"Very easy" (GM 2).

This comment '*down to ward sister level'* inadvertently reflects the hierarchical power structure, existing professional boundaries and inequality of knowledge sharing across clinical practice. It also demonstrates some antagonism for the status of nurses, perhaps because of normative-mimetic institutional forces.

Other managers, however, did not use the site and could not tell me what was on it:

"Not really no" (laughs).
KS It's actually been withdrawn
"Right" (GM 3).

Consultants did not use the site as a working resource either:

"About once a year, the last time I looked everything was so out of date there was no point (laughs).

"Probably do, don't think I have done for a little while now"
KS Can you tell me anything about it?
"No" (C 5).

However, whilst I had previously found that the clinical governance facilitators actively promoted the use of the clinical governance website for all new members of staff, C 2 gave this response:

"We don't have a CG website"
KS OK, did you, when you had one, look at it?
"No, we had a clinical governance website some time ago; we never developed, or were given the where with all, to maintain it, so it was never used" (C 2).

Despite this answer, this 'undeveloped out of date site' had been visible and accessible to all members of staff for the duration of my fieldwork.
Professions allied to Health gave similar answers in relation to the use of the clinical governance website:

"Generally speaking no" (AP 1).
KS So could you tell me anything about it?
"It's quite a long time since I looked at the Trust's clinical governance website, the thing that concerns me about the hospital website is the search facility is rubbish" (AP 1).

I interviewed a senior member of the Trust corporate board, a manager whom I understood, had overall responsibility for this site, having taken on the work of the Trust Clinical Governance Facilitator, following her departure. I asked him if he looked at the clinical governance website:

"Which website? Well it, I thought it was fairly weak, in many ways. It tended to focus on sort of guidelines and things like that."

He then summed it up:

"It is not my responsibility. It's nobody's responsibility that is the problem…neither was the Trust executive site anybody's responsibility. So somebody has to get a grip of it……. We are capable of doing that, whether we have actually thought through the infrastructure requirements to do that, and we have, in one sense, we haven't in another. No one has actually made a decision about how we are going to do that" (GM 4).

This senior member of staff was ultimately responsible for putting the Trust knowledge management systems in place and this response endorsed the confusion that the ward staff experienced in trying to report that the systems were inadequate and created more problems for them. However, the Trust had also gained external legitimacy by complying with the rules and having the relevant systems in place and producing appropriate paperwork. To this end, the Strategic Health Authority had applauded the Trust. It would seem therefore that the organization and systems within the Trust were there to produce and promote the structure for external legitimacy, acknowledged by, for example, success at CNST level two. Nevertheless, in practical terms, the system was a failure and not managed at corporate level as, clearly, nobody accepted responsibility for it. I established, therefore, as far as can be determined from interviews and observation, that it did not appear to make any difference whether or not there were good, or not so good, intranet resource facilities available to nursing staff. Their use was not evident in everyday practice.

6.7 Adverse Incident Meetings

Whilst the neurosurgical directorate incorporated their critical incident reporting and action into their management meetings, the elderly care directorate had separate lunchtime meetings for some time to discuss any adverse incidents that had occurred within the directorate. Although attendance at these meetings was erratic (sometimes there was just the convener and myself, together with a large lunch), those who were able to attend were vocal in their appreciation of the usefulness of these meetings for learning and sharing experiences. In the semi-structured interviews, I asked whether these meetings and the reporting of critical incidents had made a difference. It appeared that they had in both directorates:

"Yes it has, I can think of specific issues with drugs, when I've been to clinical governance meetings when drugs have been brought up and I've thought to myself, I could have made that mistake and it's made me think more clearly and concisely and even with time pressures stick more rigidly to the medicines policy" (EC 7 2).

Nevertheless, when questioned about the reporting of adverse incidents and if any improvement in patient care had occurred through the process of clinical governance, the same interviewee later commented:

"I don't. I think it may raise up specific issues that are then dealt with but as a general improvement in patient care I don't think feel it's made a great deal of difference"

KS "Things like critical incident reporting or audit?"

"Critical incidents…a lot of critical incidents, as far as I can see and there are exceptions, is a paper exercise. I receive probably eight to ten critical incidents per week, which are all probably slips, trips, falls of my patients and there is a standard pasted answer that I tip into that. I don't see how that improves anything." (EC 7 2)

However, other respondents were more positive:

"There's a variety of things really. Within the unit I work on, we have a transfer trolley and that was introduced as the result of an adverse incident. Prescription charts have been changed as the result of an adverse incident that's happened on the unit (N 7 4).

"I think because clinical governance pushed the medical clinicians to be involved in what's going on and it's made it a lot more multidisciplinary and even if one directorate is pushing forward the clinical governance agenda, I do think there is a lot more multidisciplinary discussions about things, even if not all the ward staff are included. Particularly around when we had our critical incident meetings they were very, very successful and one of the clinicians was leading it and we had a full range of the multidisciplinary team and I had thought that they were being very well" (EC 8a 2).

Nevertheless, with the retirement of a very dynamic professor and the appointment of a new clinical governance lead within the elderly care directorate, the critical incident meetings abruptly discontinued as the new clinical governance lead (who had not attended any meetings), felt that they were 'unnecessary.' I would argue that even though these meetings appeared to have made a difference in 'organizational learning,' there was no overall evaluation of that usefulness, or 'knowledge management' in the encouragement of staff to continue attending and that the organization did not function as a co-ordinated 'learning organization.' It could be argued in this instance that the 'structure' was dependent on an 'agent' who had the power to make a decision to discontinue the meetings that was not challenged.

6.8 Matrons' Meetings

I was interested in attending the Trust Matrons' Meetings to discover if these promoted any opportunity for identifying and discussing what was happening with regard to clinical governance within the Trust. Nevertheless, it is important to note that they were <u>not</u> designated clinical governance meetings, but working meetings for the Matrons. In this instance, as I did not receive any minutes from these meetings, I relied on my field notes.

I commenced observation at the Matrons' meetings in November 2003 but only managed to attend three. These took place on an irregular basis and were cancelled at short notice. Despite the support of the Associate Director of Nursing (Quality), it was also very difficult to gain access to these meetings, mainly due to the disorganised information system, in that there was temporary secretarial support, and information concerning the venue and dates of

subsequent meetings was not passed on to me. At the time of the commencement of the observation, the Associate Director had not been in post long and there was a newly appointed Director of Nursing Services, so there were significant changes pending within the senior level nursing structure. The Essence of Care project group[140] reported to this meeting as to the progress in the implementation of the Essence of Care Benchmarks. The advertisements for these 'market days'[141] were made through the matrons who attended these meetings.

I had noted that whilst there was a prepared agenda, issues raised involved diverse practical difficulties in the day-to-day running of the hospital. A large proportion of the time was also spent in discussion of the action required in getting the documentation ready for the CNST inspection. Clinical governance facilitators requested Matrons (during their visits to their wards on a daily basis) to ask staff for evidence for the Trust-submitted portfolio.

Other topics discussed ranged from the problem of obtaining uniforms with the closing of the sewing room, infection control problems, meeting targets (such as accident and emergency waiting times) and recruitment to the difficulty in establishing whose responsibility it was to clean the equipment used by nurses. Whilst the topic of clinical governance emerged periodically, in that there were updates on the Essence of Care project group and market days, discussion was so diverse it was difficult to establish themes. Whilst I recognized that this meeting was a *potential* resource for information on clinical governance, there was no communication in any reliable or organised format. I mention this because, if the matrons did not attend their own directorate meetings, relevant information concerning the general position of clinical governance within the Trust was not evident otherwise.

A general manager attended one meeting and stated his intention of attending every second meeting to discuss any arising issues, but, during the course of my fieldwork, he never attended again. I also observed that whilst the matrons were vocal in their 'lack of management' complaints at the meetings (such as Trust communication), they did not raise these or many other issues previously discussed when the manager attended. Matrons'

140 The matrons developed the idea of forming a project group dedicated to raising the profile of Essence of Care across the Trust. The group consisted of five nurses, seconded for 1 day each to create 1 WTE for 1 year. All the members of the group were new to each other and to project work. The Professional Development Lead and a matron facilitated the group for the Trust. The matrons devised projected outcomes prior to the project group starting and from these the group developed action plans and performance indicators. A more user-friendly document was developed using the CHI self-assessment tool married to the benchmark guidance. The group established a network of link nurses to ensure each ward/department had an identified person for Essence of Care.

141 The Essence of Care project group needed to provide a forum to facilitate the sharing and comparing of good practice. This had to reach all areas, grades and staff disciplines across the Trust. 'Market Days' were held on a two-monthly basis where sharing and comparing good practice took place.

meetings therefore did not appear to have any particular consequence for the general implementation of clinical governance, but did receive reports on the nursing component, that of the Essence of Care.

6.9 Essence of Care Meetings

This project group set up within the Trust by the Matrons specifically looked at the Essence of Care documentation and subsequent implementation of the Essence of Care Benchmarks. The Essence of Care, as has been explained,[142] is the clinical governance nurse-led component for multidisciplinary staff concerning improvement in care. Although this was supposed to be a multidisciplinary initiative, nurses were the only members of the Trust project team. One nurse per directorate was released for one day a week to meet with the project group and agree good practice, and then disseminate this information within their own directorates. There were also regular market days held throughout the Trust to disseminate and progress the Essence of Care. During the course of my fieldwork, the Trust received national recognition in respect of this work. The project team reported every six months to the corporate clinical governance committee and on a regular basis to the matrons' meetings.

I would suggest that nurses have a role to play in helping clinical governance to work, and the Essence of Care initiative in relation to clinical governance and nursing practice was instrumental in this respect. In the ensuing semi-structured interviews, when asked how the Essence of Care linked with clinical governance, matrons stated that the Essence of Care was providing a framework to improve clinical standards:

"It's all with clinical governance" (N 8a 1).
"Essence of Care is clinical governance" (SN 8a 3).

"Linking in with clinical governance, is the Essence of Care benchmarking framework and a lot of those will all be issues really around Essence of Care, is about bedside care that's delivered. So for example, one of the Essence of Care issues is on food and nutrition so we've done a lot of work and a lot of audit on exactly what happens in terms of our own patient assessed. That does lead to a care plan being devised about how food should be given to the patient, assisting patients with meals, co-ordinating the meals, introducing protected meal times and something like that" (EC 8a 2)

From a matron's viewpoint, then, the Essence of Care initiative would be evident within the two directorates, so I pursued this by the further questioning of the different grades of nursing

142 See Chapter 2:15 The nursing Component of Clinical Governance - the Essence of Care

staff. I already knew that nurses had gained a reputation for not attending meetings and I have already argued that the dissemination of information within the Trust was unreliable. I asked interviewees if they could give any examples of how clinical governance had affected their own practice in relation to the Essence of Care. The first nurse questioned was a member of the Essence of Care project group, representing her directorate:

"We've looked at, from the Essence of Care point of view, we have privacy and dignity signs to stop people going behind curtains without asking whether they can do, we've looked at how we provide nutrition in a different way so that protected meal times has been introduced across the Trust. We have looked at the presentation of meals so that things that, so that meals are produced, so that people get a starter main course and desert, rather than it all plonked on one tray and then how that is actually presented. So, tray doilies have been introduced, individual salt and pepper, things like that that make differences to patients are being introduced" (N 7 4).

It was apparent that being a member of the Essence of Care project group clearly made a difference to this interviewee and the changes observed in practice initiated by this. I asked nurses on the wards the same question and the responses varied:

"I don't know whether I can actually. I suppose Essence of Care is linked very much with clinical governance and that's affected my standard of care quite a lot in so far as it's linking with the nine benchmarks and basic nursing care and that has affected it quite dramatically over the last year" (N 5 2).

"At the bedside, the bedside, I don't know if I can actually, that's really quite difficult. I suppose I would just see it as, what I was saying before, clinical governance to me kind of encourages professional development; I would then see that as improving clinical skills for care delivery at the bedside so ensuring what you are doing are the correct procedures for a patient that it achieves the best outcome. I can't think of anything particularly specific which has changed my practice, but that's what I would associate with governance" (N 7 1).

Another staff nurse was still slightly confused as to what the Essence of Care was:

"It's seven areas I think and where things are failing, they've looked at benchmarks and producing folders" (EC 5 1).

I established that there were designated nurses on each ward responsible for one aspect within the Essence of Care but noted that the dissemination of information relating to the Essence of Care implementation within directorates was erratic. Nutritional improvements and protected meal times (where patients are left undisturbed to eat their meals) were particularly noticeable on the elderly care directorate, but although protected meal times were 'said' to take place on the neurosurgical unit, I discovered no evidence of Essence of Care directorate meetings taking place within this directorate. I therefore believe the

changes in practice that I observed on the elderly care wards, during the process of my fieldwork, were due to changes initiated by the matron whilst undertaking her own visits to the wards and it was by this method that changes filtered through to ward level. One elderly care directorate 'Essence of Care' meeting took place during my fieldwork, due to cancellations. I was able to attend and observe this meeting.

The purpose of the meeting was to feed back the findings of best practice for 'nutrition' throughout the Trust, following a recent market open day for all directorates where each displayed their 'best practice evidence.' I noted that out of the eight invited G grade ward sisters, two attended, one ward sent a student nurse and another a staff nurse. All other multidisciplinary invited staff sent apologies, or did not arrive. The matron opened the meeting by explaining to the staff nurse and student what Essence of Care and benchmarking was, identified how best practice was found and presented directives for changes in practice. In effect, it was an information giving opportunity. Following the meeting, the matron raised concern about the lack of knowledge displayed by those present, but no action was subsequently taken to encourage people to attend and no further meetings took place.

Ultimately, although it is emphasised that the Essence of Care[143] is the nursing component of clinical governance, only one interviewee associated it with a definitive example of how it had affected their practice at different levels of the organization. Being a member of the project group had made a difference. It was evident that whilst there had been changes in practice in, for instance, the introduction of protected meal times, not many nurses identified this activity with the Essence of Care. It seemed that any improvement mentioned regarding the Essence of Care was un-coordinated and incidental to the implementation of clinical governance. In retrospect, if I had rephrased questions and asked, "*do you practise protected meal times on this ward?"* (As I knew they did), one might assume that this would not be linked to either clinical governance or the Essence of Care as it had already become routinely 'standardised' within practice. It was what nurses did: their real work, performed with some mimetic function but they had difficulty in seeing the link with the Essence of Care or clinical governance.

6.10 Summary and Concluding Comments

This Chapter has given an overview of the formal clinical governance meetings taking place at all levels of the organization. I include comments made by nurses and stakeholders with

143 See Chapter 2:15 The Nursing Component of Clinical Governance – The Essence of Care

relevance to the meetings observed. The function of these meetings was to disseminate the clinical governance process within the Trust. In explaining my observation of the meetings, I describe the difficulties of staff trying to make sense of the Trust's corporate intentions. I observed that the systems set up by the Trust were fraught with problems that were not being addressed at either corporate or directorate level and that the hospital intranet is hard to use as a tool to inform practice. Nevertheless, staff complaints that the systems were not working failed to initiate any change.

Using the evidence from my field notes and observation, I therefore argue that the corporate organizational formal goals were ambiguous, not shared, and unrealistic on a day-to-day basis and that there was little knowledge management and organizational learning evident in respect of clinical governance. Nobody appeared to take control or responsibility for action, the general impression being that it was somebody else's job. Fundamentally there was no *'philosophical slant'* in *'trying to understand and conceptualize the nature of knowledge that is contained within the organization,*' (organizational knowledge) as described by Easterby-Smith and Lyles (2003:3), in effect, little evidence of a learning organization. However, if viewed through new institutionalism theory, the committees described were successful in that they achieved external organizational legitimacy for the Trust. I therefore conclude that although there is a 'coercive ceremonial' management of clinical governance throughout the Trust, the Trust used these committees primarily to achieve 'external organizational legitimacy', which, in this case, appeared to be more important than quality or effectiveness.

Chapter Seven

Nurses and Stakeholders and the Organizational Process of Clinical Governance

Section A

7.0 Introduction

The last Chapter reviewed the formal clinical governance meetings taking place at all levels of the organization and presented comments from nurses and other stakeholders about the purpose, functions of, and dissemination from, these meetings. I described how staff tried to make sense of the problematic computer systems and noted that the hospital intranet was hard to use as a means to inform practice. From my observations, I established that there was little evidence of knowledge management and organizational learning concerning clinical governance in the Trust, with nobody taking responsibility for its overall control. I concluded that there was a 'coercive ceremonial' management of clinical governance, as described by new-institutionalism, and suggested that the Trust used committees fundamentally to achieve 'external organizational legitimacy.' This Chapter presents and analyses the results from the semi-structured interviews with frontline staff experiencing the implementation of clinical governance within the organization.

I conducted semi-structured interviews with thirteen nurses of various different 'bands.' I have previously described the categories of interviewees.[144] I have explained the methodology utilised for these interviews,[145] and the schedule of questions.[146] To allow for comparisons between nursing and other stakeholder groups involved in clinical governance, I also conducted fifteen semi-structured interviews with senior members of other professional groups who had some responsibility for clinical governance within the Trust, as has been previously described.[147] I have described the methodology for the construction of the identified categories of 'Making Sense,' 'Somebody Else's Job' and 'Real Work.'[148] The next section concentrates on the analysis of these interviews. My first interest was to establish what interviewees thought 'clinical governance' meant.

144 See Chapter 4:21 Categories

145 See Chapter 4:19 Semi-structured interviews

146 See Appendix A2 and A6

147 See Chapter 4:20 Interview Arrangements

148 See Chapter 4:22 Grounded Theory

7.1 Making Sense – Nurses' and Stakeholders' Knowledge of Clinical Governance

A wide diversity in understanding the meaning of 'clinical governance' very quickly became evident: many interviewees hesitated frequently when answering. It is important to note that I have not concentrated specifically on the 'wrong' answers given to me ('wrong' in a sense that they did not conform to any of the suggested official definitions), although these have been colour coded in the nurse analysis grid in appendix A7.

Few interviewees could give a clear and specific account of any formal or official definition of clinical governance, their answers displaying different dimensions of awareness and knowledge. It was, then, difficult to group these responses under any meaningful category, as it was, in effect, their own 'Making Sense' of clinical governance. I have therefore identified this as the first theoretical category. Within this category, differences were identified depending on the band or grade of nurse asked. Matrons (who spend less time at the bedside), tended to give answers that related more to the promotional literature:

"Clinical governance is a framework within, which the Government have brought in, to embed quality into everyday practice. It has seven pillars and those seven pillars provide a framework, to enhance care and quality" (8a 1)

"I think it's up to the organization as to what clinical governance is. The way that I work, I look at the seven pillars of clinical governance, so I look at the issues of risk management, professional development, risk, I've said that already, patient focus, audit, research, all the things that bring clinical governance together… " (8a 2)

By contrast, ward managers and bedside nurses gave generalised answers.

(Laughs) "I think it's all about making patients more comfortable and making nurses more aware of the surroundings and what's available for them in their development, but the whole, altogether, holistically, it's all about patient care and making their experience better in hospital" (N 6 1).

Another F grade sister interpreted the term as the implementation within her own directorate and that of the Trust:

"Well, there's a group of people mainly headed with consultants in the Trust, where they get together, have a few meetings and it's to do with policies and procedures really and how things are actually run on a day to day basis and if there are any problems. In fact, with our clinical governance (own directorate committee) I think they get a lot of the critical incidents through and have to discuss them and discuss if there's any ways or any policies that can be made to improve on certain standards to prevent that from happening again. It's a national thing that every Trust in the country is adhering to at the moment" (N 6 2).

The answer given by an F grade sister in elderly care was closer to official definitions:

"It's quite a, it's what we call an umbrella term, that sort of covers a wide range of things in the, in the health service and the hospital to do with maintaining standards of excellence. Of maintaining or improving the standards of patient care and being able to audit these and benchmark these and to prove that what you're doing is good and to, to share information and improve your quality of care" (EC 6 2)

One staff nurse appeared to confuse clinical governance with a previously discarded NHS quality initiative, that of continuous quality improvement:

"It's all about improving quality of care and services and it's, then it's, once that's improved, continuing the improving process. It's always moving forwards and it's always improving and it's always getting better and it's making sure that people are accountable for what they're doing and what they know and even though you may think you know everything there's still a lot to learn and its constantly improving what, everybody's knowledge" (EC 5 1).

As previously discussed, definitions of clinical governance have never been clear and this as might be expected, was reflected in nurses' interpretation.[149]

General Managers (GM) related their understanding of clinical governance back to the clinicians in terms of the efficiency of the organization, but made no mention of their own roles in developing these systems:

"I think clinical governance is a way of involving the clinicians in such a way that they can reflect on the practice that they carry out, so that they can carry out proper practice, practice that is accepted professionally and also accepted by the Trust as the right thing to do, in terms of what the Trusts' priorities are" (GM 4).

"Clinical governance is, it's the systematic review of ensuring all our clinicians, doctors, nurses and other professionals, radiology department, anybody who's a clinician undertaking their clinical work within clinical guidelines, are laid out and also, … better run reviews and things like that" (GM 1).

Whilst these two managers mentioned 'systematic' and 'practice,' their 'Making Sense' of clinical governance implied that it was 'Somebody Else's Job.' A third Manager (an ex-nurse), whilst using 'we' offered an explanation directly related to improving patient care:

"To me clinical governance is 'how can we' in broad terms, rather than using all the other terminology that we hear around. It's about improving patient care and about providing a safe environment for patient" (GM 2).

149 See Chapter 2:12 Defining Clinical Governance

Within the Professionals Allied to Health Group, the first clinical governance facilitator initially sought some clarification from me as to what I wanted, but was clear in his explanation:

"Ideally, or in practice or either? Right, ideally, governance should be all about sort of making (sic) things better for patients and staff and constant improvements,… not absolutely convinced that in practice that is actually, what it's all about, sometimes you, we get pushed into paper exercises doing things because they tick the box really, but it should always come back to improvement in patient care delivery" (AP 5).

The second gave a very broad response:

"In itself clinical governance is everything that we do" (AP 6).

I found that where there were systems that are more tangible as in, for instance, pharmacy (and drug regulation), there appeared to be more clarity in the understanding and even implementation of clinical governance, although it had some resemblance to the older quality management systems:

"It is basically about getting people to do things right and doing it right first time… if we do things properly the first time round, it's a much more efficient way of working, but, most importantly, ultimately it's the safest way of doing it for the patients" (AP 2).

Like Matrons, other allied healthcare professionals used the 'official' promotional explanations:

"I always look at it basically as a sort of, in a general term about quality and it's about the quality that we provide our patients and also our staff and it's about our responsibility to ensure that all the sort of seven pillars are covered…." (AP 3).
"Well there is a definition, which is to do with quality… Its quality, its standards, and feedback from that and I think there was something else that feeds into that" (AP 1).

Consultants gave more of a critical reflective view:

"I think it is the assurance of standards and the improvement of standards of quality health care. Of course that depends on how you define quality health care, but… I'd be happy to do if you wish me to."
KS: Can you try briefly?

"Yes and in my view quality health care is patients' sense of care, it's safe care, it's effective care, it's efficient care, it's timely care and successful care and it is equitable care" (C 4).

"You don't want the standard definition presumably? Clinical governance is to ensure that what we are doing is good practice, is best practice that we reflect that practice and review what we are doing…does that sound reasonable?" (C 5).

"There is a long winded definition, but I have always thought it can be summed up in just a few words as corporate accountability for clinical outcomes" (C 2).

The explanations that clinical governance was the *'right thing to do,' 'general term about quality,'* together with promotional explanations, were not 'wrong' (in the sense that they did not meet the terms of the official promotional literature), but the explanations from all the groups questioned were not consistent. This resulted in a varied understanding of what clinical governance is supposed to be. Overall, the consultant group was able to give the most internally consistent explanations.

7.2 Knowledge Construction – The Learning Organization[150]

Mention has already been made of the potential conflict of clinical governance as being a 'top down' approach and 'organizational learning' as being essentially a 'bottom up' approach (Wilkinson, Rushmer and Davies 2004) and the importance of adopting a learning organization approach in order to succeed in bringing about cultural change. Nevertheless, it is naïve to imagine that culture change will occur if there is not a *'philosophical slant'* (Easterby-Smith and Lyles 2003:3) in association with organizational knowledge, in professional development planning to link clinical governance and organizational learning. It seemed that there should be an identifiable link between professional development and the clinical governance system, in that staff could identify their own professional development needs with the development of clinical governance (e.g. finding relevant policies and protocols for guidance, writing an adverse incident report, implementing the Essence of Care Benchmarks). With this in mind, I wanted to establish how the interviewees 'constructed knowledge' to make sense of clinical governance. This resulted in the following sub-category within the 'Making Sense' category, that of 'Knowledge Construction.' I asked interviewees how they saw professional development planning connecting with clinical governance.

Matrons could not agree:

"I don't think it does unless the person is aware of clinical governance" (n 8a1)
"Loosely" (EC 8a 2)
"It should be in everybody's professional development plan" (8a3)

The link between culture change and the learning organization was not agreed at this level, but matrons have a critical role in supporting staff development needs.

150 See Chapter 2:4 Knowledge Management, Organizational Learning, the Learning Organization and Organizational Knowledge

The Band 7 (G grade nurses) also gave inconsistent responses:

"I think people that know about it utilise it very well, junior staff wouldn't" (n 7 1).

"At grass roots very little, time constraints, trained staff replaced by practitioners, more pressure on qualified staff no time for meetings or mandatory training" (EC 7 2).
"It should, but I don't always get to find out and we don't share across the directorate" (EC 7 3).
"I think it has a huge impact, clinical governance is at the heart of improving things for patients" (N 7 4).
"Yes, but I don't know if it's implemented" (EC 7 5).

The Band 6 (F grades) were not sure:

"I think it connects quite well really, I don't know what the guidelines are" (n 6 1)

"I don't know really" (N 6 3)

The Band 5 (D grades) were realistic but contradictory:

"I think it does connect, from a trained nurse point of view it doesn't really. It hasn't changed anything because It's what we've been doing anyway" (EC 5 1)
"I suppose it gives it more of a structure making sure standards are better and people are enabled. I don't know" (N 5 2)

There was overall a general lack of knowledge in this respect, so there is little evidence of a culture change through the provision of professional development activities for nurses in support of clinical governance.

How did consultants see clinical governance linking with professional development? Firstly, the official 'top down' Trust view was voiced:

"Well I think that it's recognized that as a result of clinical governance it has been possible to insist effectively that the Trust takes continuing professional development seriously and instead of regarding it as optional it has changed its behaviour to recognizing it as sort of essential core requirement. So I think there has been a very significant change in the attitude. I don't think that we yet have really effective mechanism in place for ensuring there is training development. But there has been a big change in that" (C4).

Had this view been shared amongst colleagues?

"On a whole I don't think it does particularly" (C5).

Two consultants immediately saw the link:

"It is a difficult issue in the sense that it, an awful lot of PD planning would conform to clinical governance requirements but is not necessarily undertaken under the heading of CG, so for

example we would require all consultants to keep themselves up to date in their speciality" (C2).

"I think probably, one of the components of CG is to actually keep a hold of the PDP. The nurses' feedback how many people have been seen that year and have their annual update and doctors do. It is supposed to come through the clinical governance meetings, but a lot of people don't see that there is connection" (C1).

Therefore, consultants did generally see the link between clinical governance and the need for continuing professional development.

The managers too recognised the link, but emphasised the difficulties involved:

"Well, I can talk about a theoretical way it should do it, rather than how it does it because I am not sure….I am more interested in how it does it, practically. I think the reason why I am saying that is that I am not sure we have yet got an effective governance system within the Trust… Our history is very difficult to override" (GM5).
"I think probably better then we give ourselves credit for …. I think it does work in certain areas I can think, for example, that people have gone over training issues by highlighting clinical governance things" (GM 1).

There was inconsistency here in the comment *'work in certain areas.'* If the systems were dependable, one might question why it did not work in all areas.

Professions Allied to Health were also aware of the link in a more theoretical sense:

"Now again in theory, there should be a real link because you know education and life long learning is one of the themes under clinical governance. Obviously, PDPs are part of that process for me, your PDP should be a way of capturing everything that you're actually doing or want to do and that should show how it links into governance. Again, I'm not sure how much actually happens in practice… " (AP 5).

From these responses, in comparison to nurses, whilst consultants, managers and professionals allied to health did see the link between clinical governance and professional development, even to the extent of noting that 'professional development' was not necessarily identified under this remit, there was little evidence apparent in what was being done to strengthen the links from a 'bottom up' perspective.

7.3 Somebody Else's Job - Roles and Responsibilities in relation to Clinical Governance

When I first commenced observation at meetings, I asked the then in-post Clinical Governance Facilitator what she thought clinical governance was. Her answer *"everything nobody else wants to do"* proved to be an astute comment, because, following my analysis of

data, it became the next theoretical category, 'Somebody Else's Job.' I had already concluded that information systems and meetings were ineffective and viewed as 'Somebody Else's Job.' This category therefore covers the perceptions of roles and responsibilities in relation to clinical governance. The literature indicates that attitudes towards clinical governance vary between specialities[151] and, in particular, that nurses portrayed more positive attitudes than other health care professionals, so I was interested in identifying what nurses thought their role was in relation to clinical governance and whether they had any strong feelings about it. The next section explores the data in respect of these role perceptions.

Matrons offered varied opinions in respect of leadership:

"I think it's a role that's developed over the last fifteen, sixteen months since I've been in post. I think it would be true to say that there was no leadership really in clinical governance in the organization and I think it was a case of, the meetings took place but there was no following through of those and unfortunately I had some time off sick …it started to get going, but it's slipped back again now" (SN 8a 3).

"As a matron it's been the forefront of my remit because everything to do with the patient experience comes under my job description and so the clinical governance agenda drives what I do on a day to day basis" (8a 2).

One G grade nurse saw her role as monitoring and supervisory:

"See that Trust CNST policies, risk registering, adverse incident reporting are adhered to, systems in place so higher management can respond to change the service" (EC 7 3).

One F grade saw the role as being supportive and in acknowledging benchmarks, related to patient care:

"I think as an F grade on here, it's quite important because obviously I want to support the staff through from students, support workers, all grades of staff and disseminate information that comes through guiding clinical governance, and perhaps benchmarking and things" (EC 6 2).

Another at the same level discounted any responsibility

"From a personal point of view we're not really that involved I don't think and probably should be more involved. I'm not sure whether the ward manager gets a little bit more involved, but I don't even think that they are invited to the meetings because they are not actually on the clinical governance board. So I suppose the only way we get involved is by putting through critical incidents and having the feedback from them, but we are not actually personally involved at the moment" (N 6 2).

151 See Chapter 2:19 National Clinical Governance Research Studies

Attitudes and beliefs therefore varied. There was a constant shifting of responsibility from other bands to 'Somebody Else's Job.' Overall, nurses did not appear to have strong feelings about clinical governance. During the course of my fieldwork, I noticed that whenever there was a new directive, policy, or change within a leadership role, there was renewed energy to get the systems 'right.' Nevertheless, these actions did not last long when other priorities took their place, as, for instance, in getting ready for the clinical negligence scheme for Trust inspection.[152]

If clinical governance places responsibility on each practitioner for individual care, it would seem a logical requirement that role expansion is undertaken within professionally agreed guidelines, underpinned by education and support mechanisms (Walsh 2000). However, under the category of 'Somebody Else's Job,' this clearly was not happening. There was little committed organizational learning, or support mechanisms. From the answers given at a management level, there was the idealistic view that it should be happening (reflecting the ceremonial conformity of the organization) but there appeared to be a lack of activity and evidence of this in the Trust, especially in respect of 'workable' support mechanisms for staff. As matrons and ward managers had varied interpretations, there was confusion at the next level as the F grade nurses were unclear about their own roles.

The E grade nurse's attitude to their role was more positive.

"I think we all have responsibilities to maintain high standards and to ensure that people around us are maintaining high standards by keeping yourself up to date, by following regulations and protocols and just generally having a high standard" (N 5 2)

"Improving patient care, improving my own knowledge and skills filtering down my knowledge to students and junior staff, implementing Trust policies, making sure that things are going right, constantly keeping aware of the changes, keeping up with things" (EC 5 1).

"Following regulations and protocols" (N 5 2).

Interestingly, E grades indicated the increasingly high profile of policy guidance, although they were not able to give me an example of when they might use one in practice.

I also asked each Stakeholder to describe his or her role in specific relationship to clinical governance. The notion of 'Somebody Else's Job' appeared to be particularly strong in the management category, as demonstrated by the following extracts from the interview data.

152 See Chapter 5:7 Clinical Negligence Scheme for Trusts

The manager responsible for quality within the Trust clearly saw this as co-ordination, albeit at a corporate level, but tended to delegate the actual work onto other colleagues:

"*My specific role in CG is to support the clinical director, the executive medical director, the executive nurse in ensuring that the role within an integrated governance framework is actually carried out"* (GM 4).

The Director of Operations identified this as facilitation in that the '*<u>organization</u> undertakes some clinical governance'*

"I would say that my role has been instrumental, predominantly in allowing clinical governance to be undertaken in the Trust, …and it was my suggestion a couple of years back that we have introduced a half day on a rolling basis. So we actually had some dedicated time to allow the organization to undertake some clinical governance, the clinical governance goes on all the time but this was to allow us just to review where we were up to in individual specialities and departmental levels of clinical governance (GM 1).

KS How do you keep an eye on what is going on in your protected times?

We've taken, the technical team has taken an early, light touch, what we've been keen to do is to allow people to use the time as they see fit, from a clinical governance perspective…we do get regular reports, clinical governance reports from each of the directorates, each produce an annual plan around quite,…that they've taken in the previous year so that checks and balances that" (GM 1).

This manager appeared happy if the reports were in, and uninterested in what occurred at meetings. Protected time meetings had been taking place since at least 2004, when I started my fieldwork, but were still described as *'an early light touch,'* another example perhaps of the 'ceremonial conformity' required to achieve 'organizational legitimacy' as related to external coercion. It appears that as long as there was production of the appropriately completed documentation for corporate level meetings, everybody was happy. Yet I had previously found at directorate level that the reports submitted were inaccurate[153] and that there was wide variation in the attendance and conduct of the meetings at both corporate level and within the two directorates studied.[154]

Another manager focused on the medical profession:

"My specific role, I'm more help and facilitate, I try and drive the governance agendas through the divisional meeting. Through the directorate meetings and through the clinical governance meetings that we have, so I'm more of a facilitator kind of a role, ensuring that things are moving forward and happening, asking the clinicians to feed back 'cos I'm responsible for the medical side of things rather than the nursing side. Ensuring that they are aware of what's happening in governance" (GM 2).

153 See Chapter 6:5 The Elderly Care Directorate Protected Time Meetings

154 See Chapter 5:3 Terms of Reference and Minutes of Meetings

The perception of role here veered more towards the *'medical side of things rather than the nursing.'* Yet clinical governance is the co-ordination of activities for all health care professionals. There could be two suggested interpretations for this. Firstly, the view of nursing by this manager is that of a subordinate profession with influential medical dominance. Alternatively, the view may be that nursing is more organised and medical clinicians require attention. (Meetings within this directorate only comprise senior managers from all professions).[155]

A Professional Allied to Health had an uncertain notion as to what her role was:

"Well that's a little bit difficult because what I basically do is I represent neuro-psychology at the neuro-science clinical governance group. But that's basically as far as it goes, I don't have any other role. Our department is actually made up of three different sections of which neuro-psychology is one of them and I felt that, well, the original intention was that the Head of Department was also the clinical, well the leader for department was not a neuro-psychologist, should represent neuro-psychology at the clinical governance group. And I felt that was inappropriate, area was too specialized into experts, so I objected to that, so… it was agreed that neuro-psychology could be represented at the neuro-science clinical governance group by a member of ourselves"

KS So, do you have a system where you disseminate what is discussed at the meetings within your own department?

"The things that are discussed at the meetings I share with neuro-psychology colleagues, I don't share them with other members of the department and that's because of the way it's set up. And so there is often a situation where things are discussed at the neuro-science meetings and they're not, it doesn't come through, or it comes through at a later stage" (AP 1).

Therefore, whilst the Department only had one representative at the directorate meetings, this health care professional, because of existing 'professional boundaries,' still saw her role to be restricted to the dissemination of information to her own professional colleagues within one section of the whole Department she represented.

The clinical governance facilitators voiced concern about the reality of their role:

"The role within clinical governance is that of a facilitator with the current establishment within the Trust, it's been hard, due to the fact that basically the infra-structure within the Trust is quite embryonic and therefore there isn't a role to specifically get into and do" (AP 6).

"Well, when I came into the post my understanding was very much around assisting people on the shop floor to put governance into practice. To make improvements in practice, so basically taking Trust policies and national directives and making it happen locally and sort of supporting staff achieving that really either through top down approach or ideally through,

155 See Chapter 6:3 The Neurosurgical Directorate

you know, the staff themselves have idea about what they themselves want to improve, looking at how I can support them" (AP 5).

KS And does that happen?

"It does, it doesn't happen as much as I would like it to at the moment because of pressures of other things, but…"

KS Like?

"Well, for example with the CNST (Clinical Negligence Scheme for Trusts).[156] *At the moment we've got big, a big push on in terms of getting the portfolios together for CNST and sometimes that's very much about just getting things done, you know, for the sake of getting it done…"*

Whilst these facilitators acknowledged what needed to be done, they were already constrained within their roles by other responsibilities in order to meet external legitimating requirements.

The consultant clinical directorate leads saw their roles as leadership:

"Well I have a role as clinical director within the directorate or ensuring that we have appropriate governance procedures in place and then I have had a role over the past few years of Trust in trying to make sure that Trust wide processes that clinical governance now have, are introduced" (C 4).

"I would probably divide that into two… there is my role as a consultant on the ward, which really relates to my patients, the nurses and team that I work with, including the junior doctors…. I don't know if you want to go on later about my clinical governance lead role, but that is about trying to ensure that things that are implemented are disseminated across the directorate" (C 1).

KS How do you disseminate?

I think at the moment… we would have the clinical governance meetings which occur every two months, which representatives are supposed to come from each of the professionals …the minutes are disseminated… then there are other routes of dissemination which are more ad hoc, like the alert system… and the newsletters which come round with kind of little handy on about things that have gone wrong in other places to watch out for. So there are a variety of different routes which probably means that none of them is perfect" (C 1).
…I then attend the neuro science governance meeting which happens once a month …and I've been the chair of that meeting for the last I guess four or five years since it's happened here but obviously we've got representatives there of all the other aspects within Neuroscience, neurology, stroke, pain used to be, but no longer, …There used to then be a meeting within the Trust, which now has been terminated…" (C 3).

The medical profession were dominant in the clinical governance structure within the Trust. All directorate leads were consultants. In this respect, therefore, the medical profession still maintained control of the working environment in relation to the clinical governance remit.

156 See Footnote 121

There was an emphasis on regulation in the stakeholders' responses. The first is in relation to an account given by AP4 in relation to registration:

"We are all members as AHPs, of the Health Professional Council, which is the new body... I have just had an incident recently, all the OTs (occupational therapists) had to re-register, and I ended up with about 10% of the workforce who were not registered and they had to go home without pay or on leave, and that was because of a change in the way they had done the registration, it was just a national thing across the country. 10% of OTs hadn't re-registered they hadn't realised that they had to fill the forms in and send them off. I don't think they will ever make that mistake again, because it caused absolute chaos….So, I mean, that was a really serious thing, in effect, had quite a lot of…the clinical director was involved, the director of HR, it was quite a horrible thing really… You know, we have learnt from it, there have been changes in a few systems. HR has changed the way they do their checks as well as the PCT" (AP4).

This incident provides evidence of organizational learning and the nature of the current regulatory influence and the ability to work, or not being able to work, forcing a change in systems. The situation had changed in that, in a previous incident, an affected member of staff had been able to work, albeit as an unqualified member of staff, and in this instance, no member of staff was allowed to work.

7:4 Real Work

The third identified theoretical category is 'Real Work.' This relates to how nurses practise and see the effect of clinical governance on bedside care, which was my original interest in conducting this study. I was particularly interested in the auditing systems of clinical governance, whether they had increased the amount of paperwork with which staff had to contend at ward level and if staff could see any result linked to the improvement of care. The first Matron questioned was not involved with hands-on practice at ward level:

(Long pause) *"I don't think it has in itself, to be honest, I think it forces people to really examine what's going on and therefore you could even reduce things that you are doing, if you really look at what's going on and say well, why are we doing that, is that necessary? Can we do it in a different way?"* (SN 8a 3)

Nevertheless, at ward level, all grades linked clinical governance to a significant increase in paperwork:

"We are aware that when we deliver the care it's audited, our documentation's audited, our care plans audited. We have audits like infection control so everything's looked at and we know that where we, what we're good at and to continue doing and where we're perhaps falling behind on something that we're not doing that we can learn from" (EC 6 2).

This response was positive in that 'learning' will occur if there is awareness that documentation may be looked at and so more care might be taken with its completion. Nevertheless, a complaint from staff was that there was no knowledge management to disseminate the results of audit, so staff did not identify errors in any consistent way, as demonstrated by the following response:

"Well I suppose documentation. That's probably a major thing at the moment and always has been really. Documentation and care plans and evaluation and how important it is that every patient has appropriate documentation….Critical incidents and how important it is to always put through the adverse incident and any critical incidents…. the adverse incidents, they're the main things that we're being told, you know, no matter how much you think that nobody is actually going to listen to you when you do them, you must do them for absolutely everything that you think" (N 6 3).

This directly contradicted the matron's view:

"Even though I don't work at the bedside, I do influence practice at the bedside and that's often done through the adverse incidents reports system and through complaints. I think we have a big input, impact on that" (EC 8a 2).

It could be argued that the impact of extra ward paperwork does not affect this level of management, as can be demonstrated by the ward level answers given, but what is interesting is that the matrons questioned seemed unaware of the effect increasing amounts of paperwork were having on their own staff. This is one instance where there was major agreement amongst the G grades and they became quite passionate in their answers in respect of the increase in paperwork. When conducting ward observation I observed that it was common practice (due to the numbers of staff on duty), that G grades were involved in direct patient care:

"In respect of the paperwork around clinical governance I would say that possibly half of my time is spent providing either evidence, auditing, or responding to clinical governance issues….With the adverse incident reporting again, it's not the actual paperwork it's the system on the computer that doesn't make it particularly easy. But my web master file is absolutely full of it and there is no way of identifying, either on the system, of which, say like. If one of the gatekeepers[157] phoned me up and said, I needed some information off one of the adverse incidents she got, it's number 504, there is no way on the system you could find that without going through every single one and there must be thousands, because you've got the original report, my response, the manager's form back then you've got an incident accept, so the file is enormous and there is no way you can link any of them together" (EC 7 3).

Increased paperwork appeared to be consistent with the reduction in trained staff numbers:

157 A 'gatekeeper' refers to the Clinical Governance Facilitator for the directorate

"I don't know, it sounds as if I am whinging, but it is time constraints staffing levels. Although the Trust will say they have remained consistent, they haven't. Trained staff have been reduced and reduced and reduced. Replaced by people like assistant practitioners who are not trained nurses at the end of the day so that puts more and more pressure on qualified nurses, paperwork has quadrupled, the number of meetings that are mandatory has gone through the roof and it all adds to time constraints that previously were not there" (EC 7 1).

It appears that, within the 'Real Work' that nurses engage in, the increased administrative paperwork is seen as more of a hindrance than a help and impedes their *availability* for patient care. The increase in administrative tasks had clearly been delegated to, and fallen on, ward level staff and, as I observed, did decrease the time spent with patients. This work was also difficult to undertake because of software and reporting problems. It was noticeable however, that nurses did not consciously appear to connect escalating documentation to any improvement of direct care or even to increasing regulation of their practice.

The promotional literature states that all health care professionals have a 'role' to play in helping clinical governance to work. To this end, I asked stakeholder interviewees specifically if they could give any examples of how clinical governance had affected their working practice. The first manager (responsible for operational management within the Trust) response related to the system set up for adverse incidents within the Trust:

"Difficult one that is because while, on my own individual working practice, because I'm not a clinician I think… with clinical governance is that I'm always very clear about ensuring that whenever an incident happens within the hospital with, by the directorate, that it is important to be as proactive as possible" (GM 1).

A second manager linked changes in practice to a specific meeting, although the meeting described had not been set up under the remit of the clinical governance directive and was a general working meeting within the Trust.

"In terms of medical services the links are there through our co-coordinating meetings for governance, so we have regular co-coordinating meetings" (GM 3).

KS Which meetings, is that a general manager meeting?

"It's a medical services meeting which all the Service Managers and the Assistant Director of Nursing, and Matrons etc link together. So things get fed in through that"

Another Manager gave an extremely frank viewpoint identifying the lack of ownership for the system:

"How it's impacted on my work is that we have to produce reports, we have to quantify some of the data looking at complaints and trends and adverse incidents. It makes you look a bit more at the detail and drill down the information because if you just get a block of information we know that when reports go to the Trust board as the highest number of complaints well they also need to realise how many outpatient contacts we have, how many in patients… I mean it's not just about the numbers it's about the outcomes what do we do as the impacts. We have moved quite a way forward in addressing action planning and making sure that we learn from mistakes and put into practice, and one of our roles from operational manager is monitoring action plans making sure things are done, making sure what we do with complaints, adverse incidents is appropriate" (GM 2).

KS Do you think the system is working?

"It's not, it's ad hoc, I don't think anyone has really taken full ownership and drawn it into their everyday working practice"

KS Why do you think that is?

"I think because people see it as an add on. They don't see it as everyday practice" (GM 2).

An Allied Health Care Professional senior member of staff was more cynical:

(Pause) *"I can give you lots of examples where it hasn't …. (Long pause). One of the members of the team that I'm working with is currently working on a risk register within the department that apparently was… completed for all other departments within the Trust. But for some reason our department wasn't involved in that….But if you're asking has anything like that, you know, given me an example where something has been achieved already as a result of that, I can't think of one just now. But that's I suppose one that stands out"* (AP 1).

One manager could not identify any change clinical governance had bought about on their practice; another had indicated that practice would change through conducting meetings, a third by implying a change in culture was required and an Allied Health Care Professional pointed out the problems within the system. A manager identified that learning could occur from mistakes made, but also admitted that the system for this was 'ad hoc.' As has been previously indicated, nurses did not attend meetings, as this was linked to 'Somebody Else's Job' and there was no overall knowledge management or recognition of responsibility for the failing systems. However, it appeared that where it was possible to 'measure' (in this instance by the counting of critical incident reports) the results, although duplicated at different meetings, implied some clear organizational learning:

"*Under the clinical governance framework…for the first time we are recording everything properly, …openly admit all the mistakes we make, but more importantly with the clinical governance framework actually retrospectively analyse …looking for themes, and contributory factors , looking for how can we re- organise the way the whole department works"* (AP2).

Another Allied Health Care Professional was less forthcoming, even when given a hint.

"Oh gosh, my mind's gone a blank" (AP4).

KS "You mentioned all the audits and everything. Is that something because of clinical governance do you think, or was that something….."

"No, I think it is probably something we have probably always done, I have been here six years, and as long as I have been here we have been doing things like that. I think what it has done is give it more of a focus and a purpose as well I think" (AP4).

One aspect that had arisen in my interviews with nurses was that of lack of communication with managers, and their complaints that the managers did not appreciate what happened at ward level and the problems that existed. I wanted to establish how managers identified their role in relation to the ward areas they managed. I asked if they spent any time visiting the wards:

"No I haven't, because nursing isn't my field, I moved out of that in 89, so mine is the overall picture of the organization, and mine is really about the systems, and getting the systems right for the Board…I haven't no" (GM 4).

This manager, having previously stated:

"It is not my responsibility. It's nobody's responsibility that is the problem…"

now acknowledged '*having to get the systems right*,' but made the point that he was working at executive level and saw his responsibilities as reporting upwards. I diverted here, as he had also previously mentioned being responsible for the 'signing off' of policies and protocols but appeared less interested in my comments at the interview that ward staff found them incredibly difficult to locate and use due to the lack of clarity in their order:

"The cheapest alternative to having out of date policies is to have one place where all the policies are up to date and that is (names hospital intranet). Everyone in the departments has access to (hospital intranet). The problem with the hospital intranet is the structuring of the information within (hospital intranet). The reason for that again is a staffing problem in that when you, to be able to structure it properly you need to have people who can spend the time to understand what the particular user needs are and structure it in such away that it will meet the 100 maybe 1001 different ways that people want to use this information…" (GM 4).

To date (February 2008), the policy layout[158] on the intranet is unchanged. There appeared here to be little concern that the intranet was impossible to use in day-to-day practice. I continued with the issue of ward visits:

158 See Appendix B1 List of Intranet Policies

"I used to go and visit the wards formally with the previous director and nurses, what I tend to do these days is to drop into the departments, I visit, I do it on a sort of a ad hoc basis and I've done, to be honest I've done it far less in the last 12 months" (GM 1).

"Yes, so it's quite frustrating sitting in an office all day. So you tend to get out a little bit more, but I suppose in some ways, I very rarely go onto the wards other than… " (mentions two wards).

KS Why is that. Because you…

"Well I suppose some of it is because I don't have direct management for the wards, that's under the nursing and I think that people don't want to see that you're interfering so to speak…. I think the structure is good here in that there is a good nursing hierarchy structure but we do link very closely with the matrons and the senior nurse so that's our input in as opposed to going on the wards" (GM 2).

This manager acknowledged not wanting to be seen as *"interfering"* and *"link very closely with the matrons"* but accepted that ward visits did not take place.

Another manager in the same position (an ex-nurse) held a different viewpoint:

"Well I would hope so (laughs)… I mean I think it's the walking and talking... for me, I honestly can't see the point in being a manager in the service if I don't know… For me the service is about patients and the people who are working and I do actually like to talk to patients and carers …I think it makes you touch base to actually walk around the people who are here, see people who are looking frightened because they are going for tests and see people on trolleys, see people sitting waiting for clinics etc and I find having the opportunity to actually be involved in, in management groups that involve users and carers" (GM 3).

Overall, the majority of managers questioned clearly felt that they could manage their directorates without visiting the areas that they were responsible for managing. This lack of contact reinforced the communication problems that the ward sisters had highlighted. The consensus of suggestion that I received was that it was 'Somebody Else's' job.

7:5 Real Work - Clinical Governance and Bedside Care

The final aspect in this Real Work category was the perception of nurses and stakeholders as to whether clinical governance was working and whether it had raised the quality of bedside and patient care. I asked interviewees if they could link clinical governance with any improvement in the quality of care, firstly, with the G grade staff:

(Long pause) *"No, I don't"*

KS Could you elaborate on that?

"I had to think for a minute to say, to say no… as I said earlier that because we now have more documentation and we're more accountable and we have more risk assessments …I think sometimes the hands on nursing care is removed…we very much now have to rely on, the A Grade and support workers with the hands on care and the feedback from them, because we're actually tied up with the documentation side of things. So I don't think it has improved because sometimes I think you do actually need the trained nurse to do the hands on care, 'cos that's when things are actually identified" (EC 7 5).

(Long pause) *"I can't visually see…clinical governance is part of complaints as well …and action plans…we should be getting better patient care because we should be abiding by the action plans. But what I don't, what I could see happening, is the action plans get put in a file and not reviewed"* (EC 7 3)

"I think …it encourages better practices and questioning. Are we doing and what we're doing right you know profess, personal development that leads to people looking at what they're doing more and therefore questioning and if they're not happy with it then going and perhaps finding a piece of research and coming back to the wards…So I think that once it's really, I think more of the junior staff are more aware of it I think it will make a difference" (N 7 1)

"I think it's made people more aware of what's going on… it has improved patient care and there's a lot coming with the housekeepers... I think that things are more patient centred and bringing the patient through to be there, instead of us telling, delivering that and getting the patient involved…" (EC 6 2).

"At ward level, ha-ha, I think it's probably, I think probably the whole, I don't know whether I could give you one example… as I say, it's something that I think as nurses we have to do anyway…I think patient care is improving, but whether it's down to clinical governance is, is a different matter…in the current suing climate that we're heading in and I wonder whether that, really… has had an impact as well. I don't know" (EC 5 1).

Overall, there was inconsistent evidence that the integrated approach of clinical governance had had an effect on the quality of bedside care. Although nurses appeared optimistic that clinical governance had improved bedside care, there was no clear consensus or evidence from any grade of nurse that it had actually achieved this. Most indicated that it had raised *'awareness'* and that there were *'better practices and questioning.'* There was however tangible evidence that paperwork had increased.

Allen (2001:171) had previously warned of the danger of more systems of audit that will '*compound the burgeoning volume of paperwork with which front-line staff must contend.'* She suggested that the clinical governance agenda would cause 'an inherent tension' in the nurses' role of 'professional commitment' to individualized care and the 'standardization' likely to be driven by the clinical governance agenda, particularly in regard to definitions of 'evidence-based practice.'

I asked the consultants:

"Starting to work… but I think it has changed the attitude of the organization in a beneficial way and in that sense it's working, but it hasn't yet worked if you see what I mean. In the sense that I still think there are a lot of basic things that we've go to do to get up to sort out the first level … I think we're beginning to move in the right direction" (C4).

"It is yeah, there are problems with it… it has been used to change the structures…." (GM 3).

"I think it is a good idea" (C1).

KS Is it working within your directorate?

"I think it is perhaps starting to, but I think, I mean I have been in charge of it for about a year now and it has taken me a while I think to get to grips with what we might do with it and how we might move it forward because it didn't have any particular structure to it when I took it over, it was just meetings where things were ad hoc discussed" (C1).

The consultants therefore displayed some reserve as to whether clinical governance was working, but none of them specifically acknowledged that it had raised the quality of patient care. I asked allied healthcare professionals the same question:

"I can give you lots of examples where it hasn't I think…. Well I'd like to think that it has in some situations" (AP 1).

KS Could you give me an example of a situation?

"I would have, this is difficult, I, I'm not convinced in our department it has improved the quality of patient care directly in a sense through the sort of feedback methods. Partly because the situations we're raising now as clinical governance issues are situations that were raised three or four years ago, and you just go round and round. So obviously if it had been effective then you wouldn't be raising them again…. also not convinced that it's made any differences from a sort of medical point of view because speaking to you know, friends and colleagues who are medical staff they would be very reluctant to raise issues, medical issues or concerns with the clinical governance group. There's still this notion attached to, you know you don't sort of say anything that's detrimental to your colleague. It would be you know it's just not the done thing. So I don't, again in terms of say if your talking about organization with a memory or learning from past if you like mistakes that's not happening the culture isn't there" (AP 1).

"Generally clinical governance is perceived as an add on across the Trust and in other Trusts as well it's perceived as something that we do, like we have a half day every two months which is perceived as an activity that happens every two months. It's perceived as a burden, I think the Trust, and shape of the complexity of clinical governance puts people off" (AP 6).

Some loyalty and professionalism were evident here, but the interviewees were not convinced that clinical governance had raised the quality of patient care. Where it appeared that there had been a tangible improvement in audit or documentation, the view was more optimistic:

"I'm sure it has, in fact I had a discussion with (Name). Yesterday, when we were talking about CNST and I think, if we look back to say where we were twelve months ago and some of the things we've done round documentation audits and consent competencies we must have reduced some element of risk by doing that and to me if you're reducing risk, then you are improving patient care… I think there's a lot further that we could go you know we could go a lot deeper and embed things in practice more and improve things even more" (AP 5).

"Hopefully it has and I think it has in the fact it will have brought the areas that were not involved in it before, up to at least a baseline level…. I think that sometimes it can still be driven medically and I think sometimes consultants can have their own agenda and it's difficult to get that foot in the door …. I still think we've got a long way to go and I think in the elderly directorate they're much more open, there used to much more working in a multi-disciplinary and inter-disciplinary way and they listen. I think in neuro it's a slightly different picture, I think they tend to still be very much driven by the consultants and what their needs and wishes are" (AP 3).

Allied Healthcare professionals therefore still displayed mixed feelings about whether clinical governance had improved the quality of patient care, with an indication that there was still medical dominance and that there was a long way to go. I asked managers:

"At directorate level I think it affects, because we've had to do reports in the past on progress on governance which is quite difficult to do, because we're not always measuring our progress on governance, we measure things by adverse incidents or complaints or you know what work is ongoing we don't necessarily get feedback and I think this is one of the areas we lack" (GM 2)

KS Do you think the system is working?

"It's not, it's ad hoc, I don't think anyone has really taken full ownership and drawn it into their everyday working practice" (GM 2)
"I think it's a culture change and I think it's oh governance was originally sold as I think this is a new thing. It's not a new thing it's a way of capturing information" (GM 2).

"I think its made people think. So from that basis it's been, it's hard to say it's governance alone that's done that or has it been all the standards markers such as you know Standards for Better Health that's come out... managers…are asking what's why are we doing this? Is it an effective treatment? It all ties into what is better for the patient. You know, there are going to be, you know with the moves towards payment by results and all the other pressures that are put onto us Trusts you know, you've got to prove that this service is financially viable with some outputs in terms of the patients" (GM 2).

This manager then saw her role as being involved in ultimate clinical decisions based on evidence provided. There was recognition of an increasing evidence-base for clinical governance,[159] a change that could be explained by coercive isomorphism:

"Yeah, I think it probably has. Not the using of it, it's very, it's very difficult to quantify ….we can quantify the half days (protected time) and we can certainly quantify and you know a range of audits, range of reports has been produced. I think then that gets embedded, so therefore I think it has" (GM1).

A senior manager commented:

"I think it has, not because of the title clinical governance, because of the, it is difficult to separate out the variables of this, but if you reflect on your practice and then you redesign the systems to be aware of that practice then it should make a difference….there are more guidelines around, even though they may be more difficult to get to, and there is a lot more people around who are competent and expert to ask questions of… Having said that I know that the sort of cases mix is much harder now, and the sickness and the complexity of the illnesses is at another level now" (G M 4).

Yet this interviewee had previously admitted that he did not visit the wards and that there was a 'staffing issue' in respect of making the intranet usable for staff.
Nobody questioned, therefore, was absolutely convinced that the systems of clinical governance had improved the quality of patient care, but 'thought' that it 'might' have. Some change was evident but this could relate to other concurrent initiatives.

7:6 Summary

This first section has presented the grounded theory categories and sub-categories of findings that emerged from the semi-structured interviews with nurses and stakeholders. These were 'Making Sense,' 'Knowledge Construction,' 'Somebody Else's Job' and 'Real Work.' Nurses involved in higher-level management gave 'ceremonial' examples of how the clinical governance implementation systems worked. Senior nurses complied with the systems with some 'mimetic' understanding, and staff at the bedside level found it difficult to identify any changes that they could clearly relate to clinical governance, apart from the 'coercive' requirement to complete the increased amount of documentation that the systems promoted.

It was evident that the consultant group could best explain the principles of clinical governance. Managers generally related it more to 'Somebody Else's Job.' Other professions had some trouble, as with the nurses, in defining and making sense of it. All

159 See Chapter 2:16 The Evidence-base for Clinical Governance

professions had problems in explaining how it had affected their role. It was hard to identify individuals who took corporate responsibility when things went wrong; it was 'Somebody Else's Job.' Difficulties in communication were apparent, with some managers admitting they did not visit the wards that they were responsible for managing and relied on communicating at meetings that nurses did not attend. In the 'Real Work' category, clear professional boundaries and barriers with hierarchical structures were evident in respect of non-sharing of information and one manager acknowledged that a change in culture was still required.

There was no consistent evidence in these interviews that the integrated approach of clinical governance has had an identifiable effect on improvements in the quality of bedside care attributable to the systems set up under the remit of clinical governance. There was no clear acknowledgement from any nurse that clinical governance had raised the quality of bedside care, although there was some evidence of increasing awareness of the clinical governance structures and processes. The Trust did not have an effective knowledge management system and, although some organizational learning was evident, I would argue that this was 'ad hoc' and not related to the capacity to learn and progress.

It seems logical that clinical staff, responsible for clinical decisions, work in conjunction with managers who, I would suggest, should ultimately take the responsibility for putting reliable systems in place. From the answers given, it was evident that, at corporate level, in the context of clinical governance, there was no clearly understood delegation of responsibility and roles were misunderstood, with the result that nobody took any responsibility when things went wrong and issues remained unresolved. Ultimately, this whole process clearly affected the nursing personnel on the wards, who, at the front line, were trying to use the unreliable systems in their every day practice. The failure of the systems and the increase in documentation did result in more time spent away from the patients' bedside.

In order to provide a different perspective on 'Making Sense' 'Real Work' and 'Somebody Else's Job', the next section provides two narratives of selected ward observation to illustrate the studied phenomena. Charmaz (2006:153) states that *'grounded theory works can be written in a variety of ways.'* A narrative account of two typical mornings on various wards will help to document some relevant points about the day-to-day working of nurses on the ward, what they perceived as their 'Real Work.'

Section B

7:7 Observation of Everyday Ward Practice – Real Work

Concurrent with the interviews, I spent time observing the day-to-day practice on the wards within the elderly care and neurosurgical directorates.[160] I was specifically interested in how nurses translated available 'evidence' into their daily nursing care 'practice', what opportunities there were for this and how they saw their responsibilities in making a difference to the quality of patient care, using the Essence of Care benchmarks. I quickly realised however that I was, to a certain extent, trying to observe something that there was little evidence of in practice. From the extensive field notes taken during my observation periods, therefore, I have chosen two examples to present and discuss what I observed to be 'typical' days in practice.

Many of my observation periods captured routine day-to-day 'Real Work,' in that nurses arrived on duty, sometimes had report, or began their shift with some task, such as sitting patients out of bed for breakfast, or getting them ready for theatre. Overall, the pace of activity on the wards can be described as constantly hectic. There were occasions where staff used the computer to confirm blood results, but I never observed internet or intranet searches being performed or protocols checked for any research-based evidence, even in the few quiet periods. This was not evident either during ward reports, but was not wholly surprising as it was difficult to imagine how the hectic pace of the day-to-day routine of ward activity would allow it to happen, especially as it was difficult and time consuming to find relevant information.

7:8 A Neurosurgical Ward

"We tend to fling the staff into the deep end here as we are so busy"

I spent one morning on a busy acute neurosurgical ward. In the space of five minutes, the sister spoke to two doctors, two bed managers, two occupational therapists and a health care assistant and her computer-generated list of patients with handwritten additions was frequently referred to, as she could not remember all that had been going on. This interaction was continuous and typical of her activities that morning (Real Work). At one point, I observed a cleaner who was busy wiping the cot sides of an occupied bed in one of the side bays. The patient had MRSA and was being nursed in isolation.[161] As I watched,

160 See Chapter 4:18 Ward Observation

161 See Footnote 123

the cleaner went from the cot sides to the bin outside the bay and carefully, using the same cloth, wiped that as well. I asked the sister if the ward had separate cleaners for MRSA infected patients in bays. "*No",* she responded, *"cleaning is a problem, we are always short."* I asked how often these bays were cleaned and she did not know. She appeared not to have noticed the activities of the cleaner (Somebody Else's Job). I subsequently related this incident to a senior manager and asked what training cleaners had at the Trust. He expressed great concern and said that he was going to check and get back to me, but did not (Somebody Else's Job).

Despite my assurances that I was just observing everyday practice for research purposes, I was introduced to the doctors, as *"a tutor from the school come to check up on us."* When asked whether I was observing doctors as well, I responded in the same frame of mind, that I liked to keep a keen eye on them. This however appeared to make no difference to practice in this instance, when the same doctor asked a patient to lie on his side and took a dressing off his back to examine a wound. The ward sister, who was pulling the curtains around the bed at the same time, turned and said to him, in front of the patient *"You haven't washed your hands."* He did not respond and carried on talking to the patient. I noted however that he did not touch anything else and that he washed his hands before he left the bay (Real Work).

Another consultant carefully washed his hands before examining a patient's wound, but then dropped one of the gloves he was about to put on onto the floor. He picked it up and continued to pull it on until told by the sister to discard it and get another one. *"You are going to change that glove aren't you doctor?"* The consultant smiled and commented that he had not remembered her being so diplomatic before (Real Work). This situation was interesting to me, as I had often wondered how I would react if I was confronted with some form of ethical dilemma in practice. The consultant was about to examine a seventeen-year old who had cerebral spinal fluid leaking from his ear and as he picked up and put the fallen glove on again I froze. Four other medical colleagues accompanying the consultant on the ward round all watched, yet said nothing (Real Work, Making Sense). There seemed to be an extremely long pause before the ward sister intervened. I, however, had no doubt, as to what I would have done if she had not, in that I would have intervened and stopped the consultant from approaching the patient. This would have biased my observation in that I could have asked the ward sister why she had not intervened, but my professional responsibility as a nurse was predominantly clear to me in this instance. During the same ward round, I noted that two consultants' mobile phones rang and that three calls were answered. Other members of staff on the ward round and patients had to wait for the

consultants to return. Following the medical round, a staff nurse, looking after the patient with the ear trauma asked the sister what she should 'pack' his ear with. The consultant had stopped this practice four days previously, the ward sister knew, but the nurse looking after the patient, despite attending ward reports, had not been informed (Real Work). This was an example of just one issue that arose during my ward observation, but others observed, such as the lack of hand washing and other bad practice, gave me some cause for concern. I spoke to nursing staff and, when able to, introduced the Essence of Care topic into the conversation. The responses and knowledge about the Essence of Care reflected the recorded responses in the semi-structured interviews; there was on this ward very little knowledge about the Essence of Care good practice benchmarks. I did not observe any activity that nurses linked with the Essence of Care.

Following this hectic morning, the sister and I sat for a few minutes at the nurses' station whilst lunch was being served. *"How do you know if the care you give is evidence-based?"* I asked. She responded that she relied very much on her own experience, as she was not very good with computers (Making Sense). Using the example of the packing of the ear, she said that that was just 'common sense' as people are discouraged to clean out their ears with ear buds anyway (Real Work). I asked her if she used any hospital policies or protocols in her everyday work and she said

"I don't believe the Trust have very many, I rely on the [ ] (hospital newsletter) and (name of ward manager) and ward meetings to keep me up to date with what is going on. Like (sic) nobody has ever said to me, this is what you do, in the nicest possible way, we tend to fling the staff into the deep end here as we are so busy"

I asked if she could show me how to get on to the hospital clinical governance website and she responded by telling me that she was unaware that there was one (Making Sense).

"As I said, I am not very good with computers anyway and would have to ask somebody else to show me."

I asked her how she had been involved in the designated protected time provided for staff for clinical governance purposes and she responded, *"This is not something I've heard of."* (Making Sense). She stated that the main problem on the ward was the skill mix and that I was observing on a 'good' day. When I left the ward, she said that I had kept her on her toes that morning. During our conversation, despite the recommendation of 'protected meal times' for patients, ward activity continued. Patients were collected for X-rays and theatre

and doctors continued their ward rounds. There was no acknowledgement in the nursing documentation of any link with the essence of care practice benchmarks.[162]

7:9 The Elderly Care Wards

I also spent time in observing the day-to-day practice on the elderly care wards.[163] I observed considerable 'ward routine,' in the nursing care of patients and nursing reports on their progress to staff (Real Work). I was again particularly interested in the use of available resources for the confirmation of evidence-based or best practice in this routine, in observing the 'embedding' of clinical governance (or in the nursing context, the Essence of Care) into everyday ward life. Unlike on the neurosurgical wards there were situations where I could observe changes in practice related to the serving of meals 'protected meal times' and the privacy and dignity of patients in that signs were sometimes (but not always) put up on closed curtains; I noted too, that (generally) hand hygiene dispensers were better used. There was no acknowledgement in the nursing documentation of any link with best practice related to the Essence of Care practice Benchmarks for dependent patients on the ward.

I observed that where patient electronic records were used and laboratory results had to be located, staff had become skilled in the use of the computer. I did not observe any other use or proactive discussion of the Essence of Care or evidence-based care, despite the resources being available (Making Sense), albeit in a cumbersome way, as previously discussed.[164] This was perhaps understandable as the wards were generally busy, but even in the quiet periods staff appeared to take the opportunity to relax, rather than proactively discuss care (Real Work). It became evident to me that ward staff were inevitably involved in the result of management decisions. The following two examples demonstrate how these affected the bedside care delivered. These are examples of the 'Real Work' that nurses have to contend with which may to some extent explain their difficulties in attending meetings and experiencing the development of organisational learning in respect to the Essence of Care Benchmarks.

During the period of my observation, a women's rehabilitation elderly care ward was re-allocated as a 'step up step down' or 'transfer of care ward' for medically stable patients who were fit for discharge, but, for a variety of reasons, were experiencing a delay. I knew that staff were upset about these changes. When talking to the senior sister on the ward during

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162 See Appendix B2b

163 See Chapter 4:18 Ward Observation

164 See Chapter 6:6 Knowledge Management – the Clinical Governance Trust Intranet

my observation of a busy morning, I found that one effect this had had on senior ward staff was that it seriously decreased the amount of time they engaged in supervisory bedside care, which was of great concern to the G grade sister (Real Work). (I have previously stated that, due to staffing levels at times I observed the G grades being involved in bedside care).

She stated that she only had direct contact with patients between the hours of 07:30 and 09:30, as, after 09:30, her time was spent on the telephone liaising with social workers from all over the country in respect of patients' discharge problems. She told me that in the plans for the change of use for the ward, there had been no extra provision for more hospital-designated social worker input and this was viewed as extremely short sighted by ward staff (Making Sense). The G grade on the ward described her new role as that of a 'glorified social worker' and expressed concern that more health care assistants were engaging in unsupervised bedside care because of this (Real Work). At the time of my observation on the ward, it appeared that there had been no formal published evaluation of this initiative (Making Sense). It was evident to me, even after one morning spent on the ward, that there was no time for supervised bedside care. Staff turnover on the ward had increased dramatically and the G grade stated that, in her opinion, nursing standards had suffered, with day to day bedside care delegated to the heath care assistants due to the increased 'social problem' workload of the qualified nurses. Another knock-on effect of this change was that the student nurse allocation to the ward was discontinued, as all the mentors on the ward had left (Real Work). I was told that the senior staff on the ward had not been consulted on the decisions made by the managers[165] (Somebody Else's Job) and were the last to hear about the ward's change of use. I asked the G grade why she had not complained and she stated that it would be ignored and that she was just waiting to retire anyway (Somebody Else's Job). Following the completion of my fieldwork, the ward closed and all staff were redeployed.

I mention this example as it is pertinent to a lack of 'staff feeling valued' (stated to be a priority of the Trust board), in that they were not told about the change in use of the ward: as I previously mentioned, managers did not visit their wards. These 'Real Work' situations also help to explain nurses' lack of engagement with initiatives such as clinical governance.

At this stage, however, I had only received an account of the consequence of a managerial decision on ward practice. I felt that it would be interesting to pursue the line of thinking from a management perspective, so that I did not present a biased view. I made some

165 See Chapter 7:3 Somebody Else's Job – Roles and Responsibilities in relation to Clinical Governance

enquiries as to what the reasoning was behind this initiative from a senior member of the Trust staff. I was informed that when the service managers visited various wards throughout the medical directorate, it had been noted that there were always patients who were waiting to be discharged, but, due to a variety of reasons, this had been delayed. It was decided by the managers that a 'transfer of care ward' would be designated and would be appropriate for these patients. Medically stable patients transferred to this ward, in theory, were supposed to be ready for discharge with all the formalities and a discharge date agreed and would spend a couple of days on the ward waiting for any minor issues to be resolved (Making Sense). In practice, this twenty-four bedded ward began to be used to 'place' patients fit for discharge, but who had social problems that had not been resolved. The agreed criteria for taking patients onto the ward were not implemented. Doctors, busy on the acute wards, failed to visit and some patients subsequently remained there for months. Informally, I was told that the ward was therefore seen to be a failure. Nevertheless, the decision to close the ward also appeared to be influenced by the opening of a new community intermediate facility to which patients could be sent (Making Sense). To date, this facility still has just five beds, although twenty-eight were planned. The redeployment of the rest of the ward staff when the ward closed is linked to the next observation, as will be revealed.

A ward within the elderly care directorate had a designated bay for use as an assessment unit for acute admissions. This was a busy unit and was such a successful venture that, during the course of my fieldwork, a general hospital assessment unit subsequently opened for acute admissions and the elderly care assessment unit closed (for financial reasons), with staff redeployed to the general hospital assessment unit. Due to 'winter bed pressures' the elderly care assessment unit soon reopened at short notice, with bank staff engaged to cover the shifts. It has remained open since, costing the directorate more for the employment of bank and agency staff and increasing the senior nurses' responsibilities for both the elderly care assessment unit and the accompanying ward. During my observation periods on the ward and in talking to senior and junior members of staff, the following situation became apparent.

I was initially told by a senior member of the Trust staff that when the elderly care services had been transferred from an old hospital into a brand new facility unit, an assessment bay for acute admissions (a Later Life Assessment Unit) on one of the acute older life wards was thought to be an excellent idea (Making Sense). It was popular with the consultants and staff and situated appropriately but had always experienced staffing problems due to the acute nature of the patients admitted (Real Work). Despite the fact that the unit was

staffed internally, the volume and pace of work there frequently led to the engagement of bank and agency nurses to cover the unit 'safely' and this had proved to be a major concern, in that the budget was always in deficit (Making Sense). The managers decided to centralise this resource and redeploy the staff within the assessment unit to the hospital assessment unit. There were again two unintended consequences evident in this move: firstly, that the staff from the elderly care assessment unit were found to be better skilled than the staff within the merged medical admission unit (although it had been thought that it would be the other way around). Secondly, that one elderly care consultant in particular (from the statistics produced), showed how much more efficient he was in comparison to his other hospital colleagues, in the assessment and care of patients whilst in the unit (Real Work).

Nevertheless, due to some design problems with the hospital assessment unit, which required it to close for a while, the elderly care assessment unit reopened within a couple of months due to pressure of beds and has remained open since. However, the original staff from the elderly care assessment unit did not return to the elderly care directorate (Making Sense). The staff who had been on the elderly care rehabilitation ward, as described above (which had then become a transfer of care ward and subsequently closed, and whose staff who had had no acute care experience for some years), were all redeployed to cover the elderly care assessment unit and have remained there since (Real Work). The ward manager, based on the ward where the elderly care assessment unit is, now experiences major problems in the provision of appropriate cover for these staff (Real Work). I observed that the staff attitude was that they had been deprived of their own colleagues, who were redeployed to the hospital assessment unit, through no fault of their own. One senior member described it as a 'theft' of experienced staff. The senior nurse simply received a phone call which stated that '*the assessment unit will open tonight'* resulting in frantic activity in respect of obtaining and checking appropriate equipment and staff cover (Real Work).

7:10 Summary and Concluding Comments

I previously mentioned[166] that I was particularly attracted in observing practice concerned with the Essence of Care[167] benchmarks whilst on the wards, which in turn linked to an evidence-base under the remit of best practice. I was interested in how nurses translated available 'evidence' into their daily nursing care 'practice', what opportunities there were for this and how they saw their responsibilities in making a difference to the quality of patient care, using these benchmarks. Whilst I set out to pay attention to this, I have in fact presented two

166 See Chapter 4:18 Ward Observation

167 See Chapter 2:15 The Nursing Component of Clinical Governance – The Essence of Care and Appendix B2 The Essence of Care

accounts of everyday practice from my fieldwork notes, because, during the periods of my observation, Essence of Care benchmark best practice was not apparent on the neurosurgical ward, and only slightly more visible on the elderly care ward (protected meal times and privacy and dignity). Categorically, nursing activities were carried out as a matter of routine and were not related to the guidance provided in the Essence of Care best practice benchmarks. In making sense of what I observed therefore, I have presented what I observed as 'Real Work.'

I chose these two narrative examples for a number of reasons. Firstly, these accounts help to illustrate the day-to-day work activity as observed and demonstrate some of the reasons that nurses do not leave their wards to attend meetings. It also provides examples of how nurses feel helpless in the fluid boundaries that surround their 'Real Work.' I have previously mentioned that nurses are not only part of the organization within which they work but are dependent upon how it functions. These are examples of this dependence, as demonstrated by the incidents of bad hand washing practise on the neurosurgical ward that involved other members of the multi-disciplinary team and bad cleaning practice, both of which will ultimately reflect on the nurses if the MRSA infection rate for the ward increases. When a nurse did point out bad practice, it was ignored and the nurse did not pursue it.

The changes imposed on nurses on the elderly care ward were completely out of their control. These examples also demonstrate the inferior status of nurses in respect to communication with managers and doctors on the wards. In retrospect, it is difficult to make sense of these changes, which is why I initially sought clarification for them. This clarification, however, was still not clear and lacked some appreciation of the issues in the day-to-day 'Real Work' problems experienced by ward staff because of these decisions. Because of this, the personal care of patients was delegated to untrained staff, and it was difficult to identify evidence-based practice in helping patients with, for example, personal and oral hygiene, as described by the Essence of Care, as these particular staff were unaware of the benchmarks. The care I observed was not based on the Essence of Care guidelines.

In conclusion, I would argue that the categories of 'Making Sense' 'Somebody Else's Job' and 'Real Work' fit together to produce a workable order for staff. They all put boundaries on workload and commitment that make the job sustainable within available resources.

Chapter Eight will address the issues that this study has highlighted.

Chapter Eight

Conclusions: Clinical Governance, Organizational Legitimacy, Professional Regulation or Clinical Excellence?

8.1 Introduction

The last Chapter concluded the presentation of the empirical evidence gathered from the semi structured interviews with nurses and stakeholders. In this Chapter, I will revisit the various issues raised throughout the Thesis, but specifically address the content of Chapters Five, Six and Seven, synthesizing and evaluating their key findings. I will also indicate where these point towards issues for future investigation. I have already considered the limitations of this qualitative study,[168] and acknowledge that the findings relate to a specific organization in one region of the NHS in England. However, there is every reason to think that the findings may be theoretically typical in similar Trusts.

My original aim was to investigate how clinical governance was improving the quality of patient care by exploring the knowledge and practice of ward nurses. I defined the main objectives of the study as investigating the implementation of clinical governance in nursing practice; describing its effects on nurses' roles and the quality of nursing care; and identifying what practitioners and other stakeholders regard as good practice in clinical governance for improving the quality of direct nursing care.

Fundamentally, the study focused on what effect the implementation of clinical governance in one NHS Hospital Trust was having on bedside nursing care. I located this within the context of new institutionalism theory in that the Thesis would examine whether the process of clinical governance was *'promoting excellence, imposing control, or simply producing a symbolic image of the organization that reflects changing environmental notions of legitimacy'* (Meyer and Rowan 1977:41).[169] I will refer to the grounded theoretical categories that emerged from the data, 'Making Sense,' 'Somebody Else's Job' and, more importantly, 'Real Work,' as identified in Chapter Seven. Knowledge management, organizational learning, organizational knowledge and the learning organization, found to be significant in the findings of this study, will also be discussed.

168 See Chapter 4:2 Participant Observation

169 See Chapter 1:0 Introduction and Need for this Study

In Chapter Two Section B,[170] I established that definitions of clinical governance were vague and lacking in detail and the empirical evidence to support clinical governance to assure health care is disputable.[171] I noted that there have been few research studies on clinical governance, to obtain a definitive answer about its effectiveness as an integrated system. I also found that there are only a small number of research studies on clinical governance and any resulting improvement in patient care, and that the same people had conducted the few reported.[172] This is ironic, as the system of clinical governance recommends that the basis of care given should be on 'best evidence' from well-conducted research. Studies have highlighted that attention must be paid to the vision of a 'culture of openness' and the 'organizational and cultural environment' within Trusts as well as resource issues, if clinical governance is become part of normal practice.[173]

8.2 Organizational Legitimacy

I first raised the notion of organizational legitimacy in Chapter Three, in relation to new institutionalism theory, and returned to it in Chapter Five, with relevance to the analysis of documents. The issue of changing environmental notions of legitimacy pertinent to state intervention and regulation of health care is also covered in Chapter Three,[174] which addressed the current requirements for documented evidence demanded by some of the regulatory bodies for the National Health Service. I found that these are overwhelming in nature and clearly duplicative in content. This finding was in keeping with Meyer and Rowan's (1977) analysis of how organizations seek legitimacy and support by incorporating structures and procedures that match widely accepted cultural models with common belief and knowledge systems. Nevertheless, they also suggest that 'organizational legitimacy' may be obtained by the purely 'ceremonial' adoption actions of the organization, which can manipulate resources but remain divorced from day-to-day activities and working practices. This forms the basis of my argument from the findings in the analysis of documents and observation of meetings.

Chapter Five established that having structures and procedures in place for clinical governance was a coercive institutional and external agency requirement, and, in response to this, the Trust had to implement corporate level clinical governance and other directorate meetings. I demonstrated that, in reality, the corporate clinical governance

170 See Chapter 2:12 Defining Clinical Governance

171 See Chapter 2:18 Research Studies on Clinical Governance

172 See Chapter 2:24 Summary and Concluding Comments

173 See Chapter 2:23 Organizational and Organizational Cultural Studies

174 See Chapter 3:5 State Intervention and Regulation of Health care

committee served a 'ceremonial conformity' purpose and as such, was, in reality, relatively ineffective. I gave examples from my observation at the meetings, my examination of documents and from tracking events in the minutes: the infrequent attendance of its members; the approval of ten policies in nine minutes; and the continuing lack of any implementation strategy for the dissemination of clinical governance information throughout the Trust.

Evidence was also presented of the many discrepancies between the reports from the official documentary records and what was actually done and observed and, from the summary of events, it was apparent that information given to committee members varied in detail. This is consistent with Murphy and Dingwall's (2003:66) suggestion that documents '*can provide valuable evidence about what people and organizations would like to be thought to be doing'* rather than accurately reporting what had taken place at the meeting. This also links with Garfinkel's (1967) finding, that records should be viewed as 'contractual' rather than 'actuarial': they are not literal accounts of what happened but evidence that the appropriate personnel went about their business in a competent way.[175]

I demonstrated that there were many errors and inconsistencies in this official documentation and, as such, much of the discussion, debate, and dispute that took place at meetings was ignored, or summarized only if it was a manageable 'charter' problem.[176] This supports the constraints and conflict 'mission' and 'charter' notions of Dingwall and Strong (1997). An organization can only have one 'charter' but there may be competition to define what goes into it and how it should be interpreted. An example of this is the neglect of the purpose of the meeting as stated[177] and the disproportionate amount of time spent in giving feedback on the preparation of the paperwork for various healthcare regulatory requirements, as for the Clinical Negligence Scheme for Trusts level two inspection. Wiener's (2000) study, on the quality assurance movement in health care in North America is relevant here. She described the intense activity before inspections in documentation preparation to meet the exact preferred format for accrediting requirements. I too observed the same sort of intense activity. I would also argue that this is what those involved with the process view as 'Real Work.' It is what was done at the time.

175 See Chapter 5:2 Documents and Clinical Governance

176 See Chapter 3:17 Rationale for the use of a New Institutionalism Theoretical Framework

177 See Chapter 5 Corporate Documentation and the Organizational Process of Clinical Governance

The first question that needs to be asked, then, is did the professionals go about their business in Garfinkel's (2002) 'competent way'?[178] A passive representation of an event does not affect that event, but a study such as this can question the usefulness of the event represented. This makes representation very much more complex than it might be. Through my analysis of documents and meetings, and subsequent interviews and observation of ward activities, I would argue that there was confusion and lack of evidence that staff within the Trust did go about their business in a 'competent way.' One might then begin to question the usefulness of the committee or ask whether it is a failure. Did its activities outweigh its weaknesses? Overall, was it highlighting what is important, or making important that which it highlighted? I would argue that central Government cannot comprehensively monitor whether anything happens on the ground, but can monitor the paperwork. If a hospital demonstrates conspicuous, but ceremonial compliance everyone is happy, and it becomes legitimate, but it affects only the ceremonial order, rather than the culture, delivery of bedside care, patient experience and, indeed, how patients are recognised amongst the members of the organization. In this case, it appears that legitimacy is the pre-condition of organizational success rather than its consequence.

It seems logical that whilst clinical staff are responsible for clinical decisions, they should work in conjunction with managers who, perhaps, should ultimately take responsibility for having reliable systems put in place. From the evidence collected it would appear that, at corporate level, in the context of clinical governance, responsibilities and roles were not clear, nobody took any action when things went wrong and issues remained unresolved. This, then, affected the nursing personnel who, in trying to use the unreliable systems on the wards, spent more time away from their patients, while managers, who do not visit the wards, could not see what the problems were.[179] I noted in my interviews that managers appeared happy if they received the reports from the protected time meetings, but were not so interested in what actually took place. 'Real Work' so far as managers are concerned is to manage the ceremonial order and demonstrate compliance with externally defined targets in order for the Trust to remain legitimate.

However, in terms of new institutionalism theory, one has to look at the purpose for external organizational legitimacy and the achievements of the same Trust over the same

178 Garfinkel (2002) stipulated that the ability to recognize competence is "staff-specific, work-site-specific, discipline-specific" (p.113). The unique adequacy suggests that it is the analyst's job to document what the participants are doing, rather than what they should be doing based on some set of a priori expectations. In this way, it prohibits assessment by analysis of members' achievements.

179 See Chapter 7:5 Real Work

period of observation.[180] It obtained a three star status and recognition (for having appropriate structures and systems in place) for insurance purposes, of a higher level of compliance with the Clinical Negligence Scheme for Trusts, which carried a significant reduction in insurance premiums. The Trust was able to produce the correct and appropriate documentation necessary for this 'external legitimate recognition' and was viewed as being highly effective (in fact the best hospital in the region), which ultimately brought financial incentives to improve services.

In this respect, new institutionalism theory was particularly relevant in making sense of what was happening in the Trust and explains the finding in this Thesis that external legitimacy can still be obtained without a clear indication of improvement in quality. I also observed variation or heterogeneity in the working of the two directorates observed, in that their structures and functions were set up in different ways. Ultimately, though, both directorates 'conformed' when using the same template to write up their quarterly reports on clinical governance. I therefore believe my findings support and advance the more recent arguments identifying both homogeneity and heterogeneity activity within an organization as described by Oliver (1991), and I would argue that institutional, agency and competitive external pressures did exert strong influences on the process of change, but still ultimately resulted in ceremonial conformity at directorate level.

8.3 Cultural Change

A limitation of utilising new institutionalism theory to explain what is happening in the Trust is that it does not deal very well with change that goes on in the environment of organizations, but deals only with the impact on the organization itself. New institutional theory was very helpful in linking actions at a corporate (or 'macro'-) level, but was not as useful for explaining events occurring at other levels. Change was definitely taking place within the Trust, and the emphasis within new institutionalism theory is on the importance of changes in culture. New institutionalism says that culture matters, both externally and internally, and that change is based on the power and culture conflicts *within* the organization. However, it is evident that change has occurred and did occur in a non-linear fashion, through the emergence of new rules, as demonstrated in this case study. I found that change was occurring on the wards because of Matrons' visits[181] in respect of the Essence of Care implementation but that nurses could not identify very much change

180 See Chapter 3:13 Coercive Isomorphism

181 See Chapter 6.9 Essence of Care Meetings

on the ward due to the process of clinical governance, apart from the increase in paperwork.

I would agree therefore that culture is linked to change and argue that slowness and resistance to change are due to the traditional culture of the NHS, which is notoriously difficult to alter, as identified in the literature,[182] which is consistent with other findings reviewed in Chapter Two. As previously discussed, DiMaggio and Powell (1983, 1991) have stated that there are institutional elements involved in this, and that organizations go through a process of 'structuration.'[183] This consists of four parts and I would suggest that this case-study organization is within the phase of: '*an increase in the information load with which organizations in a field must contend'*. It is relevant in this respect that there was little reliable Trust knowledge construction in relation to promoting culture change. Frontline staff did not attend meetings or use the intranet, and the dissemination of information was unreliable. It could be argued that a regulatory system was being devised that left the fundamentals of professional discretion intact, but sought to create a structure of legitimacy. This was apparent in the corporate level writing of policies that 'were there,' but not many nurses or stakeholders appeared to use them. For external audiences, therefore, the Trust needs to appear 'managed,' but to gain the cooperation of a professional workforce, it needed to respect their autonomy and discretion.

Ultimately, it would seem that the advocates of clinical governance are adopting an old-fashioned rational model of organizations, even if they have taken on the new language of organizational culture and culture change. They are assuming that culture can be rationally redesigned. What is happening locally is not a 'failure' but an unintended consequence that results from an inadequate understanding of how organizations do work.

8.4 Imposing Control - Professional Regulation

Chapter Three provided a brief historical context to the study of the professions, and observed a shift of opinion back to the professions as making a normative and value contribution to meeting a need for social order in the global economy and international markets. It was also noted that, as with almost everything in the health service, professional regulation is currently under review. The situation is still confused at present. In relation to nursing, it was clear that it was considered a subordinate and managed

182 See Chapter 2:23 Organizational and Organizational Culture Studies

183 See Chapter 3:12 New institutionalism theory

labour force, with historical examples of State intervention blocking of actions that the General Nursing Council wished to take. Nevertheless, there appeared to be signs in the 'renewed strategy of professionalisation'[184] that this might be subject to change, with the vision of a 'professional practitioner' with the aid of higher levels of education. One of the unique features of the NHS is the number of different professional groups that are involved in service delivery. It would be difficult to imagine homogeneity and isomorphism without heterogeneity pressures because of this, and examples are given in the conflict and lack of agreement within meetings. I was, therefore, specifically interested in whether there was any further evidence emerging from my study that clinical governance was instrumental in affecting professional regulation or shifting the balance of power between these professional groups.

Firstly, I found that nurses appear to have engaged as little as possible in or simply ignored, clinical governance. The 'vision,' proposed by Currie and Suhomlinova (2006),[185] who mention an opportunity for nurses to increase their power under the 'new neo-institutional' template (which is relevant to the systems of clinical governance), had not been seized. I suggest that this is clearly related to the lack of available knowledge management systems, protected time and education opportunities available for nurses within the Trust. Secondly, Davies (1996a, 1996b) has argued that there should be shared authority with all health care professionals and especially with the patient if clinical governance is to work. I found that, while there was patient representation on the corporate clinical governance committee during the period of my fieldwork, patients did not play a clearly recognised part in the clinical governance systems at the hospital.[186] I established that the medical profession headed all the structures for clinical governance implementation and would argue therefore that there was no real shared authority and that nurses still play a subordinate role. I have presented an example of where an 'agent' overruled the 'structure' with the DNAR 'policy highlighting a concern that powerful agents might still enable a focus on issues relevant to medical interest.'[187]

A number of nurses and stakeholders' comments did demonstrate the increasing importance of regulation in the 'stakeholders' and 'nurses' semi-structured interviews. The first is in an account given by an allied health professional (AP4) in relation to

184 See Chapter 3:2 Nursing as a Subordinate Profession

185 See Chapter 3:16 Rationale for the use of a New Institutionalism Theoretical Framework

186 See Chapter 5:1 Corporate Clinical Governance Meetings

187 See Chapter 5.4. Meeting Themes

registration.[188] Nurses identified increased documentation and auditing[189] at ward level and this too has the potential to increase regulation over practice. This finding however is concurrent with Evett's (2006:139) suggestion[190] that '*these occupational changes are often perceived by the workers concerned as more paper work and additional responsibilities'* and in effect *'the quality of the service to the client is perceived by the workers to decline.'*

Whilst there is some evidence of proactive change in practice, there is not enough within this case-study to state categorically that nurses have been able consistently to engage in *'shaping services'*[191] albeit for a variety of reasons. I presented examples that suggest shifts in regulation, in terms of protocol and policies that potentially could be used as a checklist of practice standards, if the need arose,[192] and that there is a new frontier in nursing, medical and managerial relations. It is also apparent that accountability and performance indicators have become a fundamental aspect of professionalism, in that professionals and the organizations, within which they work, are subject to achievement targets in order to be measured and compared. I would therefore argue that there is evidence in relation to clinical governance of an increasing auditing process of compliance to the 'norms' as indicated by a guideline or policy for clinical practice. I suggest that there is a potential for rules to grind down co-operation and trust in clinical settings, which supports other study findings such as McDonald *et al* (2005b). I would argue that the 'norms' of clinical practice and even careers of health service personnel could ultimately be determined by conformity to these guidelines and protocols. I do not believe that the corporate clinical governance committee members realised the significance of approval of policies and protocols, as in an earlier observation from my field notes:

'*The length of the discussion of these policies depended on the actual personnel attending the meeting. Sometimes, the approval appeared more as a token, for example, at the following meeting, when ten policies were approved in nine minutes (February 2004). I wondered in this instance if anybody present had read any of the circulated policies. At other times, however, the debate became lively and policies were referred back to the authors for clarification or further work.'*[193]

In relation to the professions, I would propose that clinical governance is a process of <u>regulation</u> that will ultimately affect all health care professionals. The production of

188 See Chapter 7:3 Somebody Else's Job – Roles and Responsibilities in relation to Clinical Governance

189 See Chapter 7:4 Real Work 7:5 Clinical Governance and Bedside Care

190 See Chapter 3:1 The Professions

191 See Chapter 3:16 Rationale for the use of a New Institutionalism Theoretical Framework

192 See Chapter 7:3 Somebody Else's Job – Roles and responsibilities in relation to Clinical Governance

193 See Chapter 5:5 Policies and Protocols

policies and protocols will change the balance of power in favour of the managers and will challenge the hegemony of professional groups within the NHS, to promote the rise of managerialism. This would be consistent with Scott's (2000:22) study of San Francisco hospitals when he describes an era of *'managerial control and market mechanisms.'* What is interesting in that study is that external regulatory Governmental agencies sharply declined during this era and it would seem to indicate that this might also happen here.[194] It is argued therefore, that, viewed from a managerial perspective, making healthcare practice auditable is what policies and protocols are all about. Perhaps one might foresee an era of financial auditing emerging, once the vast amount of documentation generated reaches a stage where inconsistencies from the 'norm' can be identified. In the attempts to achieve this 'norm,' however, one might envisage ever-increasing bureaucratic administration and expense.

I would also suggest that the professional group most affected by this change would be the doctors. The basis of audit is the assumption that, if there is insufficient evidence produced, there is incompetence. Nevertheless, the important justification for clinical governance is ultimately that the 'quality' of clinical care will improve if an integrated system is implemented. Scott *et al* (1990) demonstrated that there were changes and increases in rules, normative systems and cognitive beliefs that were eroding the sovereignty of physicians and changing organizational fields. Freidson's (2001) point of view is also relevant here, that if doctors lose their autonomy, who will be able to defend patients against the encroachment of corporate rationality on common humanity? A return would be necessary, as previously mentioned, to the value of professions in making a normative and value contribution to meeting a need for social order.

8.5 Clinical Excellence – Improving the Quality of Patient Care

Did the integrated process of clinical governance improve the 'quality' of bedside care? I concluded in Section A of Chapter Two that 'Quality' and 'Quality Management' are contested social concepts and subject to negotiation within organizations. It was also evident from the literature that many previous quality initiatives within the NHS had been abandoned for a variety of reasons.[195] However, in answer to the specific question posed to staff in the semi-structured interviews: *'Do you think that, in general, clinical governance has raised the quality of patient care?*' The majority of nurses and

194 See Chapter 3:5 State Intervention and Regulation of Healthcare

195 See Chapter 2:8 Evaluations of Quality Improvement Initiatives

stakeholders questioned did not appear to think so.[196] Managers identified improvements as coming from the systems set up, the conduct of meetings and the measurement of adverse incidents, complaints and 'culture change', but still acknowledged the difficulties in that the systems did not always work.[197] Overall, whilst there was a willingness of professionals to co-operate, with some isolated examples given of increasing awareness of improvement through the adverse incident reporting system, the systems were not consistently or sufficiently robust to support this. Professional boundaries were also evident in respect of the non-sharing of information and it was acknowledged that a change in culture was still required, as identified in other studies.[198]

The third theoretical category identified through the process of grounded theory was 'Real Work.' This analytical category emerged from stakeholders and nurses' perceptions about their roles in how clinical governance had affected their practice. The promotional literature states that all health care professionals have a role to play in helping clinical governance work and the Essence of Care[199] was supposed to be instrumental in this respect. From data obtained, it was evident that there had been changes in practice, as observed for instance in the introduction of protected meal times, and patient privacy and dignity initiatives. Nevertheless, I did not observe any consistency in the practice of these initiatives on the wards as demonstrated in Chapter Seven Section B. This was not an unexpected finding, as nurses did not attend meetings and the dissemination of information was unreliable. Many nurses questioned did not connect the changes of protected meal times and privacy and dignity to the Essence of Care, evidence-based practice, or indeed to clinical governance. This may not appear important if practice is improved anyway, but I would argue that if the advance of practice is mimetic, or delegated to untrained members of staff, the *'philosophical slant'* of organizational knowledge is not apparent (Easterby-Smith and Lyles 2003:3). I did not observe care based on the Essence of Care best practice benchmarks on the neurosurgical wards and best practice only related to two benchmarks on the elderly care wards. However, it is important to note that I did observe failures of implementation, even where they were noticeable effects to progress the learning organization. In this case, change still depends on the agents, in, for instance, hand washing. Despite the empirical evidence related to hand washing (including the Essence of Care benchmarks) and the reduction in cross infection, many staff did not, as a matter of routine, wash their hands. I have

196 See Chapter 7:5 Real Work – Clinical Governance and Bedside Care

197 See Chapter 6:6 Knowledge Management – The Clinical Governance Trust Intranet

198 See Chapter 2:23 Organizational and Organizational Culture Studies

199 See Chapter 2:15 The Nursing Component of Clinical Governance – The Essence of Care

already given a detailed account of two incidents I observed on the wards, but there were many more. This was 'Real Work.'

8.6 Knowledge Management, Organizational Learning, the Learning Organization and Organizational Knowledge

The sub-sections exploring the category of 'Making Sense' focused on how staff obtained information about clinical governance. In this respect, knowledge management refers to the transformation of unconnected data into meaningful and connected knowledge. Knowledge management was also a process that allowed a 'bottom up' approach to complement the 'top down' aspect of clinical governance, in order to develop the experience and understanding of individuals, whilst moving both the individual and organization forward. It was noted that there was official acknowledgement in the 'Trust Vision'[200] that staff were its most important resource and must be trained and supported in order to deliver its precepts. However, evidence presented within this study indicated that this was variable within the Trust. There was no updating of the clinical governance intranet facility and it was debatable how much staff could use it as a working resource, especially in relation to the use of protocols and policies to guide their everyday practice. It was deemed slow and cumbersome, with a poor search facility.[201] I also established that few ward-based nurses attended meetings[202] or had protected time. There was a general lack of knowledge in this respect, so it would appear that a 'culture change' was not happening in the nursing category through this 'facility.' Few nurses saw a link between the provision of professional development activities and a clinical governance 'learning organization.' However, other health care professionals did indicate more of a link, which was perhaps reflected in their ability to attend more meetings than nurses did. Power structures were also evident in the comment made by a manager[203] '*down to ward sister level'* which, as previously stated, inadvertently reflects the hierarchical structure, and inequality of knowledge sharing across clinical practice. It also demonstrates some antagonism for the subservient status of nurses, perhaps as a result of normative-mimetic institutional forces.

Overall, this case study indicates that the implemented systems were only partially successful and, despite reports of system difficulties by staff, identified problems were not being addressed at the time I completed my fieldwork. The 'top down' approach was not

200 See Chapter 5:1 Corporate Clinical Governance committee Trust Meetings

201 See Chapter 6:6 Knowledge Management – the Clinical Governance Trust Intranet

202 See Chapter 6:4 Organizational Knowledge – Protected Time Meetings

203 See Chapter 6:6 Knowledge Management the Clinical Governance Trust Intranet

gaining compliance and effecting the desired behaviour change; as this case study has identified, there was not an effective knowledge management system to keep all staff updated. Professional boundaries were still apparent and organizational learning and the learning organization was not effective as there were constant problems with attendance at mandatory training, continuing professional development sessions and protected time meetings.[204] Indeed, if all employees fulfilled the obligation to apply for mandatory training, the Trust did not have the capacity or resources to deliver the sessions. As previously mentioned,[205] Currie and Suhomlinova (2006:3) stated *'As with any other organizational activity, knowledge sharing is subject to the constraining and enabling influence of institutions.'* I would agree, and further argue that the clinical governance systems were not successful open-knowledge sharing systems, firstly due to the lack of effective organizational management and secondly because of the day-to-day pressures emanating from the organizational environment. Staff simply did not have time for a 'bottom up' approach and, ultimately, it is the confidence in the system that the people who use it have, that makes it a success.

The statement by Currie and Suhomlinova (2006:22) that *'the old boundaries which the new institutional template seeks to overcome, are alive and well and show few signs of abating'* is supported by the findings within this study. It could also be argued that the knowledge management strategy implies a 'profession blind' concept of a 'learning organization' in that it relates to an organization that has 'lost' its memory on the division of labour, professional boundaries and perhaps even the gendered division of the health professional workforce and the social inequalities that exist. Additionally, the tensions between political, managerial, professional and personal values and the organizational mission that drive any organization and the fact that actual day-to-day activity may be different, all exacerbate the problem.

Alternatively, it could be argued, that clinical governance had achieved some organizational learning, albeit unintentionally, in that there were systems that existed that collected evidence when things went wrong. The problem was with the constant failing of these systems and the dissemination of their results that required attention. It would appear in this instance, that there is much to be done to bring clinical governance and organizational learning together to take advantage of the potential benefits of each.

204 See Chapter 5:6 Education and Training – Organizational Learning

205 See Chapter 3:16 Structure, Agency and Processes of Institutional Change

I could not connect real change or improvement in bedside practice to the integrated system of clinical governance at ward level through the process of the 'Knowledge Construction' categories. There was some evidence of change and improvement in bedside practice, but this was due to other means, such as Matrons' visits to the ward. I would propose therefore that this is an important finding for developing an effective means to change and improve nursing practice.

In relation to the category of 'Somebody Else's job' it had been noted that the clinical governance facilitators had voiced concern about the gap between the rhetoric and reality of their role and the professions allied to health, like nurses, had slightly more obscure notions as to what their roles were. I identified that the notion of 'Somebody Else's Job' appeared to be particularly strong in the management category,[206] yet it was stated by the Department of Health (1998b) that health service managers are similarly required to manage knowledge effectively to facilitate an environment in which excellence in clinical care will flourish. However, if management is about delegation, the point here is that nobody appeared to pick up the delegation, as it was still 'Somebody Else's Job,' as portrayed succinctly in the comment made by a senior manager:

"It is not my responsibility. It's nobodies' responsibility that is the problem" (GM 4).[207]

The manager responsible for quality within the Trust clearly saw his role as that of 'co-ordination,' albeit at a corporate level, but I would suggest that nobody took responsibility when things went wrong. As long as reports were in, and fulfilled the 'ceremonial' need to have the right documentation to meet the requirements of organizational legitimacy, all was well. Yet I have described the discrepancies and variation found within this documentation.[208]

The finding that few managers visited the wards considerably lowered their credibility with nurses and did affect 'Real Work' on the wards. I also acknowledged that the medical profession had become very dominant in the clinical governance structure, in that all the directorate leads for clinical governance were doctors, so I would suggest that the medical profession, as a group, maintained control and engagement with the working environment in relation to the clinical governance remit.[209] This situation is still consistent with

206 See Chapter 7:3 Somebody Else's Job – Roles and Responsibilities in relation to Clinical Governance

207 See Chapter 6:6 Knowledge Management - the Clinical Governance Trust Intranet

208 See Chapter 5:3 Terms of Reference and Minutes of Meetings

209 See Chapter 7:3 Somebody Else's Job – Roles and Responsibilities in relation to Clinical Governance

Freidson's work (1970a, 1970b) about professional dominance, in that the professional monopoly of medicine was based both on the physicians' expertise together with their role as control agents.[210] Freidson also argued that, despite all the changes in the organizational environment, the expert knowledge of professionals remained an important source of resistance to managerial control.

I would argue from the evidence presented that ultimately the 'Real Work' of 'Somebody Else's Job' fell heavily onto the nursing staff on the wards. They were the personnel who had to fill in the adverse incident forms, complete the audits, provide the evidence for CNST and cope with the failing systems as part of their everyday work, as well as their own perceptions of 'Real Work,' which was caring for patients.[211] This paperwork was also difficult to undertake because of constant software and reporting problems. My criticism is not that this is necessarily wrong, but that the time and resources invested in ineffective systems compromises the time spent in 'hands on' patient care. There was little or no feedback as to what ultimately happened to the nurses' reports and complaints, which made the responsibility meaningless to them. In summary, the increase in paperwork related to clinical governance had fallen on ward level nursing staff. This had decreased the time that nurses spent on bedside care with more of this activity allocated to untrained members of staff who do not have specialised knowledge in respect of best practice benchmarks.

8.7 Concluding Comments

The provision of healthcare is becoming increasingly complex and fragmented and it is useful to remember that within any profession there are multiple 'segments,' with distinct identities, values and interests (Bucher and Strauss 1998). There are many professions within the health service, each with their own set of priorities, which introduces complications in evaluating what might otherwise be viewed as 'apathy' or lack of success in policy implementation. One must also appreciate the practical implications in shaping policy goals into acceptable and workable structures. Ham (2004) proposed that it is vital to consider the negotiation and bargaining within the policy community (in this case, the National Health Service) in order to understand its processes. It is also apparent that health care professionals in England are experiencing rapid and radical change. This provides an extensive sociological field for study, as there are claims that this compromises the ability to care for patients with targets, efficiency and cutbacks interfering with professional experience and judgment, and the patients' best interest.

210 See Chapter 1:1 The Importance of Studying Healthcare and 3:7 The Regulation of Health Care Professionals

211 See Chapter 7:4 Real Work and Chapter 7:5 Real Work – Clinical Governance and Bedside Care

Alternatively, of course, these claims could be dismissed as ploys to protect professional authority, control and privilege.

In Chapter One, I noted that, according to Davies (2003), organizational studies of the NHS have not been prominent in recent years. The study of the hospital as a social organization had declined significantly in the last thirty years. Davies also made it clear that health care organizations are very different from the hospitals studied by medical sociologists forty years ago and that there was a particular need for research into their contemporary forms. I have shown that there are few ethnographic studies in medical sociology that considered clinical governance. I argue, therefore, that this Thesis, by explicating and analysing local knowledge, beliefs and practices has made sense of the social actions and behaviours, which are characteristic of the specific health care context described. I have also identified the relatively powerless and vulnerable position of nurses and acknowledged what has contributed to their gaps in knowledge, how knowledge is imparted and how nurses and stakeholders make sense of this knowledge in respect of clinical governance. By doing this, it has been possible to obtain a different perspective on the practical effect of policy implementation. This ethnographic study, in using new institutionalism theory as a basis for the study of the organization, has contributed to medical sociology through its emphasis on descriptive detail and actors' meanings and it has increased the empirical data about the implementation and interpretation of clinical governance. In summary, the Thesis shows that because the hospital is good at producing external paperwork, it disguises that fact that organizational effort is apparently not making care better for patients and may indeed be making it worse, but nobody appears to notice. New institutionalism theory provides a coherent framework to understand why organizations adopt procedures and practices which appear to promote uniformity and standardisation. Nevertheless, the evidence from this case study of clinical governance reveals some of the complexities - and local difficulties – of such processes in a health care setting.

From the data obtained in this study, I would also argue that clinical governance has created some potentially unreliable systems. It would appear that health care personnel might well not want to adopt these new ways of working, as they are not confirmed as credible. While there is some evidence of change, there is only moderate effort to adapt to new ways of working, particularly at ward level. Nurses do not appear to have been proactive nor to have had very much of a voice in the implementation of clinical governance. I would endorse the need for further independent studies on clinical governance and organizational studies and the consequences of these changes for

nurses' workload and patient care, as there is still limited evidence for any improvement in the quality of care as a result of the integrated approach of clinical governance.

Nevertheless, the reduction in nurses' time to care for patients will ultimately reflect on the organization's capacity to care for patients. The more adversarial nurses become with managers, the less collaboration there will be. In addition to its encroachments on doctors' autonomy, clinical governance seems to question the 'therapeutic' value of a nurse's relationship with patients. In protecting this, it could be finally argued that nurses are the only ones standing their ground by not attending meetings and not fully engaging in clinical governance (the latest in a line of quality initiatives that have mostly been abandoned),[212] in order to protect the time to 'care' for their patients. On reflection, in resisting the engagement with clinical governance, nursing may have emerged as the strongest profession of all.

If asked whether clinical governance was working, the answer would really depend on the reasons as to why it was initiated in the first place. While change agents promoted and endorsed its success, the lack of organizational processes and knowledge management equally promoted its failure, by denying the commitment and resources to implement the desired actions. Clinical governance has been a 'ceremonial success;' but the actual adoption of the desired actions and progress within the organization will remain a paper exercise until organizational and practice issues are addressed. In terms of making an organization legitimate, clinical governance has been highly successful in bringing reputational and financial rewards to the Trust.[213] The regulation of professional staff has increased. Nevertheless, from the results of this study, there is limited evidence that the integrated system of clinical governance is improving the quality of patient care at the bedside.

212 See Chapter 2:1 General and Healthcare Quality Assurance - Historical Aspects

213 See Chapter 8.2 Organizational Legitimacy

Appendix A 1 Notice to Patients on Ward

UNIVERSITY OF SALFORD

NOTICE TO PATIENTS ON WARD

From TUESDAY 19 OCTOBER
AN INTERMITTENT OBSERVATIONAL STUDY OF NURSES WILL BE CONDUCTED ON THIS WARD

FOR FURTHER INFORMATION ON THIS STUDY

PLEASE CONTACT THE WARD SISTER

OR

KAREN STANILAND

UNIVERSITY OF SALFORD

TEL 0161 295 2724.

Information Sheet for Nurses on Ward xx

k.staniland@salford.ac.uk

Tel 0161 295 2724

My name is Karen Staniland and I currently work in the School of Nursing, University of Salford as a Senior Lecturer/Flexible learning Co-ordinator.

I am completing a PhD study entitled The Effect of Clinical Governance on Nurses' Roles and the Quality of Nursing Care' which will examine the impact of Clinical Governance on nurses' roles and consider whether a cultural change in the routine of nursing work is occurring. This will be achieved by comparing the implementation of clinical governance in two directorates within the Trust with specific regard to nursing practice. As a result of this study, it is intended to suggest strategies for the sharing of good practice. Ethical approval has been given for the study.

The study is in two parts and will involve:
1. Observation
2 Ward Interviews

I intend to visit ward xx to observe nursing practice. This will involve being present at ward handovers and identifying how nursing care is delivered and organised at ward level.
The Trust and participants will remain anonymous throughout the study as I will not identify to others those who take part.

Thank you for taking the time to read this information. Please do not hesitate to contact me if you have any questions.

Appendix A 2 Nurses' Questions

General Questions

1. What do you think clinical governance is?

2. How would you describe your specific role in relation to CG?

3. Can you give me any examples of how clinical governance has affected your own practice at the bedside?
   i. at ward level?
   ii. at directorate level?
   iii. at hospital level?

4. Could you give me an example of a situation in which you or a colleague might consult a protocol or guideline?

5. Do you look at the CG website?

6. Can you tell me anything about it?

7. How far do you think clinical governance connects with professional development planning?

8. Do you think that in general, clinical governance has raised the quality of patient care?

9. Is there anything else you would like to say?

Appendix A 3 Letter to Participants

Mrs K. Staniland

Return address

Date
Participant address

Dear

I am writing to invite you to participate in a research study exploring your experience of clinical governance.

As you may know, I currently work in the School of Nursing as a Senior Lecturer and have educational links to the elderly care directorate within the Trust. I am completing a PhD study entitled 'The Effect of Clinical Governance on Nurses' Roles and the Quality of Nursing Care.' and am interested in undertaking semi-structured interviews with various grades of nursing staff.

Please find enclosed an information sheet, which explains the study in greater detail and the level of involvement you can expect if you agree to participate. Please contact me if you would like to take part in the study.

I may follow up this letter and information sheet with a further letter (if necessary) to identify if you are interested in becoming involved in the research study. If you have any questions or wish for further information please do not hesitate to phone me on 0161 295 2724.

Yours sincerely

(Mrs) Karen Staniland

Appendix A 4 Information Sheet for Participants

Information Sheet for Participants
k.staniland@salford.ac.uk
Tel 0161 295 2724

My name is Karen Staniland and I currently work in the School of Nursing, University of Salford as a Senior Lecturer/Flexible learning Co-ordinator. I have had educational links to the elderly care directorate within the Trust for several years.
I am completing a PhD study entitled The Effect of Clinical Governance on Nurses' Roles and the Quality of Nursing Care' which will examine the impact of Clinical Governance on nurses' roles and consider whether a cultural change in the routine of nursing work is occurring. This will be achieved by comparing the implementation of clinical governance in two directorates within the Trust with specific regard to nursing practice. As a result of this study, it is intended to suggest strategies for the sharing of good practice. Ethical approval has been given for the study.
I intend to visit a number of wards to observe nursing practice. This will involve being present at ward handovers and identifying how nursing care is organised and delivered at ward level. I am hoping that by sending this letter and information sheet to a large number of nursing staff in both directorates, that enough nurses will volunteer to take part in a semi-structured interview, but I will follow up this letter and information with a telephone call, if necessary, until I have recruited at least ten staff from each directorate.

If you agree to participate in the study, you will be invited to attend one taped interview that should last between 30-60 minutes. I will attempt to make the interview as relaxed as possible in a time and place that suits you. You will be asked to comment on a number of clinical governance aspects, the exact nature of which will be informed by the preceding observation data collection.
Myself, or an independent transcriber will transcribe the interviews, which I will analyse and provide you with a summary of the themes and comments extracted from the text. You may if you wish request a copy of the interview transcript.

Your involvement is voluntary and you must not feel obliged to be involved. If you change your mind, you can do so without offering an explanation. Any data that you have provided will be destroyed and not used in any part of the study.
The Trust and participants will remain anonymous throughout the study as I will not firstly, identify to others those who have volunteered and will secondly, use a coding system that is known only to myself. Comments by grade and code, or false name, however could be discussed in the final research report, as these may be pertinent to the study. Confidentiality of responses will be maintained as only me and an independent transcriber will have access to the taped interviews. Once the study is completed, the tapes will be destroyed.

Thank you for taking the time to read this information. Please do not hesitate to contact me if you have any questions.

Appendix A 5 Consent Form

Research Study Title: The Effect of Clinical Governance on Nurses' Roles and the Quality of Nursing Care

Researcher: Karen Staniland

This research study will look at two directorates within the Trust and will focus on the nursing care given at ward level in order to investigate the implementation of clinical governance in nursing practice and describe its effects on nurses' roles and the quality of nursing care.

THIS IS TO CERTIFY THAT I_____

agree to participate as a volunteer in the study and will attend one taped interview that should last between 30-60 minutes. I understand that I will be asked to comment on a number of clinical governance aspects, the exact nature of which has been informed by preceding data analysis. I understand that these tapes will be stored safely following the interview.

I understand that the researcher, or an independent transcriber (who will not be aware of my identity), will transcribe the interviews and that these will be analysed and that I will be provided with a summary of the themes and comments extracted from the text. I can ask for a transcript of the interview if I so desire.

I understand that the information may be published, but that my name will not be associated with the research, or any comment traced to an individual in the final written report.

I understand that I can refuse to answer any question. I also understand that I am free to withdraw my consent and terminate my participation at any time.

I have been given the opportunity to ask questions and all such questions have been answered to my satisfaction.

_____ _____

Participant (Date)

_____ _____

Researcher (Date)

Appendix A 6 Stakeholders' Questions

Stakeholders General Questions

1. What do you think clinical governance is?

2. How would you describe your specific role in relation to CG? (?dissemination)

3. Can you give me any examples of how clinical governance has affected your own working practice
    i. At directorate level?
    ii. At hospital level?

4. Could you give me an example of a situation in which you or a colleague might consult a protocol or guideline?

5. Do you look at the CG website?

6. Can you tell me anything about it?

7. How far do you think clinical governance connects with professional development planning?

8. Do you think that in general, clinical governance has raised the quality of patient care?

9. Do you practice Management by Walking about? (Manager's question)

10. Is there anything else you would like to say?

Appendix A 7 Nurses' Analysis Grid

Questions	Matrons AD Band 8a Respondents N8a 1 EC 8a 2 8a 3	Y	N	U	G Grades Band 7 Respondents N 7 1 Ec 7 2 Ec 7 3 N 7 4 Ec 7 5	Y	N	U	F Grades Band 6 Respondents N 6 1 Ec 6 2 N 6 3	Y	N	U	E and D Grades Band 5 Respondents Ec 5 1 N 5 2	Y	N	U
What do you think clinical governance is? **Themes** **Quality** **Clinical governance terms** **Patients** **Professional/ Personal development** **Practice** Research Making Sense Care Somebody Else's Job Making sense	Framework n8a 1 Quality n 8a 1 Seven Pillars n 8a 1 Term for different quality issues n Ec 8a 2 Audit ec8a 2 Anything to do with the quality of patient care Ec 8a 2 Up to the organization as to what it is	+			Improving standards for patients n71 Quality of care delivery n71 Encouraging professional development n 71 Better working environment in the NHS n 7 1 Something you look up before an interview. Ensuring practice remains up to date Ec 7 2 Good standard Ec 7 2 Support network Ec 7 2	+			Making patients more comfortable Making nurses more aware of their surroundings Making their experience better in hospital N 6 1 Umbrella term Maintaining standards of excellence, maintaining standards of patient care, audit, benchmark, improve care Ec 6 2 Its basically,	+			Improving quality of care and services Making sure people are accountable for what they are doing Ec 5 1 Improving knowledge N 5 2	+		

	8a 3 Risk management 8a 3 Professional development Ec 8a 3 Patient focus, research, seven pillars 8a 3	Identify problems Ec 7 2 Process standards guidelines are adhered to make service better Ec 7 3 Terms to improve quality, essence of care, incident reporting, standard setting n 7 4 Term for setting and improving clinical standards and patient care Ec 7 5	well there's a group of people mainly headed with consultants in the Trust where they get together, have a few meetings and it's to do with policies and procedures really and how things are actually run on a day to day basis N 6 3	
How would you describe your specific role in relation to clinical governance? Themes **Quality** **Clinical governance terms** **Patients** **Professional**	Represent practice development teams on cg committee Imbed cg into everyday practice	Ensuring staff are competent, safe with skills, have knowledge about cg, patients are aware of their rights. N 7 1	Making student's life bearable n 6 1 Support the staff Disseminate information Maintain high standard of patient care n	Improving patient care, my own knowledge, implementing Trust policies, keeping aware of

Personal development
Practice
Research

Themes
Quality
Clinical governance terms
Professional
Personal development
Practice
E o C

Somebody Else's Job

at ward level n 8a 1
Cg drives what I do on an every day basis Ec 8a2
Managing the clinical role focus for all staff 8a 3

+

Supporter of the staff, attend cg meeting to keep myself updated, have support from the group Ec 7 2
See that Trust CNST policies, risk registering adverse incident reporting are adhered to, systems in place so higher management can respond to change the service
Ec 73
Manage project for E of C, adverse incident reporting improving quality, introducing Government

+

+

6 2
we're not really that involved, I don't think and probably should be more involved.
Em, I'm not sure whether the ward manager gets a little bit more involved but I don't even think that they are invited to the meetings because they are not actually on the clinical governance board, so I suppose the only way we get involved is by putting through critical

+

changes Ec 5 1
Maintain high standards, keep p to date following regulations and protocols n 5 2

			initiatives n 7 4 Communicatio n, audits assessment, monitoring of patient care, monitoring of staff Ec 7 5		incidents and having the feedback from them but we are not actually personally involved at the moment N 6 3			
Can you give me any examples of how clinical governance has affected your own practice, firstly at the bedside? **Themes** **Quality** **Clinical governance terms** **Patients** **Professional** **Personal development** **Practice** Research **Dissemination of information** Real Work	Impleme nting current research findings in patient care, dissemin ation of informati on to bring about change in practice n 8a 1 Essence of care, nutrition, audit on how food should	+ + +	Encourages prof development improving clinical skills n 7 1 Drugs careful, critical incident meetings Reduce falls MRSA reduction of infected cannula sites Ec 7 3 Trolley provided – prescription charts changed, result of adverse incident, privacy and dignity signs,	+ + +	Patients have more say in how they are cared for n 6 1 Standard setting, evidence-base Ec 6 2 whether I'm right or wrong, is with the adverse incidents, they're the main things that we're being told you know no matter how much you think that	+ +	Essence of care meal times organised Ec 5 1 Don't know- essence of care n 5 2	+ +

Can you give me any examples of how clinical governance has affected your own practice at ward level?

Themes

Quality

Clinical governance terms

Professional

Personal development

Practice

Dissemination of information

Increased documentation

Somebody Else's Job

Real Work

be delivered Ec 8a 2 Influence through adverse incident reporting, complaints 8a 3

Raised profile of accountability, ensuring right structures and systems in place, dissemination of information n8a 1 Doing audits, opening up cans of worms, checking resus

presentation of meals n 7 4 Risk assessment, falls E c 7 5

Ensuring other people are aware of cg making sure they know its about improving standards of quality, how they would get this information n 7 1 Drugs and MRSA bad practice hand washing raising awareness Ec 7 2 Following policy re

nobody is actually going to listen to you when you do them, you must do them for absolutely everything that you think. N 6 3 work hierarchy gone, work more as a team N 6 1 NSF essence of care, continence, nutrition, benchmarking, audit Ec 6 2 I 'd say again the main thing I can think of, whether I'm right or wrong, is with the adverse incidents, they're the

Whole issue, skills can't give example Ec 5 1 Complaints, PALs communication big problem N 5 2

trolleys every day
Ec 8a 2
Probably the same prof dev of staff, leadership

visiting times because of the crackdown on MRSA and cleaners not being able to clean Ec 7 3
Nothing to add
SN 7 4
Increase in the monitoring of standards, increased documentation more accountability no added resources EC 7 5

main things that we're being told you know no matter how much you think that nobody is actually going to listen to you when you do them, you must do them for absolutely everything that you think. Even if it is you think that you've had an inappropriate admission, that you should do the critical incident for them which should then be taken up in clinical governance

Can you give me any examples of how clinical governance has affected your own practice at directorate level?

Themes

Quality

Clinical governance terms

Professional

Personal development

Practice

E of C

Dissemination of information

Working on a action learning workshop from clinical governance to everyday practice for practitioners N 8a 1

Appraisals cnst nursing staff do not attend protected time meetings, ward managers meeting with complaint mainly N 6 3

Build up relationships with managers n 7 1

MRSA standing up to doctors nc 7 2

Nurses don't get protected time nc 7 3

Specialist nurse request for mental care essence of care sent to corporate level, no feedback as of yet, folders on ward about mental health n 7 4

Attending the medical managers meeting Ec 754

I've never thought about it n 6 1

Sharing of information essence of care ec 6 2

I'd say again really it is mainly the adverse incidents that I can think of. I'm sure there's loads of things that it's affected but this is quite bad really em but mainly I'd say the adverse incidents, critical incidents.. N 6 3

I don't know ec 5 1

Benchmarks market days for essence of care, attending meetings on epilepsy n 5 2

Can you give me any examples of how clinical governance has affected your own practice at hospital level?

Themes
Clinical governance terms
Practice
E of C
Dissemination of information

Real Work

s and adverse incidents Ec 8a2
No different to ward level 8a 3
Written eight evidence -based Trust policies n 8a1
Sharing adverse incidents with other directorates
Through matrons meeting Ec8a2
Reviewing a complaint from ombuds man and HCC involved in risk register corporate cl gov

I don't understand that, policies CNST n 7 1
Same as directorate level ec 7 2
I can't E c 7 3
Privacy and respect, PALS customer care course n 7 4
More aware of risks and accountability Ec 7 5

Same answer as directorate level N 6 1
We meet up more as a directorate and in the medical and surgical side as a directorate ec 6 2
I'd say that's one of the main things infection control at the moment and I think that's a lot to do with the media and things as well, because it's always been in place and it has to be shown now to relatives and patients can see that you are actually washing your hands and

No again ec 5 1
I've become more politically aware with essence of care, but that's at directorate level n 5 2

comm. How that effects directorates 8a 3

Could you give me an example of a situation in which you or a colleague might consult a protocol or a guideline?
Themes
Clinical governance terms
Practice

Whenever I was unsure about an area of practice N 8a 1 +
Adult protection, suspicion of abuse nc 8a 2
Involved in the development of them, investigating a complaint 8a 3

Drug errors – looked to see who we should report it do n 7 1 +
Rarely, Care of the dying Ec 7 2 +
Ng feeding MRSA, sometimes get told about new policies Ec 7 3 +
Very protocol driven positioning, sedation, types of mask for ventilation n 7 4 +
Passing a naso gastrc tube Ec 7 5

things they think that you are more, if you've got something hooked on to the end of your uniform. N 6 3

Tracheostomy care, computers really slow, n 6 1 +
Blood transfusion ec 6 2 +
Infection control would be one of them, if you've got a patient. Because at the moment we've got a patient who we were querying whether they had pulmonary TB and so you want to

I always look at nursing skills I haven't done for a while, pharmacy ones health and safety, syringe drivers ec 51 +
We have printed off a lot of policies recently n 5 2

know what the appropriate policy for infection control for them N 6 3

Do you look at the clinical governance website? **Professional** **Personal development** Somebody else's job	I did, I haven't recently, it wasn't very good.n 8a 1 No ec 8a2 I look at it thinking we must do somethin g about it 8a3	+	+	+	Not routinely n 7 1 Looked at it not had time to read it. ec 7 2 Not very often I think briefly n 7 4 No I don't E c 7 5	+	+	+	Occasionally yes n 6 1 To be honest I haven't looked at it for a while E c 6 2 No, no, it's on the list N 6 3	+	+	+	No ec 5 1 No n 5 2
Can you tell me anything about it **Quality** **Professional** **Personal development** Somebody else's job	Seven pillars identified key people n 8a 1 No nc 8a 2 Not been updated for 3 years, it's	+	+	+	Not really n 7 1 No ec 7 2 Not really ec 7 3 No not really n 7 4 No E c 7 5	+	+	+	It's quite clear and informative, not been on for a few months, it's not been updated n 6 1 What's happening in the	+	+	+	No, I can't say I knew there was one ec 5 1 No n 5 2	+

How far do you think clinical governance connects with professional development planning?

Themes
Clinical governance terms
Professional
Personal development
Practice

Somebody else's job

Real work

Making sense

not accurate 8a 3
I don't think it does unless the person is aware of clinical governance n 8a 1
Loosely nc 8a 2
Should be in everybody's PDP 8a3

I think people that know about it utilise it very well, junior staff wouldn't n 7 1
At grass roots very little, time constraints, trained staff replaced by assistant practitioners, more pressure on qual staff no time for meetings mandatory training ec 7 2
It should but I don't always get to find out and we don't share across the directorate ec 7 3
I think it has a huge impact clinical gov is at the heart of

Trust
No N 6 3

I think it connects quite well really, I don't know what the guidelines are n 6 1
I think it does E c 6 2
I don't know really N 6 3

I think it does connect, from a trained nurse point of view it doesn't really. It hasn't changed anything because its what we've been doing anyway E c 5 1
I suppose it give it more of a structure making sure standards are better and people are enabled. I don't know n 5 2

improving things for patients n 7 4
Yes but I don't know if it's implemented ec 7 5

Do you think that in general clinical governance has raised the quality of patient care?

Themes
Quality
Clinical governance terms
Professional
Personal development
Practice
E of C
Dissemination of information

Somebody else's job

Making sense

I'd like to think it has element of ivory tower, I don't think it's making a big impact. n 8a 1
Definitely More disciplinary discussion. Adverse incident meetings good, stopped nc8a2
People

Yes I do I'm not quite sure how n 7 1
No, critical incidents are a paper exercise, pasted answers, I don't see how that improves anything ec 72
Only specifically like falls but action plans get put in a file and not reviewed E c 7 3
Definitely, no blame culture, looking at adverse incidents look at best

In general yes, still some areas that need improving such as infection control n 6 1
I think it has made people more aware of what is going on, audits, care plans audited, listening to what patients want.
E c 6 2
It probably has, it probably has because people, you

I think patient care is improving but whether it's down to cg is another matter, current suing climate, people more accountable ec 5 1.
Yes I like to think it has to a certain extent but I think there are other things as well. Like the work we are doing with essence of care and PALS n 5 2

	won't recognise it as clinical gov, but CNST, mandatory training8 a 3	practice n 7 4		know are more aware and I do know that I think there have been certain things that say that we've put through as incidences that have actually been discussed at clinical governance N 6 3				
Is there anything else you'd like to say? **Quality** Practice Somebody else's job Making sense	CG was not the right place to be – opportunity to change with clinical effectiveness 8a 3	Not particularly n 7 1 People at the top need to come and see what it's really like ec 7 2 No Ec 73	+ + +	No not really n 6 1 No ec 6 2 I just think that people, we should probably be a bit more involved but it's the same as everything we're busy on the ward, the shifts busy, it comes to the	+ + +	No E c 5 1	+	

end of the day you think do I want to go to a meeting or do I want to go home and it's bad you choose you want to go home I mean..
Talking about the protected time, now that you mention it I do remember we were told the X-ray dept, once, I remember them saying we've got protected time this morning so we're not doing any, and I remember thinking well, if they can

					get it , but we're never going to get protected time because who's going to be left on the ward if that happened? But we should get something to be more involved really. It will never happen. Well I don't think it will anyway. It might do now that you are doing this (laughs) N 6 3.
How are the staff on the wards informed about cg? **Themes** **Dissemination of information**	Notice boards protected half days bring cg into	+	General meeting on ward, notices pinned up behind the nurses' station.	+	

Making sense	conversations try to sort of use it in development issues n 8a 1		Ec 7 5					
How does essence of care connect with cg? **Quality** **Practice** Making sense Real work	It's all with cg n 8a 1 E o C is clinical gov 8a 3	+ +	Used as a nursing tool. We have our own website it's not under their umbrella, people are more likely to access our website Huge resistance from doctors involved n 7 4	+			They are quite interlinked really n 5 2	+
Examples of E of c on the wards **Themes** **Clinical governance terms** **E of C** Real work	Nutrition, protected meal times n 8a 1	+	Specific areas, nutrition yes ec 7 2	+			It's seven areas I think and where things are failing, they've looked at benchmarks and producing folders ec 5 1	+
Increased the amount of paperwork?	No, doing things in a	+	Quadrupled ec 7 2				Just to an	+

Themes
Clinical governance terms
Increased documentation

Real work

different way ec 8a 2
If I was a nurse on a ward I would say yes. More electronic recording, 8a3

+

Yes cnst, risk register incident reporting half my time is spent on paperwork but nobody is talking to each other 4 or 5 people are sent the same information, no way of retrieving information re air unless every one is gone through. ec 7 3
No good it facilities
Being computer literate helps N 7 4

+
+

+

extent but it gives more structure to things n 5 2

Intranet policies easy to use?
Clinical governance terms

Making sense

Very difficult, you have to trawl through them, many complaints eca2

+

Protected time essence of care

Themes

Protected time

Real work

Bringing in of abbreviations to do with risk assessments,

Clinical governance terms

Making sense

One day a week has made a huge difference n 7 4 +

I've not attended any meetings overwhelming, don't understand what they stand for CNST risk registers E c 7 5 +

I'm not aware of protected time ec 5 1 +

Other Comments

Trust should acknowledge who is and who is not going to clinical governance meetings, lot of pressure, who's going to look after the patients? They can't have it both ways. Nc 8a 2

Y = Yes
N = No
U = Uncertain

Highlighted negative or 'wrong' comment

Yes

Don't know

Coding

N = Neurosurgery
Ec = Elderly Care
8a – 5 = band or grade
Numbers = interviewees

Emerging Themes

Quality

Clinical governance terms

Professional Personal development

Practice Issues

E of C

Dissemination of information

Protected time

Increased documentation

Categorised Segments

Making Sense

Knowledge Construction – Trust Organization of Clinical Governance Information

Clinical governance terms

Dissemination of information

Protected time

Knowledge Construction

Policies, Protocols and Guidelines

Knowledge Construction – The Learning Organization

Professional Personal development

Somebody Else's Job

'People' themes

Real Work

Quality

Increased documentation

Practice Issues

Essence of Care

Appendix A 8 Link w ***Mission and Chart***	**Question One What clinical governance is?**		**Matrons Band 8a**	**G Grades Band 7**	**F Grades Band 6**	**E and D Grades Band 5**
Theory						
New instil						
Mission/Charter						
Matrons		**Quality**	3	2	0	1
?External legitimacy						
Rest internal legitimacy			Literature	Care		Care
		Patients	1	0	1	0
			Improving standards		Comfort able	0
		Patient care	1	1	1	0
			Quality		Standards	
		Practice	1	1	0	0
Imposing control		**Audit**	1	0	1	0
Imposing control		**Standards**	0	3	2	0
		Accountable	0	0	0	1
		Non specific	1	1	3	1
		Essence of Care	0	1	0	0
	Question Two Role					
Ceremonial conformity		**Every day practice**	3	0	0	0
Belief systems		**Attending meetings**	1	1	0	0
Imposing control		**Following protocols**	0	1		2
		Disseminating information	0	0	1	0
Imposing control		**Following systems**	0	4	1	1

		Non specific	1	2	3	1
		Essence of care	0	1	0	0
	Question three a. Affected own bedside practice					
Imposing control		**System example**	3	4	2	0
		Personal example	0	5	0	1
		Don't Know	0	0	0	1
culture		**Essence of Care**	1	1	0	2
	Question three b ward level					
Matrons external legitimacy		**accountability**	1	1	0	0
		systems	1	0	0	0
		audits	1	0	0	0
		Essence of Care	0	0	1	0
		Standards	0	2	0	0
		None/same	1	1	0	1
		Dissemination	1	1	0	0
Imposing control/culture		**Increased documentation**	0	1	1	0
culture		**Complaints**	0	0	0	1
	Question 3 c directorate level					
culture		**Everyday practice**	1			
		Relationships	1	1		
Imposing control/coercive		**Systems**	1			
		No difference	1	1	1	
		Meeting difficulty	1	2		

Open system theory		**Dissemination**	1		1	
		Appraisals/CNST	1			
		Meetings	2	1	1	1
		Complaints	1			
		Essence of care initiative		2	1	1
legitimacy		**Risks and accountability**		1		
		Never thought about it			1	
legitimacy		**Adverse incidents**			1	
		Don’t know				1
Ceremonial conformity	**Hospital Level**	Policies/writing following	1			
		Meetings	3			
		Complaints	1		1	
		Don’t know		2		1
		Essence of Care		1		1
		Risks/Accountability		1		
		Same		1	1	1
		Infection control			1	
Mimetic isomorphism	**Consult protocol/ guideline/policy**					
		Practice	1			
		Develop	1			
Changing culture		**Example given**	2	4	3	1
		Rarely		1		
		General comment				2
	Clinical governance website					
Formal rule?		**No**	1	4	2	3
		Yes			1	
		Have done, not for a while	2			

Change in culture	**Tell anything about it**					
		No	2	5	1	3
		Yes				
		Wrong	1		2	
	Connects with personal development planning					
Ceremonial conformity		**Doesn’t**	1			1
No normative pressure?		**Loosely**	1		1	
		Should do	1	3		
		Very little		1		
		Time constraints		1		
		Hugh impact		1		
		Connects well			1	
		Don’t know			2	1
		Think so				1
		Hasn’t changed anything				1
	CG Raised the quality of patient care					
Ceremonial conformity		**Like to think so**	1			1
		Not a big impact	1			
		definitely	1	1		
		People don’t recognise it as clinical governance	1			1
		CNST mandatory training				
		Yes unsure how		1	1	1
Ceremonial		**No Paper exercise**		2		

conformity					
		More aware			2
	Increased Paperwork				
Change in culture		**Different way**	1		
		Yes	1	1	
		More electronic	1	1	
		No		1	

Appendix B 1 List of Intranet Policies

Karen

Here is a list of the policies on the Intranet that are governed by the Document Control Policy. I think it would be difficult to identify those that were written after the DCP came into force. I am also attaching a spreadsheet that shows those listed after the process of entering them on the spreadsheet was instituted.

1. Bed Closure, Temporary
2. Bed Management
3. Board Assurance Framework
4. Bodies Direct from the Ward - Authoring, Recording and Issuing
5. Car Parking Operational Policy
6. Caring for Children on the Adult Site
7. Claims Management Policy
8. Clinical Audit Projects - Registration of
9. Complaints
10. Concerns Reporting Whistle blowing
11. Consent Policy
12. Contacting Junior Medical Staff during the normal working day and out of
13. hours
14. corporate Induction
15. corporate Plan
16. Copyright for Written, Artistic and Other Original Material
17. Frequently asked questions
18. Data Quality
19. Diversion Policy - GMEA
20. Document Control Policy
21. Email
22. Electronic Patient Record Access Policy
23. Emergency Admissions Policy - Greater Manchester NHS Trusts
24. Environmental Management Strategy
25. Fire
26. First Aid Policy
27. Freedom of Information
28. Health and Safety Policy
29. Health Issues Policy
30. Health Records Policy
31. High Professional Standards in the Modern NHS (Medical Staff) -
32. Maintaining
33. Human Rights Act
34. Hygiene Policy
35. Incident Management
36. Information Governance Policy
37. Information Governance Principles
38. Information Governance Statement
39. Information Security
40. Intellectual Property
41. Internet Access Policy
42. Last Offices - Procedure for

43. Locum Nurse Policy
44. Lone Worker
45. Media in Response to a Major Incident - Managing the
46. Missing Patients
47. Mortuary Services out of hours
48. Non-emergency PTS use
49. Pathology Quality Policy
50. Patient Advice and Liaison Services - Protocol for the Introduction and
51. Use of
52. Preceptorship Policy - Nursing
53. Publication Quality Assurance
54. Radiation Protection Policies
55. Records Management
56. Registration Authority Policy
57. Research - Policy for Dealing with Allegations of Misconduct and Fraud
58. in

59. Research Governance Utilising EPR - Enhanced
60. Risk Management Strategy and Plan
61. Risk Profiling and Risk Assessment Procedure
62. Risk Register Protocol
63. Risk Register Template
64. Salford Link
65. Signage Policy
66. Smoking Control Policy
67. Standards of Service
68. Training in the safe use of Medical Equipment
69. Transfer of Care
70. Using Taxis on Trust Business
71. Waiting List Policy
72. Waste Procedures
73. Website Policy 1 - Content and Presentation
74. Website Policy 2 - Independent Websites
75. Website Policy 3 - Departmental Intranet Sites
76. Workwear

77. Incident Management
78. Health and Safety Policy
79. Risk Management
80. Control of Substances Hazardous to Health
81. Bomb Policy R Smith Oct 2001
82. Display Screen Equipment - Computers
83. Fire Safety - corporate
84. First Aid
85. Latex Allergy Policy A Trail /
86. Medical Devices & Equipment
87. Needlestick and Sharps
88. Personal Protective Equipment
89. Portable Electrical Appliances
90. Risk Profiling and Risk Assessment
91. Safer Handling of Patients and Loads K
92. Security of Personnel and Property
93. Sharps - Management of
94. Spillage (including Mercury)
95. Stress, Management of

96. Waste Management

97. Safe Bathing of Patients
98. Tagging of Babies

99. Facilities Management S Phillips Feb 2005
100. Facilities - Estates H Evans Feb 2005
101. Facilities - Hotel Services S Brine Feb 2005
102. Facilities - Support Services I Ramsay Feb 2005

103. A.B.C. Protocol
104. A.B.G Sampling
105. A.C.S. Guidelines - Flowchart
106. A.C.S Guidelines - Explanatory Information
107. Acne - withdrawn from use - currently being revised
108. Acute Asthma, Management of
109. Acute Atrial Fibrillation
110. Acute Left Ventricular Failure, Management of (Currently under revision
111. -
112. Nov 99)
113. withdrawn from use - currently being revised
114. Acute Liver Failure, Management of
115. Acute Mono-Arthritis
116. Acute Pain Manual
117. Acute Normovolaemic Haemodilution Guideline
118. Administration of a drug by Intermittent Central Vein Infusion
119. Administration of Drugs via Bolus Injection Peripheral Cannula
120. Administration of Intravenous Fluids by a Central Vein Infusion
121. Administration of Intravenous Fluids by Peripheral Vein Infusion
122. Agitated and Restless Patients - Management of
123. Alcohol Withdrawal - Management of
124. Allergies, Hypersensitivities, Intolerances & ADRs. ("The Allergies
125. Policy") - Policy for the Recording of
126. Anaphylaxis Protocol
127. Anogenital Warts
128. Antibiotic Guidelines
129. Anticonvulsants and the Contraceptive Pill
130. Artificial Rupture of Membranes
131. Atopic Eczema - withdrawn from use - currently being revised
132. Baby Born Before Arrival - Guidelines
133. Bacterial Meningitis
134. B.C.G. Vaccine
135. Bed Management
136. Bed Management - Temporary Closure of Beds
137. Benign Prostatic Hypertrophy Guidelines
138. Bereavement Support (following the death of a baby)
139. Birth Centre/ Midwife led care booking criteria - Guideline for
140. Birth Environment
141. Birthing at Home - Guidelines for care of women
142. Bladder Tumours
143. 'Block-replace' regimen for Thyrotoxicosis
144. Blood Glucose during labour Gestational Diabetes - Management of

145. Blood Glucose during labour Pre-Gestational Diabetes - Management of
146. Blood Transfusions - Indications for
147. Blood Transfusions - Neonatal
148. Blood Transfusion Protocol
149. Blood Transfusion Record Sheet
150. Bolus Dose - Epidural Infusion
151. Bottle Feeding
152. Breast Feeding
153. Cardiopulmonary Resuscitation, Guidelines for Withholding
154. Care Planning - Early Pregnancy Loss
155. Caring for Children on the Adult Site
156. Central Venous Catheter Site, Management of a
157. Chemotherapy induced diarrhoea - The prevention and treatment of
158. Chest Drain Consent
159. Chest Drain Insertion Argyle
160. Chest Drain Insertion Seldinger
161. Chest Drain Management Argyle
162. Chest Drain Management Seldinger (Portex)
163. Chest Drain Record
164. Chest Drain Removal (Seldinger and Argyle)
165. Child Protection
166. Concerns Reporting
167. Consent Policy
168. Cushing's Syndrome Investigation
169. Cytotoxic Policy
170. Day Case Surgery
171. de Soutter cast saw and Extraction System - Cleaning of
172. Death Certification and Post Mortems
173. Dermatology Surgery Unit - Lignocaine, Adrenaline Use of
174. Diabetic Foot Ulcer - Management of
175. Diabetic Gastopathy - Management of
176. Diabetic Patients to the Diabetes Specialist Nurses. Criteria for
177. Referral
178. of
179. Diabetes - Management of Day Case
180. Diabetes - Management of During Surgery
181. Diabetic Inpatients with at Risk Feet
182. Diabetic Renal Disease - Screening policy
183. Diarrhoea Unexplained
184. Discharge - Nurse led
185. Dipyridamole stress for Myocardial Perfusion Imaging (MPI)
186. Dopamine to treat epidural hypotension guidelines - use of
187. Doxycycline Pleurodesis Protocol
188. Dying - Care of
189. Dyspepsia - Algorithm
190. Eczema - withdrawn from use - currently being revised
191. EEG requests & reports in adults
192. Emergency Blood Stock Management Plan
193. Epidural hypotension guidelines dopamine to treat - use of
194. Epidural Infusion - Bolus Dose
195. Erythropoietin Protocol
196. External Ventricular Drains for Neuroscience Patients - Protocol for the
197. Management of

198. Extravasation Policy
199. Top Falls Assessment of
200. Fentanyl lozenges for procedural pain - Guidelines for the use of
201. Fetal Condition - Assessment of
202. Flexible sigmoidoscopy and treatment undertaken by the Nurse
203. Endoscopist.
204. Protocol for the management and care of patients requiring
205. Flushing Policy
206. Foot Ulcers
207. Glucagon Test
208. Grommets - Guidelines for Minimal Follow Up
209. Group Protocol Template
210. Guillain-Barré Syndrome Diagnosis, Investigation and Early Management of
211. Health Issues Policy Haematuria Haemodilution - Procedure for the
212. performance of Acute Normovolaemic

213. H.R.T.
214. Hyperlipidaemia - Management of
215. Hypertension in the Elderly
216. Illicit Drug Users in General Hospitals - Management of
217. Illicit Substances brought into Hospital by Patients - Operational
218. Policy
219. for the Management of
220. Immunoglobulin therapy at home between Immunodeficiency Team and GP -
221. Interface Clinical Guideline for
222. Incontinence in the Elderly
223. Infant Feeding
224. Inhaler Technique - Assessment of
225. In-patient Transfers - Nursing policy on
226. Internal Transfer via the Trust Electronic Patient Record (EPR) System.

227. Intrathecal Chemotherapy Policy
228. Intravenous Cannulation for Midwives
229. Intravenous Therapy - Revised Audit
230. Irrigation of Nephrostomy Tube
231. Iron Deficiency Anaemia in the Elderly
232. IVIg in Neurological Diseases Use of
233. Ketoacidosis - Management of
234. Kurgan Method of Pin Site Care
235. Labour and Birth - The Use of Water for
236. Labour - Assessing Progress
237. Labour - Latent Phase of
238. Labour - Low Risk Induction of
239. Labour - Nutrition in
240. Labour - Pharmacological Pain Relief for
241. Labour - Position for
242. Labour - Pre-Labour Rupture of the Membranes at Term
243. Labour - Second Stage of
244. Labour - Supporting Women in
245. Labour - Third Stage of
246. Top Last Offices - Procedure for
247. Laxative Screening

248. Lipid Control in Patients with Established Cardiovascular Disease and
249. Diabetes - Salford Guidelines for
250. Long Synacthen Test
251. Low Molecular Weight Heparin dosing in patients with kidney disease
252. Lung Cancer Service
253. Medical Devices Policy
254. Medical HDU - Operational policy
255. Medicines Management Policy
256. Medicines Policy
257. Membrane sweeps in women with uncomplicated, yet post term pregnancies -
258. Midwifery led guideline to undertake
259. Methadone to Patients who are Registered Illicit Drug Users -
260. Operational
261. Policy for the supply of
262. Midodrine Therapy for Syncope
263. Midwife Led Guidelines
264. Minimum Observation Standards
265. Missing Patients
266. Multiple Sclerosis - use of beta-interferon, glatiramer acetate and
267. other
268. disease modifying drugs
269. Multiple Sleep Latency
270. Myocardial Infarction, Metabolic Management of
271. Naso-Gastric Feeding Policy
272. NCEPOD theatre second theatre and cut-off policy
273. Nebulised Antibiotic Therapy
274. Nebulisers on Wards - Use of
275. Neurophysiology Service
276. Newborn - Immediate Care of
277. New techniques or major modifications to practice (not part of an
278. ethical
279. committee approved research programme) Policy for consultants
280. Nurse led chest X-ray EMAU and Emergency Dept protocol
281. Obstetrics & Gynaecology Audit Tool
282. Opioid Loading Dose (PCA/IV Titration) Protocol for the Administration
283. of Osteoporosis in Men and Women - Prevention and Management of
284. Osteoporosis - Steroid Algorithm Oseltamivir in the Treatment and
285. Prophylaxis of Influenza A, Guidelines
286. for
287. Oximeters - Use of
288. Pain and Symptom Management
289. Pandemic Influenza
290. Patient Pathways
291. Patients' Own Drugs - Reuse of
292. PEG/RIG Guidelines
293. Peptic Ulcer - Management of patients with endoscopically proven
294. Percutaneous Nephrostomy Tube Care
295. Perineum - Care of
296. Perioperative Management of Drug & Alcohol Dependent Patients
297. Peripheral Cannulation
298. Peripheral vascular disease - Protocol for the assessment of - and the
299. application of anti-embolic stockings.
300. Peripheral Venous Cannula Site, Management of a

301. Photographic Consent Policy
302. Pituary Surgery Checklist
303. Pre-Operative Patients - Protocols for investigations to be done in
304. Pre-Operative Patients - Protocols for investigations to be done in -
305. Flowchart
306. Prescribing by Non-Medical Personnel (including Supplementary
307. Prescribing
308. and Extended Nurse Prescribing) Trust Policy and Guidelines for
309. Physio On-call
310. Pneumothorax - Guidelines
311. Pneumothorax - Initial Management of
312. Poisoning - Management of Acute
313. Polyuria
314. Post Term Pregnancy - Management of
315. Preceptorship Obs & Gynae
316. Pregnant Diabetic Woman - Care of
317. Pre-operative Investigations
318. Pressure Sores
319. Prevention and Management of Bone Disease in the Renal Dialysis
320. Population

321. Prostate Cancer
322. Proton Pump Inhibitor (PPI) Joint Strategy and Prescribing Guidelines
323. for
324. Salford
325. P.S.A. Tests
326. Radial Artery Blood Gas Sampling
327. Recombinant Factor VIIa (NovoSeven) in Major Haemorrhage -
Protocol for
328. the Extended Use of Reconstitution of Drug Solution and Powered for
Bolus
329. Injection or Syringe Pump Infusion
330. Reconstitution of Drug Solution or Powder for Bagged Infusion
331. Refuse Nurse Administration of Medications on Non-Self Medicating
Wards
332. -
333. Protocol for Patients who
334. Refusal of Treatment
335. Renal Failure Patient, Liverpool Integrated Care Pathway for the
Dying
336. Renal Tumours Resuscitation Safe Bed Sharing Policy
337. Self Administration of Medicines
338. Sleep Deprived EEG
339. Small Bowel Overgrowth - Patients suspected of having
340. Specimen Acceptance Policy - Pathology
341. Spleen - Recommended Guidelines for the Prevention of Infection in
342. Patients with an Absent or Dysfunctional
343. Stoma formation - Protocol of the siting of patients undergoing
344. Stroke Care in Greater Manchester - Guidelines
345. Stroke - Echocardiography post TIA and ischaemic stroke. The use
of
346. Stroke - Management of Central and Regional Pain Stroke - Protocol
for
347. the management of elevated blood glucose in the
348. first 24 hours

Stroke Management - Which anti-platelet agent to use with a patient when more than 14 days post non haemorrhagic stroke.

Stroke Management - Protocol for anti-platelet therapy in acute stroke. (Up to 14 days post onset)

Stroke patients - Monitoring of the Physiological Parameters during the first 72 hours

Stroke, Protocol for the therapeutic handling of stroke patients by permanent nursing staff on the Stroke Rehabilitation Ward (L1)

Stroke - Suspected - CT Scan request by non-medical staff
Stroke - Water swallow screen
Surgical Blood Order Schedule Protocol
Suturing the Perineum
Syringe Drivers (Graseby MS26) in Controlling the Symptoms of Advanced Cancer and Terminal Illness, Guidelines for the use of Temporary Closure of Beds
Theatre List Compilation Policy
Theophylline Poisoning, Management
Thromboprophylaxis for medical patients, guidelines for
Tracheostomy Care Policy
Tracheostomy Tube, Changing a Policy
Tracheostomies - Protocol for Oxygen Therapy and Humidification for patients with
Tracheostomy stoma care, dressing changes and cleaning, Policy for
Tracheostomy tube - Suctioning of a patient with, Protocol for Training in the safe use of Medical Equipment Trans-cutaneous Electrical Nerve Stimulation Training for Midwives Transfer of Care Transfer of a woman and/ or her baby from home to hospital at or around the time of birth
Transfer to the Community Following Birth
Unlicensed Medicines
Upper GI Haemorrhage - Management of
Upper Tract Dilation with Renography, Evaluation of
Ureteric Stones - Management of
Urethral Catheters - Insertion and Management of
Urethral Strictures
Urinary Incontinence - Women
Urine Specimens, On-call
Variceal Bleed - Management of
Varicella Zoster Virus Infection, Management of
Venepuncture using the 5-Monovette System
Vein Infusion (Central) Administration of a drug by Intermittent Vein (Peripheral) Infusion, Administration of Intravenous Fluids by
Videofluoroscopy examinations for oropharyngeal dysphagia - Non medical requesting of
Videofluoroscopy service - Guidelines for practitioner-led

394. Warts

395. Procedure for Implementing a new patient group direction
396. Procedure for reviewing an existing patient group direction

397. ALA (5-Aminolevulinic acid) preparations and derivatives - Administration
398. of:
399. ALLERGENS - supply/administration of by specialist nurse
400. AMETHOCAINE 1% Eye Drops - Prior to Peri-orbital Laser Treatment
401. AMOXYCILLIN - Supply and administration of Amoxycillin by Podiatrists in
402. the management of diabetic foot infections
403. AMOXYCILLIN - Supply and administration of Amoxycillin by Podiatrists in
404. the management of orthopaedic foot infections
405. ANTIHYPERTENSIVES -Supply and Administration of Antihypertensive agents
406. for Diabetic Patients by a Specialist Nurse
407. ASPIRIN Supply and administration of Aspirin 300mgs to non haemorrhagic
408. stroke patients.
409. AZITHROMYCIN Supply/admin of Azithromycin (Obs & Gynae Department of
410. Sexual Health)
411. BCG INJECTION - The supply and administration of Bacillus Calmet-Guerin
412. (PCG) injection
413. BUPIVACAINE Supply/admin of Bupivacaine Hydrochloride (Marcain) 0.15% -
414. Mohs Micrographic Surgery
415. BUSCOPAN Supply/admin of Buscopan (hyoscine-N-butylbromide) to adult
416. patients undergoing nurse led flexible sigmoidscopy
417. CEFUROXIME Supply/admin of Cefuroxime (Obs & Gynae Department of Sexual
418. Health)
419. CHOLESTEROL Lowering Drugs Supply/administration of
420. CIPROFLOXACIN - Supply/administration of Ciprofloxacin to Urological
421. Patients undergoing Nurse-led endoscopy
422. CIPROFLOXACIN - Supply and administration of Ciprofloxacin by
423. Podiatrists
424. in the management of diabetic foot infections
425. CIPROFLOXACIN Administration of Ciprofloxacin for uncomplicated genital
426. gonorrhoea
427. CIPROFLOXACIN - Supply and administration of Ciprofloxacin by
428. Podiatrists
429. in the management of orthopaedic foot infections
430. CLINDAMYCIN prior to Permanent Pacemaker Insertion - Admin/Supply of:
431. Prophylactic IV administration of
432. CLINDAMYCIN - Supply and administration of Clindamycin by Podiatrists in

433. the management of diabetic foot infection
434. CLINDAMYCIN - Supply and administration of Clindamycin by Podiatrists in
435. the management of orthopaedic foot infection
436. CODEINE PHOSPHATE - Supply/Administration of
437. DICLOPHENAC SODIUM EC - Supply/Administration of
438. DERMATOLOGY - Supply and Administration of topical treatments in adult
439. and
440. child eczema
441. DERMATOLOGY - Supply and administration of topical treatments in Adult
442. and
443. Child Psoriasis by Specialist Dermatology Nurse
444. DOCUSATE SODIUM to Periotoneal Dialysis Patients for the prevention of
445. constipation - Supply/admin of
446. DOXYCYCLINE Administration of Doxycycline for untreated uncomplicated
447. chlamydial infection
448. DOXYCYCLINE Supply/administration of Doxycycline to Patients undergoing
449. termination of pregnancy on the day case surgery unit

450. Drugs to be administered at the Discretion of the Nurse
451. DUOFILM. (Salicylic Acid Preparation). Supply/administration of:

452. Emergency Nurse Practitioners: Medicines under Patient Group Direction
453. EMLA - Supply/admin of Emla Cream: Lignocaine 2.5%, Prilocaine 2.5%
454. EMLA - Supply and administration of EMLA for local anaesthesia prior to
455. Laser Treatment by the Laser practitioner
456. ENTONOX - supply/administration of Entonox to manage the pain of
457. intermittent procedures during medical or surgical care.
458. EPINEPHRINE Supply/admin of Epinephrine by a respiratory nurse in the
459. event of severe anaphylactic reaction to allergy test administered in
460. chest clinic
461. EPINEPHRINE Supply/administration of Epinephrine by a respiratory nurse
462. specialist in the event of a severe anaphylactic reaction to nebulised
463. antibiotics administered in chest clinic.
464. ERYTHROMYCIN - Supply and administration of erythromycin by Podiatrists
465. in
466. the management of diabetic foot infection
467. ERYTHROMYCIN - Supply and administration of erythromycin by Podiatrists
468. in
469. the management of orthopaedic foot infection
470. FLUCLOXACILLIN prior to Permanent Pacemaker Insertion - Prophylactic IV
471. administration of

472. FLUCLOXACILLIN - Supply and administration of flucloxacillin by
473. Podiatrists in the management of diabetic foot infections
474. FLUCLOXACILLIN - Supply and administration of flucloxacillin by
475. Podiatrists in the management of orthopaedic foot infections
476. FLUMAZENIL Supply/admin of Flumazenil (Anexate) to adult patients who
477. require reversal of a sedative agent (midazolam) following nurse led
478. flexible sigmoidoscopy
479. GENTAMICIN for the initial treatment of suspected or confirmed bacterial
480. peritonitis in patients undergoing dialysis therapy
481. GLUCAGON HYDROCHLORIDE - Supply/administration of 1 mgm of via a Novo
482. Nordisk 'Gluca-Gen' Injection Kit
483. HEPATITIS B VACCINATION Administration of Hepatitis B vaccination to
484. patients at high risk
485. IMIQUIMOD Supply/admin of Imiquimod (Obs & Gynae Department of Sexual
486. Health)
487. INHALED DRUG THERAPIES Supply/admin of inhaled drug therapies by the
488. respiratory nurse specialist to facilitate optimisation of inhaled therapy
489. for patients with a diagnosis of asthma.
490. Inhaled medication in COPD patients
491. Inhaler Devices in Asthmatic Patients
492. INSULIN - Supply and Administration of Insulin by Diabetic specialist
493. Nurses
494. LACRI - LUBE - Ocular lubricant prior to peri-orbital laser treatment
495. LIGNOCAINE (Lidocaine) Hydrochloride PhEur 2% (20mgs per ml)
496. Supply/administration of
497. LIGNOCAINE Supply/admin of Lignocaine (Lidocaine) Hydrochloride PhEur 1%
498. (10mgs per ml) laser treatment
499. LIGNOCAINE Supply/admin of Lignocaine (Lidocaine) Hydrochloride PhEur 1%
500. with Adrenaline (Epinephine) - laser treatment
501. LIGNOCAINE Supply/admin of Lignocaine (Lidocaine) Hydrochloride PhEur 1%
502. (10mgs per ml) with Adrenaline 1:200,000 (Mohs Micrographic Surgery)
503. LIGNOCAINE Supply/administration of Lignocaine (Lidocaine) Hydrochloride
504. PhEur 2% with Adrenaline 1:200,000
505. LIGNOCAINE Supply/admin of Lignocaine (Lidicaine) Hydrochloride PhEur 1%
506. with Adrenaline 1:200,000 (Photobiology Unit)
507. LIGNOCAINE Supply/admin of Lignocaine (Lidocaine) Hydrochloride PhEur
508. 1%
509. (Photobiology Unit)
510. LIGNOCAINE supply/admin of Lignocaine (Lidocaine) Hydrochloride PhEur 1%
511. (10mgs per ml) Dermatological Surgery Unit

512. METHYLPREDNISOLONE with LIDOCAINE (Depo Medrone) Supply and
513. administration
514. of Depo Medrone by Podiatrists in the orthopaedic management of
515. musculo-skeletal pain in the foot and its related structures
516. METRONIDAZOLE - Supply and administration of metronidazole by
517. Podiatrists
518. in the management of diabetic foot infection
519. METRONIDAZOLE - Supply and administration of metronidazole by
520. Podiatrists
521. in the management of orthopaedic foot infection
522. MIDAZOLAM SupplyAdmin of Midazolam (Hypnovel) for intravenous sedation
523. of
524. adult patients undergoing nurse led flexible sigmoidoscopy -
525. MUPIROCIN 2% nasal ointment - Supply/admin of:
526. NALOXONE - Intravenous Administration of
527. NICOTINE REPLACEMENT Supply/admin of Nicotine Replacement Therapies to
528. Pregnant Women.
529. ORAL ANTIBIOTIC THERAPY Supply/admin of oral antibiotic therapy by
530. respiratory nurse specialist to facilitate early treatment of an
531. exacerbation of COPD
532. ORAL HYPOGLYCAEMIC AGENTS - Supply and Administration of Oral
533. Hypoglycaemic Agents by Diabetic Specialist Nurses.
534. ORAL STEROID Supply/admin of Oral steroid therapy by respiratory nurse
535. to
536. facilitate early treatment of a severe exacerbation of asthma
537. ORAL STEROIDS Supply/admin of oral steroid therapy by the respiratory
538. nurse specialist to facilitate early treatment of severe exacerbation of
539. COPD.
540. OXYGEN Supply/administration of Oxygen by a Respiratory Nurse Specialist
541. in the event of a severe anaphylactic reaction to allergen test in chest
542. clinic.
543. OXYGEN Supply/admin of oxygen by a respiratory nurse specialist in the
544. event of a severe anaphylactic reaction to nebulised antibiotics
545. administered in the chest clinic.
546. OXYGEN Supply/Admin of supplemental oxygen to all adult patients
547. undergoing nurse led flexible sigmoidoscopy with conscious sedation
548. Pain and Symptom Management
549. PAMIDRONATE Supply/admin of Intravenous Pamidronate 60mg (@1mg/min) by
550. Metabolic Bone Nurse Specialist in the management of Pagets Disease
551. PARACETAMOL - Supply/Administration of
552. PARACETAMOL IV - Supply/Administration of
553. Patients in post anaesthetic care unit, management of
554. PICOLAX® sachets for patients having peritoneal dialysis catheter
555. insertion

556. or removal
557. PODOPHYLLOTOXIN Supply/admin of Podophyllotoxin (Obs &
Gynae Department
558. of
559. Sexual Health)
560. PODOPHYLLUM Administration of 25% podophyllum resin BP in
compound
561. benzoin
562. tincture BP or "trichloroacetic acid for common genital warts
563. Pre-Anaesthetic Theatre List and Equipment Checks
564. PROXYMETACAINE Supply/admin of Proxymetacaine eyedrops
during Mohs
565. Micrographic Surgery of Eyelid tumours
566. Supply/Administration of a named medicine/s by midwives in an
identified
567. clinical situation e.g. the antepartum, intrapartum and postpartum
stages
568. of childbirth
569. SYNALAR CREAM - supply/administration of for patients with contact
570. allergic reactions
571. SUNSCREENS - Protocol for direct prescribing, supply and
administration
572. TETANUS ADSORBED VACCINE- Administration in Occupational
Health
573. TRICLOSAN 2% (Aquasept) - Patient Group Direction for the
supply/admin
574. of:
575. TRIMETHOPRIM - Supply/administration of Trimethoprim to Patients
576. undergoing Nurse - led endoscopy
577. TROPICAMIDE - supply and administration of Tropicamide 1%
eyedrops by
578. nurses in the Diabetes Centre
579. UNIPHYLLIN Continuous by the Respiratory Nurse Specialist for
patients
580. with COPD
581. UNIPHYLLIN Supply/admin of Uniphyllin Continuous by the
respiratory
582. nurse
583. specialist to facilitate optimisation of therapy for patients with asthma.

584. VANCOMYCIN for the initial treatment of suspected or confirmed
bacterial
585. peritonitis in patients undergoing peritoneal dialysis therapy -
586. Admin/Supply of:
587. Varicella Zoster Virus Infection, Management of

588. Acromegaly - Medical Management of
589. Apomorphine use in PD patients.
590. Growth Hormone Replacement in Growth Hormone Deficient Adults
591. Ciclosporin and tacrolimus in renal transplantation

592. Procedure to identify correctly the individual to be exposed to ionising
593. radiation (IRMER Employer's Procedures [Schedule 1a])
594. Procedure to identify individuals entitled to act as referrers,
595. practitioners or operators

(IRMER Employer's Procedures [Schedule 1b])
Procedure to be observed in the case of medico-legal exposures
(IRMER Employer's Procedures [Schedule 1c])
Procedure for making enquiries of females of childbearing age to establish
whether the individual is or may be pregnant or breastfeeding
(IRMER Employer's Procedures [Schedule 1d])
Procedure to ensure that quality assurance programmes are followed
(IRMER Employer's Procedures [Schedule 1e])
Procedure for the assessment of patient dose and administered activity
(IRMER Employer's Procedures [Schedule 1f])
Procedure for the use of diagnostic reference levels in radioisotope procedures (IRMER Employer's Procedures [Schedule 1g])
Procedure for determining whether the practitioner or operator is required
to effect one or more of the matters set out in regulation 7 (4)
(IRMER Employer's Procedures [Schedule 1h])
Procedure for the giving of information and instructions to nuclear medicine patients in order to restrict dose to others (IRMER Employer's
Procedures [Schedule 1i])
Procedure for the carrying out and recording of an evaluation for each medical exposure IRMER Employer's Procedures [Schedule 1j]

Absent or Dysfunctional Spleen - Recommended Guidelines for the Prevention
of Infection in Patients with an
Cleaning Carpets, Protocol for Clinical Areas
Diarrhoea and Vomiting and other communicable diseases - Procedure to be
followed following outbreak in hospital
Diphtheria
Disinfection
Hand Hygiene
Identification on patients who pose a risk of infection
Infection Control Management Policy
Infection Control Precautions
Infectious Disease - Notification of
Influenza, Pandemic Plan
Louse Infestation
Mattresses and Pressure Relieving Cushions
Meningococcal and Hib disease - guidelines for control
MRSA (Infection Control Precautions Policy)
Mycobacterium Tuberculosis, Management of Patients with - in Hospital
Needlestick/Sharps Injury, Code of practice of 2 Pregnant Health Care
Workers, Infection Risks to SARS Guidelines Scabies, Management of
Transfer of Care Policy Transmissible Spongiform Encephalopathies (TSE)
including
Creutzfeldt-Jakob Disease, Management of (CJD)
Trust terms of reference for ICC Policy

643. Varicella Zoster Virus Infection (Chicken Pox and Shingles), Management
644. of
645. Varicella Zoster Virus Infection, Management of
646. Viral Haemorrhagic Fever, Assessment of a Patient with suspected

647. Alcohol and Substance Abuse Policy
648. Annual Leave Calculator
649. Annual Leave Management - Department
650. Annual Leave Management - Ward
651. Breastfeeding and Returning to Work
652. Capability Policy & Procedure
653. Carer Policy
654. Concerns Reporting Whistleblowing
655. Disciplinary Procedure
656. Disciplinary Rules
657. Employment Break Scheme
658. Employing people with disabilities
659. Equal Opportunities
660. Fitness to Practice - Self Reporting on Own
661. Flexible Working
662. Harassment
663. Harassment of Staff by Patients, Service Users, Contractors or other
664. Members of the Public
665. Ill health and disability: redeployment and permanent adjustments
666. Infection Risk to Pregnant Health Workers Jobshare Secure Storage,
667. Handling, Use, Retention and Disposal of Disclosures and
668. Disclosure Information Received from the Criminal Records Bureau
Special Leave Guidance
669. Staff Charter
670. Staff Recruitment Advertising Policy
671. Stress Policy
672. Student Work Experience
673. Training in the safe use of Medical Equipment
674. Violence and Aggression - Zero Tolerance
675. Work Experience Policy

676. Breastfeeding and Returning to Work
677. Disciplinary Procedure
678. Grievance Procedure
679. Maternity Entitlements
680. Staff Redeployment Policy
681. Special Leave Guidance
682. Staff Charter

683. Allocating Consultants' Discretionary Points - Procedures for

684. Criteria for Associate Specialists Discretionary Points
685. Guidelines on Criteria for Consultants Discretionary Points
686. Guidelines on Criteria for Staff Grade Practitioners
687. High Professional Standards in the Modern NHS (Medical Staff) -
688. Maintaining New techniques or major modifications to his/her practice and

689. which are not part of an ethical committee approved research programme -
690. Policy for consultants wishing to embark on Professional Review and
691. Disciplinary Procedures

(name)
corporate Systems Manager

Appendix B 2a The Essence of Care

The Essence of Care (DH 2001).

The Essence of Care benchmarking is a process of comparing, sharing and developing practice in order to achieve and sustain best practice. Changes and improvements focus on agreed indicators, since these are the items that patients, carers and professionals believed were important in achieving the benchmarks of best practice. The stages involved in benchmarking are: Stage 1 Agree best practice, Stage 2 Assess clinical area against best practice, Stage 3 Produce & Implement action plans aimed at achieving best practice, Stage 4 Review achievement towards best practice, Stage 5 Disseminate improvements and or review action, Stage 6 Agree best practice.

The Essence of Care benchmarking toolkit comprises of an overall patient-focused outcome for nine aspects of care. This expresses what patients and or carers want from care in a particular area of practice. A number of factors need to be considered in order to achieve the overall patient-focused outcome. Each factor consists of a patient-focused benchmark of best practice. Indicators for best practice have been identified by patients, carers and health care personnel and support the attainment of best practice.

Appendix B 2b Essence of Care Benchmarks for Food and Nutrition

1 Screening and assessment to identify patients nutritional needs	Nutritional screening progresses to further assessment for all patients identified as 'at risk'
2 Planning, implementation and evaluation of care for those patients who require a nutritional assessment	Plans of care based on ongoing nutritional assessments are devised, implemented and evaluated
3 A conducive environment (acceptable sights, smells and sounds)	The environment is conducive to enabling the individual patients to eat
4 Assistance to eat and drink	Patients receive the care and assistance they require with eating and drinking
5 Obtaining food	Patients and or carers, whatever their communication needs, have sufficient information to enable them to obtain their food
6 Food provided	Food that is provided by the service meets the needs of individual patients
7 Food availability	Patients have set meal times, are offered a replacement meal if a meal is missed and can access snacks at any time
8 Food presentation	Food is presented to patients in a way that takes into account what appeals to them as individuals
9 Monitoring	The amount of food patients actually eat is monitored, recorded and leads to action when cause for concern
10 Eating to promote health	All opportunities are used to encourage patients to eat to promote their own health

Appendix B 3 Examples from the Clinical Governance Development Plans

2004/2005

2004 *Action Point*	*Trust Action*	**Outcome Indicator**	**Target Date**	**Executive Lead**	**Progress to October 2005**
Ensure that all clinical staff are competent to perform the duties they undertake	Review current systems, which assess the competency of medical staff in training. Develop a Policy requiring consultants to have attended a relevant training programme before embarking upon techniques which are new to him or her and which are not part of an Ethical committee approved research programme. Update the Medical Devices policy to include the requirements to have an up-to-date inventory of medical equipment and record of staff competent to use the equipment. In addition the Policy will include a specification of the type of training required and mechanism for ensuring staff competencies are achieved and maintained.	Corporate assurance that staff will be competent to perform the duties they undertake. Reduced risk of harm to patients Reduced risk of potential litigation claims. Compliance with CNST level 2	February 2004	Medical Director Medical Director Director of Operations	In progress In progress In progress

From the Clinical Governance Development Plan 2005

Ensure that all clinical staff are competent to perform the duties they undertake	Develop and implement competency policy/system for all staff	Corporate assurance that staff will be competent. Reduced risk of harm to patients. Reduced risk of potential litigation claims	July 2005	Director of Human Resources/ Executive Nurse/ Executive Medical Director	
	Implement the Medical Equipment Policy and Training calendar across the Trust.	Compliance with CNST Level 2	Feb 2005		Medical equipment policy implemented
	Develop the LMS to include a database for recording Medical Equipment training		March 2005		Development of LMS in progress Contributor: Head of Professional Development

From the Clinical Governance Development Plan 2004

Action Point	*Trust Action*	***Outcome Indicator***	***Target Date***	***Executive Lead***	***Progress to October 2005***
The Trust needs to establish a consistent approach to non medical Staff Appraisals and Personal Development Plans	Training and development needs to be assessed at least once a year. Generic approach/documentation identified. Clear guidelines established for recording appraisals and personal development plans. Training for line managers. Audit quality/satisfaction with appraisal process. Overall appraisal rate to be monitored via Clinical Governance Reporting Mechanism.	All staff will have a Personal Development Plan delivered through an annual appraisal. Relevant managers trained in appraisal techniques.	March 2004	Director of Human Resources	Ongoing Generic documentation in place In place Established In place

From the Clinical Governance Development Plan 2005

Action Point	Trust Action	Outcome Indicator	Target Date	Executive Lead	Progress
Establish a consistent approach to non medical Staff Appraisals and Personal Development Plans	Training and development needs to be assessed at least once a year. Generic approach/documentation agreed and implemented through introduction of corporate Learning Management System (LMS) Training for line managers in use of Learning Management System (LMS) Identification of Learning and Development needs by staff groups and inclusion in LMS Audit quality/satisfaction with appraisal process	100% of staff will have a Personal Development Plan delivered through an annual appraisal. Line managers trained using LMS to record learning and development plans and appraisals Relevant managers recording training to comply with CNST Level 2 All Mandatory Learning and Development needs of staff identified Staff satisfaction shows a positive trend	March 2005 As for Agenda for Change roll out Oct 2005 Oct 2005	Director of Human Resources Director of Human Resources Director of Human Resources Director of Human Resources	Revised Appraisal documentation devised and being implemented - includes the post outline for KSF and linked to SfBH. Appraisals occurring before any pay increments can be triggered. Appraisal structures and monitoring system being implemented. Relevant mandatory training linked to each post and monitoring. Since April 2005 181 members of staff have received an appraisal training update and 50 new appraisers have been trained, overall in excess of 400 members of staff have been trained. Contributor: Head of Training and Development

From the Clinical Governance Development Plan 2004

Continue to implement the national strategy for patient involvement which systematically puts the patient experience at the head of the Trust's processes	Appoint a designated lead at Associate Director Level for Patient and Public Involvement		January 2004	Executive Nurse Director	Person appointed
	Trust Board to ratify SRHT Patient and Public Involvement Strategy	Ratification of strategy	January 2004	Executive Nurse Director	Ratified by Trust Board
	Build a robust working relationship with the newly formed Patient Forums.	Achievement of objectives set out in the strategy.	Ongoing	Associate Director Patient and Corporate Services	Trust Board have met formally with the Patient Forum and ongoing work has commenced
	Monitor action plan *(appendix3)* developed to address areas requiring quality improvement as identified by national/in house surveys.	Continued quality improvement	Ongoing	Corporate Clinical Governance Committee	Work programme identified and ratified by Trust Board
	Increase patient and user involvement in Clinical Governance at Management Group/Directorate levels.	Management Groups will have recruited a patient representative to their Clinical Governance Committees	December 2004	Corporate Clinical Governance Committee	PPI event on 1st October 2004, process agreed and has commenced
	Trust-wide rollout of bedside TV information service for use by patients.	All patients have access to bedside TV information service	December 2004	Director of Operations	Over 75% installed
	Implement a Trust wide procedure to provide patients with a copy of correspondence sent to their GP or referring Clinician.	Patients will have the choice of receiving or not receiving correspondence. Patients will be better informed and feel involved their care management.	April 2004	Corporate Clinical Governance Committee	Procedure in place

From the Clinical Governance Development Plan 2005

Action Point	Trust Action	Outcome Indicator	Target Date	Executive Lead	Progress to October 2005
Continue to implement the Patient and Public Involvement (PPI) strategy.	Regular Patient and Public Involvement meetings taking place. PPI champions in place throughout each directorate. Maintain partnership working with Patient Forum	Work Programme commenced. Champions trained and effective in role. Joint working continues.	June 2005 April 2005 quarterly	Executive Nurse Director	Patient and Public Involvement Committee established and meeting. Revision of PPI Strategy has commenced taking into account that Trust is an aspirant Foundation Trust (FT) and will shortly have thousands of members who will form an integral part of the Trust's PPI work. PPI Champions continue to work across the organisation. A second cohort of Champions will be sought in early 2006. Partnership working with the PPI Forum continues and they have been involved with Trust PPI Committee and FT Council of Governors when it is established. **Contributor**: Associate Director – Patient and Corporate Services

Appendix B 4 CNST Action Plan

- *Trend analysis of clinical incidents and reports of actions taken. (Name) to produce a trend analysis report for discussion at the next meeting.*

- *Two areas to be identified which are complying with the standard on Induction of staff and assurances of competences to function in the role within the speciality to which they have been assigned.*

- *Comprehensive risk assessments, risk profiling and risk registers in all parts of the Trust and integrated with the Trust's Board Assurance reporting requirements are being progressed.*

(Name) reported that there were plans for Governance Facilitators to be appointed for each clinical group in order to ensure local ownership and action on Clinical Governance and CNST standards.

(Name) will liaise with the Deanery over clinical training requirements of CNST once there is a unified way forward. This is being discussed at a meeting of (senior nurses) across (region identified)

(Name) together with a senior nurse manager and service manager from each key area of the Trust to develop and provide CNST seminars to their staff in preparation for the CNST audit. Staff will be required to attend these training sessions. The core slides to be made available to senior managers and clinicians for use in briefing their own areas.

A personal letter to senior nurses and lead clinicians to be sent from (names) informing them of their need to attend the above awareness training.

(Name) to speak to (name) to confirm 'Training Department's ability to record attendance at these and other training sessions.

(Name) will meet each General Manager and give them a copy of the CNST standards and ask them to report back on how well their areas comply.'

Appendix B 5 Extract from the May 2003 CG Sub-Committee Meeting

Matters Arising PALs Issues Not clear who was responsible for informing patients of procedures at other hospitals. (name) to clarify	
Special Needs Communication Project (name) to report at next meeting re Communications and this project	
IRP Progress Report Renal (name) to lead on IRP Action plans. It was decided to invite clinicians on a quarterly basis to update the group. (name) will liaise.	
Intrathecal Incident (name) to update group at next meeting	
CNST Action Plan To be tabled at next meeting	
PALS Issues In the absence of (name) there were no issues tabled	
Action Plan Updates (names) updated their plans. All plans to be updated by next meeting	All
Any Other Business (name) reported that the Ombudsman had visited A&E re a case that occurred in 2000. It will be some months before the report is issued as there are people to be interviewed that have moved away from the Trust. First thoughts are that they were 'happy.' (name) to keep Group informed. (name) informed the Group that there was a complaint involving Obstetric care which was raising serious issues. (name) to keep Group informed.	
Date and Time of Next Meeting	

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