CLINICAL GOVERNANCE

A STUDY OF IMPLEMENTATION; A STUDY OF CHANGE

by

LINDA ANN LATHAM

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Health Services Management Centre
University of Birmingham
Birmingham
B15 2TT

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ABSTRACT

The concept of clinical governance was first introduced to the National Health Service in the White Paper published in 1997 (Department of Health); it has been described as the *'linchpin'* of the quality reforms and, as of April 1999, is one of the statutory duties placed on NHS Trust Boards. Clinical governance is defined as:

> *'A framework through which NHS organisations are accountable for continuously improving the quality if their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.'* (Department of Health, 1998; p33).

The research project upon which this thesis is based took place over an 18 month period and has followed one NHS Trust as it implemented this new policy. Implementation may be conceptualised as both a change process and an end state; to capture this duality, two broad research questions are posed namely: what constitutes the local clinical governance agenda (content) and how has clinical governance been implemented (process). Given that the main purpose of these research questions is to explore and describe, an overarching qualitative framework has been adopted and, within this, an action research approach utilised.

To Dilys Davies……

my grandmother and a fellow traveller

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INTRODUCTION AND OVERVIEW OF THESIS

'The new NHS will have quality at its heart'
(Department of Health, 1997; p17)

1.1 THE EMERGENCE OF CLINICAL GOVERNANCE

Historically, the quality of care provided by the National Health Service (NHS) had been regarded as an inherent component of the system and, as such, thought to be assured by the '*ethos and skills*' of the health professionals who worked within it (Donaldson and Muir Gray, 1998). However, there has been growing disquiet over the medical profession's claim to self-regulation and concern that this mechanism is no longer sufficient to assure the quality of health care (Sutherland and Dawson, 1998). This has been fuelled by changes in health policy (Øvretveit, 1998) and by a steady increase in public access to the '*coded knowledge base*' of professionals (Sutherland and Dawson, 1998). There have also been a number of high profile failures in health service quality which have received a considerable amount of publicity. Amongst those which have achieved a particular notoriety is paediatric cardiac surgery at Bristol Royal Infirmary and also the cervical screening service at the Kent and Canterbury NHS Trust. More recently, the disturbing activities of Harold Shipman have come to light; a GP convicted of murdering hundreds of patients over years spent in general practice.

The negative impact on public confidence in the NHS of cases such as those described has not gone unnoticed by policy makers (Donaldson, 1998). Such incidents also highlight another cause for concern - the variations in health service quality that appear to exist not only *between* health care organisations but also *within* the same health care

provider. Shortly after gaining office, the UK Labour Government identified quality assurance, quality improvement and unexplained variations in health services as areas which must be addressed (Department of Health, 1997; 1998). Thus, when the ambitious programme of reform of the NHS was launched through the White Paper 'The new NHS: Modern, Dependable' (Department of Health, 1997), the Government signalled that quality of health care would be high on the policy agenda. This was backed by the pledge that *'the new NHS will have quality at its heart'*; quality *'in its broadest sense: doing the right things, at the right time, for the right people, and doing them right – first time'* (Department of Health, 1997; p 17).

The White Paper (ibid; p 17, 18) announced that *'new and systematic action is needed to raise standards and ensure consistency'* and that the aim of this action would be to *'drive quality into all parts of the NHS'*. This document briefly introduced the mechanisms that would deliver the quality agenda (Table 1.1).

Table 1.1: Mechanisms for delivering the national quality agenda

- National Institute of Clinical Excellence (NICE);
- The Commission for Health Improvement;
- Clinical Governance;
- National Patient and User Survey;
- National Service Frameworks (NSF);
- National Performance Framework;

Department of Health (1997)

The quality framework was outlined in greater detail the following year in the consultation document 'A First Class Service' (Department of Health, 1998) (Table 1.2). At the time, several commentators on health policy pointed to a promising degree of consistency and coherence in approach across the key components of the quality framework (Walshe, 1997; Thomson, 1998); in particular the introduction of

mechanisms to set standards nationally, deliver locally and monitor centrally.

Table 1.2: A framework for quality

	National Institute for Clinical Excellence National Service Frameworks	Clear standards of service
Patient/ Public Involvement	Professional self-regulation Clinical governance Lifelong learning	Dependable local delivery
	Commission for Health Improvement National Performance Framework National Patient and User Survey	Monitored standards

Department of Health (1998)

Whilst strengthening the existing notions of patient/public involvement, professional self-regulation and lifelong learning, the quality framework also introduces a mix of new structures and initiatives. The centrepiece or rather the '*linchpin*' of the quality strategy (Department of Health, 1999) is the new system of clinical governance; defined below as:

> '*A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish*'. (Department of Health, 1998; p 33)

Clinical governance applies to all areas of the NHS and, as part of an overall governance framework, it is explicitly linked to the concept of corporate governance (Department of Health, 1998). Whilst the latter approach reaffirms the importance of maintaining financial probity within the Health Service, the former recognises the need to increase the status of quality at the corporate level. Consequently, as of 1 April 1999, health organisations now have a *statutory duty* to maintain and improve standards of heath care (Donaldson, 1999); a development that the public might have assumed

was already present in the current system even pre-reform.

Although quality is to become *'everybody's business'* in the *'new'* NHS (Department of Health, 1997; 1998), clinical governance brings a greater emphasis on the corporate responsibility for quality. Within the clinical governance framework (ibid), the chief executive is explicitly identified as the officer accountable for quality on behalf of the board of all NHS Trusts. In future, quality, which includes clinical quality, should be awarded a status on the corporate agenda that is equal to finance. In the past, it has not always been clear exactly who was responsible for this aspect of the service (Walshe, 1998a) and problems with clinical quality issues have often been regarded as the province of the individual clinician (Walshe, 1998b).

Whilst the clinical governance concept is closely linked to that of corporate governance, it also incorporates a number of quality-specific components (Department of Health, 1998) (Table 1.3).

Table 1.3: Key components of clinical governance

- Clear lines of responsibility and accountability for the overall quality of clinical care;
- A comprehensive programme of quality improvement activity;
- Clear policies aimed at managing risks;
- Procedures for all professional groups to identify and remedy poor performance.

Department of Health (1998; p36)

Although the White Paper (Department of Health, 1997) provided a taster of what was to come, it was the later consultation document (Department of Health, 1998) which provided further detail on the nature of clinical governance; a concept which had not previously been presented in this form as a search of Medline pre-1997 demonstrated.

NHS Trusts were now provided with a clearer idea of the sort of systems needed to support the quality improvement activities they would be required to undertake. Many of these activities such as risk management and clinical audit are not new to the NHS although their effectiveness, and in particular that of clinical audit, in delivering improvement appears in some doubt (Walshe, 1999). However, what is new is the notion of deliberate action to integrate what are often completely unconnected vehicles for improvement into a unified, whole-organisation approach to quality. Whilst 'A First Class Service' (Department of Health, 1998) gave an insight into the key components of clinical governance, there was little in this document to guide Trusts in terms of implementation; this guidance did not appear until the following year. This gradual unveiling suggests that policy makers were developing the detail over time - thus clinical governance was not a fully formed concept when introduced to the NHS back in 1997.

'Clinical governance: Quality in the new NHS' (Department of Health, 1999) provided the first detailed guidance on the implementation of this policy. According to the document, its intention was to be developmental and this notion seemed to translate as - although a *'clear framework for action'* would be outlined, there would be no prescription as to the methods to be used by the organisations. In reality, the document does present a clear action set which, in some areas, is distinctly prescriptive with objectives explicitly stated. In other areas there is more scope for local interpretation and objectives are rather more abstract - however, the guidance does make it clear that all Trusts must show progress against these objectives. The actions outlined in Table 1.4 below are an attempt by the Department of Health to ensure that a number of key

elements of the clinical governance agenda (leadership, strategy, structures, infrastructure) are addressed at an early stage in the implementation process. However, the guidance essentially stops short of providing a blueprint that would address *all* of the design elements required for effective implementation.

Table 1.4: Four key steps in clinical governance implementation

- Establish leadership, accountability and working arrangements;
- Carry out a baseline assessment of capacity and capability;
- Formulate and agree a development plan in the light of this assessment;
- Clarify reporting arrangements for clinical governance within Board and Annual reports.

Department of Health (1999)

Taken together, the aforementioned White Paper, Consultation Document and guidance constitute the key, centrally-generated documents that refer to clinical governance in terms of policy/implementation in any detail. Despite the fact that 'The NHS Plan' (Department of Health, 2000) outlines a 10 year strategy for investment and reform of the NHS, constitutes a major improvement programme to address a multitude of quality issues and outlines specific improvement methodologies such as the collaboratives, it is rather curious that the most substantial reference to clinical governance seems to consist of a single paragraph and this is in connection with the regulation and development of medics. This does little to reinforce the connection between clinical governance as a concept and the practice of Continuous Quality Improvement (CQI). Publication of the NHS Plan (ibid) has been followed up with clear statements of detailed targets and milestones for the achievement of specific elements, an implementation plan, and the year 2002 saw the publication of a progress report - essentially a centralised approach to implementation which is in sharp contrast to the one adopted in relation to clinical governance.

The National Clinical Governance Support Unit was created to provide support to NHS Trusts around the clinical governance agenda. The Support Unit has developed a model of clinical governance consisting of 13 key components (Nicholls, Cullen, O'Neill et al, 2000) (Table 1.5) and this has largely been disseminated through presentations, training courses and journal publications. The Commission for Health Improvement (CHI) which undertakes clinical governance reviews of all NHS Trusts, publishes, on its web site, details of the pre-information currently sought from Trusts which should give organisations an idea of how this national body conceptualises clinical governance. In addition, CHI is also developing a model for clinical governance; however, from the details on the web site (CHI: www.chi.nhs.uk), it seems that this is still being refined (Table 1.5).

Table 1.5: Clinical governance conceptualised

Clinical Governance Support Unit	**Commission for Health Improvement**
1. Patient-professional partnership 2. Clinical effectiveness 3. Risk management effectiveness 4. Patient experience 5. Communication effectiveness 6. Resource effectiveness 7. Strategic effectiveness 8. Learning effectiveness 9. Systems awareness 10. Teamwork 11. Communication 12. Ownership 13. Leadership **Nicholls, Cullen, O'Neill et al (2000)**	1. Strategic Capacity • Patient focus • Leadership • Direction and Planning 2. Resources and processes • Processes for quality improvement • Staff focus 3. Results • Patient experience • Outcomes 4. Use of information **CHI web site (www.chi.nhs.uk) accessed 30 Oct 02**

Whilst there is clearly some overlap between the two models from the information presented here (Table 1.5), there is insufficient detail on the CHI web site of the sub-components of the four main areas to make any meaningful comparisons between them. In reality, there is no single, agreed model of clinical governance to guide Trusts in

their efforts to implement this complex, far-reaching policy. Commenting on this two years after the concept of clinical governance was introduced to the NHS, Lugon and Secker-Walker (1999, p16) note that:

> *'Clinical governance is such a new concept that there is no 'right' way to manage it and each Trust will adapt to fit its own circumstances and a national consensus will be arrived at by trial and error over a period of time'.*

The observation above might well turn out to be an accurate description of the development of clinical governance over time; however, those Trusts preparing for a visit from CHI might appreciate more explicit guidance from the centre given that the extent of each Trust's *'trial and error'* will be published on the Department of Health web site for all with an interest in these matters to see. It seems that, in the early days, there was a lack of clarity in the field about just what clinical governance meant as a concept never mind what it would look like in practice (Walshe, 1998b; Grainger, Hopkinson, Barrett et al, 2002). This obviously adds to the challenge faced by NHS Trusts; that of turning policy into practice.

1.2 CASE STUDY SITE PROFILE

This thesis presents a detailed description of one NHS Trust as it implements clinical governance. The Trust will be referred to throughout as the Emerald NHS Trust or the Emerald Trust although this is not its real name. Since achieving Trust status in the early 1990s, the Emerald NHS Trust has grown and expanded due to a combination of service reconfigurations and mergers. As a result, the Trust provides a complex array of community, mental health and learning disability services from a large number of dispersed sites over a wide geographical area. The Trust employs around 3,000 staff

and the turnover for year 2000/01 was £64 million.

The Chief Executive, the Trust Chair, the Executive Team and two of the Non-executive Directors have been in post since the Trust was formed; the membership of the other Non-executives has changed intermittently. The forum for senior management is the Management Team (MT); membership of which includes the Chief Executive, the Clinical Governance Lead, the Finance Director, six Divisional Managers (two of whom are also Executive Directors), the Head of Human Resources, the Information and Technology Manager, and the Estates Manager. A number of Management Team members have been in post since the Trust formed originally and although others have joined more recently, tenure has, for the most part, been stable and consistent for several years; thus, senior people at the corporate level are well used to working with each other.

During the research period, consultation took place on the development of a county-wide Primary Care Trust (PCT). The outcome of this consultation was that the Emerald Trust was later dissolved and its services transferred to the PCT as of April 2002. Thus it is against a backdrop of significant structural change that the Trust was and is taking forward the clinical governance agenda albeit that the organisation, as described in this case study, no longer exists.

1.3 THESIS OVERVIEW

This research represents perhaps the most in-depth, action research study of the clinical governance implementation process to have taken place over an extended period of

time (18 months) and, as such, it is hoped that it will provide interesting insights for the reader. Implementation may be conceptualised as both a change process and an end state; to capture this duality, two broad research questions have been posed namely: what constitutes the local clinical governance agenda (content) and how has clinical governance been implemented (process). However, before this account of the Trust's journey proceeds any further, an overview of the structure of the thesis will now be presented.

The purpose of this introductory chapter has been to provide an overview of the emergence of clinical governance as a national policy and this will now be followed by a review of the relevant literature. The literature on clinical governance will be presented, and, as this body of literature is still emerging, it will be complemented by two further chapters which consider the related literatures of Total Quality Management (TQM)/Continuous Quality Improvement (CQI) and change/change management. A comprehensive description and discussion of the research methodology will then be presented. Three chapters will be devoted to presentation of the results; two dealing with implementation at the corporate level and a third with divisional findings. The following chapter will focus on a discussion of the results and the final chapter will present the concluding comments and draw the thesis to a close.

CHAPTER 2

LITERATURE REVIEW - CLINICAL GOVERNANCE

'A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'
(Department of Health, 1998; p33)

2.1 INTRODUCTION

The previous chapter has outlined the emergence of clinical governance as national policy (Department of Health, 1997; 1998; 1999). The purpose of this chapter is to give an overview of the body of literature which has been steadily growing since the publication of 'The new NHS; Modern, Dependable' (Department of Health, 1997) in which the term clinical governance appears to have been first utilised in relation to UK health care. As the main focus of this study is on the implementation of a national policy - clinical governance, a number of important insights on aspects of implementation from the wider policy literature will also be presented.

2.2 CLINICAL GOVERNANCE - AN EMERGING CONCEPT

As a further testimony to the newness of the clinical governance concept and its literature-base, it is worth noting that a search for 'clinical governance' using the Medline database produces no hits pre-1997 but yields 357 between the years 1997 to 2002. Early contributors to the emerging literature include academics, clinicians, clinician/managers and managers. With little to draw on in terms of the specifics of clinical governance other than the policy documents themselves, they sought to put some 'flesh on the bones' of this new concept. The first papers were often dedicated to

the clarification of what clinical governance might actually mean. Most authors seem to start with and indeed stay with the Department of Health definition cited at the start of this chapter. This definition highlights the need for an integrated approach, stresses corporate accountability, implies not only quality assurance but also a more dynamic aspect of quality - continuous improvement. Although the goal is the achievement of high standards of care, the definition implies that a whole organisation approach will be needed to create the alignment necessary to deliver this objective.

Some writers have sought to offer an alternative definition to the one cited above:

> *'A proper level of clinical governance in an organisation requires that substantially the whole of clinical activity meets commonly accepted standards, where these exist, and can be shown as meeting them'* (Scotland, 1998).
>
> *'It (clinical governance) means corporate accountability for clinical performance'* (Walshe, 1998b).
>
> *'It (clinical governance) can be defined as the action, the system or the manner of governing clinical affairs. This requires two components; an explicit means of setting policy and an equally explicit means of monitoring compliance with such policy* (Lugon and Secker-Walker, 1999, p1).
>
> *'A systematic approach to assure the delivery of high quality health services with the active participation of clinicians and patients supported by managers'* (Winter, 1999).

Unsurprisingly, given the concept is *clinical* governance, there is a distinctly 'clinical' flavour to the above. There is a risk that the focus is explicitly on clinical activity which could ignore the fact that health care provision does not rely on clinical input alone. As an example, the neurosurgeon waiting in theatre relies on the porter to deliver the right patient to the right place at the right time; the right investment in the service to provide appropriate staffing levels, skill mix and so on all contribute to the

surgeon's ability to undertake almost any form of clinical intervention. Also, the definitions cited above appear to offer more of an assurance flavour as opposed to that of continuous quality improvement.

Walshe's definition (1998b) emphasises the corporate accountability for clinical performance which seems to assume an active role for managers as well as clinicians in the delivery of the clinical governance agenda. In contrast, Winter (1999) seems to relegate managers merely to a supporting role which, perhaps, gives added weight to the concern expressed by Bloor and Maynard (1998) that managers may be held legally accountable for the standard of clinical care and yet have little influence over practice due to professional self-regulation. Nevertheless, this chief executive clearly regards clinical governance as a key element of the business planning process and thus an integral part of the management function (Lloyd, 2001; p47):

> *'If the outcome of clinical governance processes - which include service development based on evidence and examples of good practice - is placed at the heart of the business planning process in the NHS, real, quantifiable improvements in patient care might be made that can be underpinned by an effective monitoring system.'*

2.3 CLINICAL GOVERNANCE AND RELATED CONCEPTS

2.3.1 Total Quality Management and Continuous Quality Improvement

In 1998(b), Walshe commented that *'no-one seems entirely sure what it* (clinical governance) *means'*. Perhaps the secret to understanding this concept lies in the original definition, and perhaps clinical governance is intended as Total Quality Management/Continuous Quality Improvement (TQM/CQI) by another name - in effect, a new prescription for an old remedy. Whilst some authors draw attention to

past experiments with whole system approaches to quality in the NHS, namely TQM and Re-engineering (Walshe, 2000a), there are few who seem to have noticed how closely the language and philosophy of clinical governance resonates with TQM and CQI. In contrast, Huws (2000) sees a clear link with *'a TQM-style framework'* and regards this approach as a realistic mechanism for taking clinical governance and the wider quality agenda forward. In addition, one of the early and perhaps seminal papers on the emerging concept points clearly in the direction of TQM and CQI. Scally and Donaldson (1998) advocate quality improvement through:

> *'.....A more widespread adoption of the principles and methods of continuous quality improvement initially developed in the industrial sector and then later applied to health care. Generally these involve an organisation-wide approach to quality improvement ... ... '*

The authors (ibid) also talk of the well managed organisation which integrates *'financial control, service performance, and clinical quality at every level'*. This suggests a holistic conceptualisation of clinical governance as a way of running the business and not merely a narrow definition of quality in terms of clinical or technical quality alone. This notion does not appear to be an explicit theme in the early literature but there is a flavour of it in the Commission for Health Improvement (CHI) Clinical Governance Review Process (CHI, 2002) and the approach of the Clinical Governance Support Unit (Hallett and Thompson, 2001). The models of both organisations include a focus on strategic effectiveness which might reasonably be regarded as a precursor to the creation of the environment of excellence referred to in the original definition of clinical governance (Department of Health, 1998).

2.3.2 Corporate Governance

The notion of 'governance' is addressed by a number of authors. There are those who highlight the parallels with corporate governance (Scally and Donaldson, 1998) and the requirement for openness, probity and accountability in corporate affairs. Others, such as Bloor and Maynard (1998), also draw parallels with the concept of corporate governance and emphasise clearly the regulation and accountability aspects of the clinical governance agenda. Davies and Mannion (1999) consider clinical governance in terms of principal-agent theory and explore the notions of trust and checking. The authors (ibid) conclude that there must be a balance between the two elements and that trust should not be synonymous with the abandonment of management controls.

2.3.3 Hospital Governance

Whilst clinical governance was a new concept to the UK NHS, the notion of '*hospital governance*' has received considerable attention for some time in the US. This notion of governance seems to have preceded the clinical governance agenda in the UK by at least a decade and offers some valuable insights for those trying to make sense of the more recent UK initiative as the following discussion will seek to demonstrate.

Arrington and colleagues (Arrington, Gautum and McCabe, 1995) suggest both a broad and a narrow definition of governance:

> *'In the largest sense, governance is the process of leading and directing the work and effective performance of an organisation, a group of organisations or of a community that involves shared effort or partnership among directors, executives and other relevant leaders. Governance, in its narrowest sense, is commonly considered a synonym for the work done by boards of directors'.*

Thus from the above, it would appear that, in the US context, governance is concerned with the way the business/organisation is run; so much so that the effectiveness of governance arrangements are considered to mean the difference between organisational success or bankruptcy (Alexander, Weiner and Bogue, 2001). Many writers refer to the strategic management element of the hospital governance agenda and, way before the emergence of clinical governance in the UK, there were calls to combine the governance of clinical and administrative aspects of governance in an effort to increase effectiveness (Kovner, 1990). In addition, although quality improvement had traditionally been in the domain of the clinicians, the growth of competition in the US health care industry was causing a shift in the responsibility for the development and oversight of quality improvement efforts so that this rested *'first and foremost with the hospital governing board'*, the body ultimately accountable in law for the quality of care (Weiner and Alexander, 1993). Thus, it appears the notion of clinical governance, whilst new to the UK, was already being promulgated in the US.

The established and growing body of literature on US hospital governance is testimony to the length of time the notion of governance has been around the wider health care industry. Although there does not appear to be a universally accepted definition of governance, one can detect a shift in the content of US literature from sense-making to other more practical issues. Authors highlight problems in board performance such as lack of vision, reactiveness, passivity and rubber stamping, and inexperience (Carver, 1990). Others suggest approaches to ensure the effectiveness of hospital governance (Umbdenstock, Hageman and Amundson, 1990) which may serve as useful learning points for the NHS Trust Boards (Table 2.1).

Table 2.1: Five critical areas for effective governance

- A common working definition of governance;
- A clearly defined mission with specific goals and objectives;
- A well-planned decision-making process;
- A board structure tailored to the priorities at hand;
- An information, reporting and communication system that focuses priorities.

Umbdenstock, Hageman and Amundson (1990)

Whilst it is sensible to try and learn from the experience of others, it is also important to remember that any comparison between governing boards in the US and Trust Boards in the UK is not generally on the basis of like for like. Alexander and colleagues, (Alexander, Weiner, and Bogue, 2001) highlight the fact that governance arrangements differ *within* the US depending on the nature of the institution; specifically whether it is not-for-profit, public, or investor-owned. Vertical integration of health care organisations in the US create multiple levels of governance even at the corporate level and accountability to a higher authority might vary between a combination of state and local government, religious organisations or universities depending on ownership arrangements. Unlike the Trust Boards in the UK which are composed of executive and non-executive directors, the governing boards in the US do not necessarily incorporate the senior management team. In the case of some US boards, the chief executive is the only representative of the management function and s/he may not have full voting rights.

2.4 MAKING SENSE OF CLINICAL GOVERNANCE

Thus, the above discussion provides a flavour of how a number of writers have attempted to get to the core of clinical governance, either by trying to dissect the term itself or drawing on other literature; not the easiest task when the policy does not

necessarily arrive fully formed and ready for implementation. This is, apparently, not a rare occurrence in the policy process and, according to Gunn (1978), complete understanding of the objectives is more an ideal than the reality. This will no doubt strike a chord with Scotland (1998) who comments on the lack of consensus around the concept of clinical governance. Whilst the resemblance to TQM and CQI has been suggested earlier in this chapter, the lack of an explicit policy statement in this respect or the apparent absence of any other empirically tested theoretical basis for clinical governance leaves the policy open to charges such as Goodman's (1998) who argues that the Department's definition represents little more than '*empty phrases*'.

Whilst there is an obvious need to make sense of clinical governance at a conceptual level, it is also necessary to try and translate this into tangible objectives for implementation at both the corporate and operational levels of real organisations. Although the consultation documentation (Department of Health, 1998) highlighted the key components of clinical governance, advocated structural arrangements at the corporate level and spoke in broad terms of a comprehensive framework for quality improvement, it was the perception of some in the field that there was little else to go on (Huws, 2000). This absence of a blueprint has not prevented authors bringing a prescriptive flavour to much of the early literature which has aroused criticism for an overuse of words such as *'should'* and *'need to ensure'* (Wall, 1999).

Early papers often revisit the policy documentation and/or reflect the writer's personal view/interpretation and, in this, there are offerings from managers, academics, clinicians and clinician/managers. Some writers have addressed a particular aspect of

clinical governance in practice: Walshe (1999) and Garland (1998) highlight the importance of an initial baseline assessment of existing systems for quality improvement given that their effectiveness is often highly variable - particularly with regard to clinical audit. Others address the implications of clinical governance with respect to clinical competence and clinical behaviour (Scotland, 1998), or issues such as the information requirements to support the clinical governance agenda (Hopkinson, 1999). The Clinical Governance Support Unit published a series of articles which appeared monthly in the journal 'Professional Nurse' from July 2000 to June 2001. Each deals with an aspect of the clinical governance model outlined in the previous chapter (Table 1.5) and, taken together, provides a coherent overview of the 'what' of clinical governance as conceptualised by the Support Unit; however, there is little on the 'how' of implementation per se.

The need for effective leadership and culture change is often cited in the literature but generally not dealt with in any depth. Walshe (2000b) includes a very brief comment on leadership and clinical governance in an early, superficial review of the literature. The author (ibid) presents the notions of transformational and transactional leadership and suggests that the former is likely to be more appropriate in order to meet the demands of clinical governance.

Hackett and Spurgeon (1999) provide a more in depth discussion on culture change and clinical governance. They draw attention to the fact that there are multiple cultures within NHS organisations and argue that culture change is a secondary outcome to the implementation of clinical governance rather than an end in itself. The authors (ibid)

point to the different levels of organisational culture and suggest that making structural changes to support clinical governance may address the more visible and perhaps more easily manipulated manifestation of culture - the artefacts. Other interventions will be required to change the deeper, less apparent aspects of culture such as values and beliefs.

Davies and colleagues (Davies, Nutley and Mannion, 2000) warn that culture change should be approached with caution for a number of reasons; not least because the *'cultural destination'* in terms of clinical governance has not been clearly and unambiguously specified. It is also argued (ibid) that wholesale, simultaneous change in all aspects of organisational culture is unfeasible and probably undesirable. Although certain aspects may need changing, there are others which serve as a sound basis upon which clinical governance may be built.

Other writers have attempted to provide a more holistic sense of clinical governance and take a wider organisational perspective. In one of the early edited texts on the subject, Lugon and Secker-Walker (1999) present clinical governance from a variety of perspectives. Thus an organisational framework for clinical governance is offered which outlines the structures and systems that should be introduced - not only at the corporate level but also at the clinical team level where it is envisioned that the operationalisation of clinical governance would take place through improvement groups. The roles and responsibilities from the chief executive and the board to clinical teams and individuals are outlined and chapters deal with some of the building blocks of clinical governance such as clinical audit, risk management, complaints and so on.

Importantly, the text makes explicit the need for effective change management processes and also the need for a clear clinical governance implementation plan which is linked to the organisation development plan for the organisation as a whole.

Still others (BAMM, 1998; Holt, 1999; Wright, Smith and Jackson, 1999) have sought to offer a broader sense of clinical governance within the organisation. Whilst there is, in some cases, a sense of internal consistency in what is being proposed, the lack of a common model for clinical governance means that it is not always possible to discern why elements have been included for discussion and others omitted. Each of the writers provide a perspective which offers interesting insights in itself; it is also possible to identify some early themes amongst the 'should do's' reproduced in Table 2.2. These may be regarded as sensible suggestions but, in the absence of a coherent whole, are offered for consideration only.

Table 2.2: Clinical governance - emerging themes

- Clinical governance needs to be part of the main business of the organisation - it is not an add-on or optional extra;
- There needs to be a structure at both corporate and directorate levels to both support clinical governance and clarify lines of accountability;
- There needs to be systems in place to ensure the alignment of corporate and directorate quality goals; achievement of these goals is through performance management;
- Communication needs to be up, down and across the organisation;
- People need to be trained in quality improvement methods - not only clinical audit etc but also CQI methods;
- Leadership and management development to ensure people have the skills to take forward the agenda; change management skills important;
- Clinical governance activity needs to be supported by trained facilitators;
- Clinical governance needs to be appropriately resourced in terms of funding, time, training and information technology;
- Culture change required but from-to highly variable.

2.5 CLINICAL GOVERNANCE - EARLY IMPLEMENTATION

The early literature outlined in the preceding discussion is extremely valuable in that it provides a flavour of the emergent thinking both in terms of how clinical governance has been perceived - as a *'big idea that has shown that it can inspire and enthuse'*, (Scally and Donaldson, 1998), inevitable so make the best of it (Wright, Smith and Jackson, 1999), '*empty phrases*' (Goodman, 1998) - and also how the concept is being interpreted for implementation. Gradually, this literature pool has been augmented by the emergence of accounts providing details of actual implementation efforts. Holland and Fennell (2000) describe an approach to the mandatory initial baseline assessment using the European Foundation for Quality Excellence Model (EFQM). Although this initiative apparently raised issues around the maturity of some of the clinical teams and the time needed to undertake the assessment, the reported view was that the use of the model brought positive outcomes - a common approach to assessment was achieved and the self-assessment aspect contributed to the ownership of the resulting action plans. Hewer and Lugon (2001) focus on the development of Clinical Improvement Groups which serve as the main vehicle for the operationalisation of clinical governance down the organisational hierarchy and into the directorates.

Greater detail is provided by Hittinger (2001) on the implementation of clinical governance in a teaching Trust. The framework used incorporates the elements of strategy, structure, technical support and culture. The more recent paper by Lewis and colleagues (Lewis, Saunders and Fenton, 2002) demonstrates the importance of evaluation and a recognition that the initial approach had *'not facilitated effective progress'*. The authors (ibid) subsequently describe the changes made to address the

gaps identified.

These accounts are important as they provide information on actual attempts to implement clinical governance. Although the level of detail varies, each offers different insights which range from the benefits of using a uniform approach to assessment (Holland and Fennell, 2000), the need for a clear, widely communicated strategy to guide clinical governance (Hittinger, 2001), to the need for structures at both the corporate and directorate levels to support clinical governance (Hewer and Lugon, 2001; Lewis, Saunders and Fenton, 2002). Although the focus of these papers varies, a consistent theme is evident - the need to prepare staff for their role in relation to the clinical governance agenda, whether it is to support the baseline assessment or to function effectively as a member of a quality improvement group. This finding inevitably highlights the need for appropriate investment in education and training.

In addition to the within-organisation accounts described above, in a relatively short space of time, a number of research reports have also been published which focus on a variety of aspects of implementation, some of which will now be considered.

Latham and colleagues (Latham, Freeman, Walshe et al, 2000) undertook a postal survey of NHS Trusts located within two English Regions to explore, amongst other things, the early activity associated with implementation. The majority of the Trusts reported that they had undertaken the baseline assessment and existing systems for quality improvement were found to be highly variable in terms of effectiveness and coverage both within and between these organisations. Most had developed or were in

the process of developing a strategy for clinical governance; all had established a clinical governance committee although the size and membership varied. All Trusts had put in place leadership arrangements for clinical governance at the corporate level although most leads had little or no time formally allocated for this new responsibility. The study also reported a number of anticipated barriers to implementation; an overview is presented in Table 2.3 below; some of which, particularly the time element, were also highlighted by Dewar (1999) during interviews with chief executives.

Table 2.3: Perceived barriers to clinical governance implementation

- Lack of time and money;
- Lack of access to library facilities;
- Lack of IT systems to underpin clinical governance;
- Fear of change;
- Too much change;
- Lack of understanding;
- Cultural change needed;
- Competing priorities;
- Professional boundaries.

Latham, Freeman, Walshe et al (2000)

As part of the same project as that described above, Walshe and colleagues (Walshe, Freeman, Latham et al, 2000) visited all of the Trusts in one Region and undertook a series of structured interviews with the senior people charged with taking clinical governance forward in the organisation. Usually the interview set comprised the chief executive, the non-executive director lead, and the executive lead(s) - often a joint appointment of the medical and nurse directors. This confirmed that early attention had been devoted to putting structures and systems in place. Although the need for leadership and culture change was often mentioned by interviewees, there was little evidence to suggest that deliberate interventions were being introduced to address the second of these two issues.

Conduit and colleagues (Conduit, Morgan and Willetts, 1999) devised a 20-point self-assessment tool which was sent out to all Trusts in the Trent region. Apparently scores ranged from 8-63 out of a possible 80 and the 'weakest' category tended to be quality improvement. Although the paper highlights the contribution this tool made to the completion of baseline assessments and the development of subsequent action plans, there is little else in the way of detail to this publication and it would have been interesting to know if/how the gaps identified were addressed by the Regional Office driving the assessment.

Firth-Cozens (1999) reports on a study of the development needs of a cross section of employees in relation to clinical governance. The findings demonstrate that needs differ depending on the background of the interviewee; the author states:

> *'There were very large differences between the development of chief executives and those of clinical staff: the former had had considerable personal and management development covering areas like team leadership, change management, decision-making and negotiation; the latter, including consultants, had had very little development with most of their education being clinically focused'.*

Firth-Cozens (ibid) also highlighted common areas for development; these include: risk management, change management, team dynamics, basic clinical audit training, IT training. Interestingly, the research highlighted the fragmented way in which the elements of clinical governance were being considered in contrast to the integrated whole aspired to in the policy (Department of Health, 1999). Thus, it is proposed that development programmes do not address individual elements as such but instead are problem based so that staff learn to integrate the tools of quality management through practical application. Barriers to development included: time pressures, a lack of

information technology, inadequate funding, and the lack of a coherent strategy for post-qualification training in general outwith the demands of clinical governance. Professional isolation and the geographical demands of life working in the community were also cited as barriers for those not in a secondary care setting.

In addition to the academic research reports, there has also been a steady stream of reports from CHI which are published on the internet and are the outcome of the routine review process. This is an extremely valuable source of information on the progress of implementation as the reports highlight both the positive and negative aspects of this process and each is supplemented with an action plan for further work. Searching the CHI web site, there does not appear to be any summary of key themes from the reviews; hopefully this is already under consideration by the policy makers.

The literature described above makes a valuable contribution to what appears to be a rather emergent understanding of clinical governance. This review of the literature highlights the virtual absence of data from longitudinal, in-depth case studies of clinical governance implementation - hence the decision to undertake the study which will form the focus of this thesis. However, before moving from clinical governance to related literatures, it is worth noting some of the issues surrounding the notion of 'implementation' to be found in the wider policy literature.

2.6 IMPLEMENTATION INSIGHTS FROM THE POLICY LITERATURE

Firstly, although not always acknowledged by writers on the subject, it is important to make explicit that implementation has a double meaning (Lane, 1987) - *'either the act*

of implementing or the state of having been implemented' thus, from this description, implementation constitutes a process (how) and an end state (what). Of these two notions of implementation, it seems that the former had received the least attention (Elmore, 1978; Hogwood and Gunn, 1984; Parsons, 1995). An area initially considered as *'a series of mundane decisions and interaction unworthy of the attention of scholars'* (Van Meter and Van Horn, 1975; p450) the implementation process has apparently attracted greater interest as policy has, in some areas, failed to deliver the anticipated outcomes (Hogwood and Gunn, 1984). Consequently, policy analysts have sought to understand the *'implementation gap'* (Dunsire, 1978) not only in terms of end state success or failure but also with regard to process effectiveness. Given the newness of clinical governance, it will be important to capture both facets of implementation in order to start building up a sense of how policy is turned into practice and what that looks like on the ground.

Secondly, it is worth noting that Hogwood and Gunn (1984), in considering implementation failure, distinguish between *non-implementation* and *unsuccessful implementation.* The authors (ibid) view the former as a policy which has not been put into effect as intended; in the case of the latter, the policy has been carried out in full but fails to produce the outcomes intended. Apparently, either of these circumstances may arise from what has been described as bad implementation, bad luck and bad policy - apparently the latter is usually the least likely to be offered as a cause of failure.

Wolman (1981) makes a similar point and suggests that failure is not necessarily due to

poor implementation but may in fact be the result of problems or inadequacies in one or more components of the policy process either in the policy formulation stage or what he calls the *'carrying out stage'* or both (Table 2.4).

Table 2.4: Factors influencing the success of policy implementation

Components of the formulation process	Components of the carrying out process
1. Problem conceptualisation 2. Theory evaluation and selection 3. Specification and objectives 4. Program design • Causal efficacy • Political feasibility • Technical feasibility • Secondary consequences • Regulation vs. incentives implementation considerations 5. Program structure • Co-ordination • Intergovernmental administration • The carrying out process **Wolman (1981)**	1. Resource adequacy • Program funding • Staff resources 2. Management and control structure • Authority leakage due to lack of knowledge/will 3. Bureaucratic rules and regulations 4. Political effectiveness 5. Feedback and evaluation • Substantive • Agency response

If, as Wolman (ibid) suggests, policy failures are more often due to failures of formulation than implementation, then this poses an additional challenge for the implementers. Successful implementation will not only depend on their skills in relation to the implementation process but will also depend on their ability to critically evaluate the policy process upstream and also the level of discretion they have been afforded to overcome any problems inherited from the earlier part of the process. Given the problems that may originate upstream, it would seem prudent not to make the assumption that policy, in the form it reaches those charged with its implementation, is necessarily amenable to implementation with any degree of success.

Finally, Gunn (1978) has taken the ideal type approach in presenting a model of *'perfect implementation'* (Table 2.5). Although the author (ibid) regards this as an *'unreal*

concept', its purpose is to aid systematic thinking, not only about the reasons for implementation failure but also about possible ways in which these elements may be addressed in order to improve the chances of success.

Table 2.5: Perfect implementation

1. That circumstances external to the implementing agency do not impose crippling constraints;
2. That adequate time and sufficient resources are made available to the programme;
3. Not only are there no constraints in terms of overall resources but also that, at each stage in the implementation process, the required combination of resources is actually available;
4. That policy to be implemented is based upon a valid theory of cause and effect;
5. That the relationship between cause and effect is direct and that there are few, if any, intervening links;
6. That there is a single implementing agency which need not depend on other agencies for success or, if other agencies must be involved, that the dependency relationships are minimal in number and importance;
7. That there is complete understanding of, and agreement upon, the objectives to be achieved, and that these conditions persist throughout the implementation process;
8. That in moving towards agreed objectives, it is possible to specify, in complete detail and in perfect sequence, the tasks to be performed by each participant;
9. That there is perfect communication among and co-ordination of, the various elements or agencies involved in the programme;
10. That those in authority can demand and obtain perfect obedience.
Gunn (1978)

To those involved with policy implementation generally, and clinical governance in particular, there is probably no need to labour the notion of ideal type when considering the 10 aspects of 'perfect' implementation outlined above. Although Harrison (2000) commenting on this makes the point that Gunn's ideas do not represent a model of organisational change, he still seems to regard them as constituting *a 'classic management text'* equally relevant after the passage of over 20 years as both a mechanism for illuminating implementation situations and as a tool for getting policy into practice.

2.7 CHAPTER SUMMARY

This chapter has provided an overview of the emerging literature around clinical governance. From this, it has been possible to follow the shift from contributors offering personal perspectives and views on what clinical governance 'should' look like in practice and how it 'should' be implemented to details of actual implementation efforts from insider and outsider researchers. There is, apparently, no consensus on the meaning of clinical governance and interpretations seem to range from business excellence through to clinical standards.

The newness of the clinical governance concept and the absence of a definitive model of clinical governance or a blueprint for the implementation process is likely to pose something of a challenge to health care managers and practitioners. However, insights from the wider policy literature on implementation suggest this level of under-development is not uncommon. This literature also alerts the reader to the dual meaning of implementation and to the fact that problems with implementation are not necessarily due to the implementation process but may originate from a number of sources 'upstream' in the policy formulation process. Finally, the notion of perfect implementation is a sobering one and clearly highlights some of the pitfalls that may lie ahead.

The lack of any 'received wisdom' concerning exactly what clinical governance should look like or how it should be introduced into the Trusts also poses a challenge in terms of research design. Given the lack of literature around clinical governance per se, the

most logical step is to seek out related literatures; and, since clinical governance seems to resonate with the language of TQM and CQI, a review of this body of literature seemed perfectly appropriate under the circumstances.

CHAPTER 3

LITERATURE REVIEW - TOTAL QUALITY MANAGEMENT & CONTINUOUS QUALITY IMPROVEMENT

Total Quality Management... 'a sort of Rorschach test'
(Dean and Bowen, 1994)

3.1 INTRODUCTION

With the publication of documents such as 'The new NHS: Modern, Dependable' (Department of Health, 1997) and 'A First Class Service' (Department of Health, 1998), the UK government has undoubtedly raised the profile of Health Service quality; however, it would be wrong to think that a regard for quality in medicine is a new phenomenon. On the contrary, Ellis and Whittington (1993) argue that this interest in quality dates back to ancient times and cite early guidelines for education and practice as examples. Whilst this may indeed be so, Morgan and Murgatroyd (1994) point out that *concern* for quality is quite different from *systematic management* which needs an *'intentional framework'*. This rather suggests that the emphasis on quality management is a more modern concept and the emergence of Total Quality Management (TQM) as a whole system approach would appear to support this.

As highlighted in earlier chapters, the influence of TQM on the language of clinical governance is evident. What is less clearly expressed is the contribution the field of TQM may make to the implementation of clinical governance; a notion that will be explored in this chapter. Firstly, the complexity of health care quality will be discussed; the review will then move on to the wider TQM literature focusing on the philosophy and principles of this concept and certain aspects of implementation; in

particular, frameworks, critical success factors and barriers. Finally, the review will consider the challenge of implementing TQM in health care with specific reference to earlier experiments in the UK (Joss, Kogan and Henkel, 1994; Joss and Kogan, 1995) and Norway (Øvretveit, 1999; Øvretveit and Aslaksen, 1999).

3.2 QUALITY IN HEALTH CARE

3.2.1 Quality in Health Care - A Mixed Picture

Over the years, there has been a wide variety of quality initiatives. Taylor (1996) lists a total of 25 examples ranging from accreditation systems to TQM whilst Pollitt (1993) paints an evocative picture of the NHS *'bubbling with a mixed stew of quality initiatives'*. Whilst there has undoubtedly been an admirable amount of activity taking place in this area, much of this has been less than a resounding success (Pollitt, 1996). More recently, in a review of Continuous Quality Improvement (CQI) in American health care organisations, Blumenthal and Kilo (1998) conclude:

> *'.....there simply are no organisation-wide success stories out there – no shining castles on the hill to serve as inspirations for a struggling industry'.*

One of the reasons for the rather mixed picture of health care quality presented above is an apparent failure of the NHS to learn from past experience. According to Klein (1998), the NHS consistently seems to fall pray to a *'collective amnesia'* and in doing so not only loses its *'collective memory'* but also its *'understanding of NHS history'* (Øvretveit, 1998). Governments have been struggling for decades with the notion of quality in health care (Klein, 1998) and the boards of NHS Trusts will do well to remember this as they strive to discharge their new statutory duty for quality through the clinical governance framework. Given this tendency to forget, it is less than

surprising to find the importance of learning from the past stressed both in policy documents (Department of Health, 1998; 1999) and also in the recent literature (Donaldson and Muir Gray, 1998; Klein, 1998; Walshe, 1998b). It therefore seems appropriate to explore further the concept of quality and consider some of the reasons why it seems to represent such a challenge for its many stakeholders.

3.2.2 Quality – A Complex Concept

Quality is notoriously difficult to define irrespective of whether the concept is applied to health care or the commercial context (Ellis and Whittington, 1993; Dale, 1994). Quality is often used as an umbrella term which covers everything but touches nothing in particular; however, in order to manage quality, it is necessary to be explicit about what is meant when the term is used (Moss, 1995). This is no easy task particularly in the absence of any universally agreed definition of health care quality (Walshe, 1998c). In fact, there seems to be almost as many definitions as there are authors on the subject and a number of factors which contribute to this lack of consensus will now be considered.

Quality - 'in the eye of the beholder'

Few would deny the complexity of the arena within which health care is delivered. There are multiple stakeholders, both internal and external to the organisation. These include a variety of professional groups who deliver a myriad of services ranging from physical to psychosocial interventions. In addition, there are the consumers of health care who invariably have needs which are highly heterogeneous. Added to this, individual perceptions of service quality may be influenced by personal values, beliefs,

past experience and even one's own vested interests. This richness is often captured by writers in their descriptions of health care quality; a concept some see as complex and often contested (Sutherland and Dawson, 1998) or even *'slippery'* (Kerrison, Packwood and Buxton, 1994). For others, *'quality is like beauty'* and whilst it has positive connotations, its meaning usually lies *'in the eye of the beholder'* (Kritchevsky and Simmons,1991).

Table 3.1: Dimensions of quality

Maxwell (1984)	Klein (1998)	Øvretveit (1992)
• Relevance to need	• Respect	• Client quality
• Effectiveness	• Choice	• Professional quality
• Access to services	• Information	• Organisational quality
• Equity	• Technical competence	
• Social acceptability		
• Efficiency and economy		

Quality: more to it than meets the eye

Just as the context of quality is multidimensional, so it seems is the concept; elements of which are illustrated in Table 3.1. Maxwell (1984), for example, describes six dimensions to which Klein (1998) has added a further four (perhaps somewhat tongue in cheek) to make the '10 Commandments' for the NHS and still another perspective is offered by Øvretveit (1992).

Quality: a political concept

Given the complexities described above, the difficulties in reaching a universal definition of health care quality may be appreciated; however, there are those who argue that the lack of an explicit definition is not accidental and suggest this is due to the political nature of the quality concept (Øvretveit, 1998). Within this paradigm,

issues of power and professionalism are interlinked both at the macro and micro levels.

At the macro level, control of quality is considered to lie at the heart of professionalism. Through control of both initial entry to the profession and also of subsequent practice, professional bodies such as the General Medical Council and Medical Royal Colleges claim to provide their own quality assurance (Pollitt, 1990). At the micro or individual level, the unique body of knowledge which distinguishes the professions from other groups in the NHS also confers a significant level of autonomy (Weiner, Shoetree and Alexander, 1997) which, it is argued, is translated to mean that the professionals know best and if left alone will assure quality in health care (Pollitt, 1996). This medical model of quality is criticised as paternalistic as the needs of patients are invariably defined by the professionals (Pollitt, 1996; Packwood, Pollitt and Roberts, 1998) and, within this model, the voice of the patient tends to be the one least heard (Hart, 1996).

The introduction of clinical governance has made explicit the fact that the quality of health services is a corporate concern. The whole system approach which is embedded in the concept brings clinical as well as non-clinical quality within the remit of managers as well as individual clinicians who are professionally responsible and accountable for their actions. Certain objectives contained within the modernisation agenda and outlined in the NHS Plan (Department of Health, 2000) will be delivered using quality improvement methodologies which have been imported from industry and which are based on the philosophy of TQM and CQI. In this way, clinical governance poses an interesting challenge to the notions of professional control over the quality agenda; how this will be played out in practice remains to be seen but some of the

reasons for this challenge will now be discussed.

3.2.3 Quality and the Challenge of CQI

The concept of CQI, defined as *'an ongoing effort to provide care that meets or exceeds customer expectations'* (Weiner, Shoetree and Alexander 1997; p493), is at the heart of a total quality or a whole systems framework and the ideas contained within the above definition may be regarded as a considerable challenge to the medical model of quality in two ways.

Firstly, whilst all change may not bring improvement, CQI always implies change (Berwick, 1996; Garside, 1998) so it follows that individual clinical practice will have to change to reflect this if improvement is to occur. Such change is not always welcome. Preferred ways of working may have been followed for many years and not only serve as a frame of reference for the working life of the clinician concerned but can also form the basis of empires carefully nurtured over a long career (Marris, 1993).

Secondly, CQI focuses on the customer definition of quality whereas, in health care, the concept of the patient as a customer is relatively new and *'the very idea of asking customers what they value is seen by some as revolutionary'* (Morgan and Murgatroyd, 1994; p74). In addition, the notion of the customer relates to internal customers in addition to the patient or carer as end user. The idea of internal customer-supplier relationships brings a focus onto the processes of care and clinical teams, which, for those who operate in a more individualistic mode, seems to suggest something of a change in practice which is not always appreciated.

Thus, from the preceding discussion, it can be seen that the concept of quality is, in itself, a complex phenomenon which invariably serves as a challenge to all associated with it. As the next section will demonstrate, the complexity of quality is matched by the complexity of TQM, not only as a concept but also in practice.

3.3 TOTAL QUALITY MANAGEMENT - THE CONCEPT

3.3.1 TQM - A Hazy and Ambiguous Concept

Given the growing body of literature addressing some or other aspect of TQM, Dean and Bowen's (1994) assertion that it is a *'ubiquitous organisational phenomenon'* has some resonance. The anacronyms TQM/CQI not only feature widely in the peer reviewed literature but also in general discussion within organisations around the topic of quality -a discourse not uncommonly peppered with associated slogans such as 'right first time', 'quality is everyone's business', 'a journey not a destination'. Whilst such slogans may be regarded as buzzwords, they may also contribute to a sense that this 'phenomenon' is based on a codified theoretical base, reinforced by some who refer to the notions of *'conventional wisdom'* (Boerstler, Foster, O'Connor et al, 1996), or *'received wisdom'* (Dale, Boaden and Lascelles, 1994).

This author's initial exploration of the literature was accompanied by a growing sense of bewilderment. It was, therefore, somewhat comforting to find that this sense of confusion is not uncommon (Teixeira, 1999) and that, far from being a *'cut and dried reality'* (Spencer, 1994), TQM is variously described as *'a hazy ambiguous concept'* and *'a sort of Rorschach test'* (Dean and Bowen, 1994), an *'amorphous philosophy'*

(Spencer, 1994), which means *'different things to different people'* (Yong and Wilkinson, 2001). It is therefore unsurprising to find a profusion of definitions in the literature which gives credence to those who highlight the fact that there is no universal definition of TQM (Wilkinson and Witcher, 1993; Grant, Shani and Krishnan, 1994; Teixeira, 1999).

Dean and Bowen (1994) suggest that the meaning attributed to TQM is a function of belief and experience, aspects of which are also likely to colour one's perception of TQM and vice versa. TQM has been described as, for example, *'a major change movement'* (Scott and Cole, 2000), *'a tool for change'* (Yong and Wilkinson, 2001), *'a new and emerging paradigm of management'* (Wilkinson and Witcher, 1993; Teixeira, 1999), *'a company-wide philosophy of quality improvement'* (Grant, Shani and Krishnan, 1994) and *'a systematic approach to management'* (Spencer, 1994). Whilst understanding is likely to influence definition, Boaden (1997) also suggests that authors tend to adopt that which is most suited to their own particular purposes whilst some avoid any explicit definition altogether. This is apparently not confined to the literature but is also a feature of practice; diversity of academic background and opinion contributed to the decision of one project team not to adopt a single definition of TQM (Boaden, 1997) - unfortunately the author does not comment on whether this proved problematical for either the team or the research process as a whole.

In the absence of a universal definition, Teixeira, (1999) advises the practitioner to return to core principles as a means of navigating what he has termed *'an oversupply of ideas'*. However, this approach does not offer the safe passage suggested as, in reality,

much of the generic TQM literature appears to present a very varied picture of the conventional/received wisdom. Hill and Wilkinson (1995) rather optimistically suggest that there is now reasonable agreement around the basic principles of TQM; however, this was apparently not borne out by The Conference Board (1993). In citing this study, Boaden (1997) highlights the fact that out of the 20 studies examined by the Board, only six out of 23 elements were cited three or more times and these in only seven studies.

3.3.2 The Search For Core Principles

To demonstrate this lack of consistency, Table 3.2 highlights some of the ways in which TQM has been conceptualised. Some authors offer three similar albeit not entirely the same principles (Dean and Bowen, 1994; Sitkin, Sutcliffe and Schroeder; Hill and Wilkinson, 1995), others opt for eight elements (Dale, Boaden and Lascelles, 1994), ten points (Oakland, 1995) or twelve factors (Powell, 1995). In some instances, the origins or the process by which the author has arrived at these conceptualisations have not been stated. In several cases they have been distilled from the writings of the 'gurus'; in others they represent a synthesis of the syntheses of others. Dean and Bowen (1994) on the other hand present their notion of TQM in terms of principles, practices and techniques; however, Boaden (1997) does not appear convinced this categorisation is as neatly nested as it first appears. The author (ibid) challenges the value of such 'lists' except as a basis for discussion and debate.

Table 3.2: TQM conceptualised

Dean and Bowen (1994)	**Sitkin, Sutcliffe and Schroeder (1994)**	**Hill and Wilkinson (1995)**
• Customer focus • Continuous improvement • Teamwork	• Customer satisfaction • Continuous improvement • Organisation as a total system	• Customer orientation • Continuous improvement • Process orientation
Dale, Boaden and Lascelles (1994)	**Oakland (1995)**	**Powell (1995)**
1. Commitment and leadership of CEO 2. Planning and organisation 3. Using tools and techniques 4. Education and training 5. Involvement 6. Teamwork 7. Measurement and feedback 8. Culture change	1. Organisation needs long term commitment to constant improvement 2. Adopt the philosophy of zero defects and change culture to right first time 3. Train the people to understand the customer-supplier relationship 4. Do not buy products or services on price alone - look at total cost 5. Recognise that improvements of systems need to be managed 6. Adopt modern methods of supervision and training-eliminate fear 7. Eliminate barriers between departments by managing the process - improve communications and teamwork 8. Eliminate - arbitrary goals without methods; all standards based on numbers alone; barriers to pride of workmanship; fiction - get facts by using the correct tools 9. Constantly educate and retrain - develop the 'experts' in the business 10. Develop a systematic approach to manage the implementation of TQM	1. Committed leadership 2. Adoption and communication of TQM 3. Closer customer relationships 4. Closer supplier relationships 5. Benchmarking 6. Increased training 7. Open organisation 8. Employee empowerment 9. Zero-defects mentality 10. Flexible manufacturing 11. Process improvement 12. Measurement

The diversity of offerings in Table 3.2 does not indicate a consensus in the core principles of TQM. One might look to the work of the 'quality gurus' to illuminate this quest - but apparently this does not provide a neat solution either. Although there is a recognition that TQM has evolved from the work of a number of early 'founding

fathers', views about who enjoys membership of this club appears to vary. In the literature supporting this part of the review, where the authors have referred to the 'gurus', each has included Deming and Juran; however, as Table 3.3 demonstrates, the configurations vary, usually without any explanation as to why a trio has been selected rather than a quintet.

Table 3.3: The TQM 'Gurus'

Dean & Bowen (1994)	**Hackman &Wageman (1995)**	**Boaden (1996)**
• Deming • Juran • Crosby	• Deming • Juran • Ishikawa	• Deming • Juran • Feigenbaum
Dale, Boaden &Lascelles (1994)	**Wilkinson (1995)**	**Hill & Wilkinson (1995)**
• Deming • Juran • Crosby • Feigenbaum	• Deming • Juran • Feigenbaum • Ishikawa	• Deming • Juran • Crosby • Feigenbaum • Ishikawa

These multiple configurations may demonstrate the richness of the landscape but any syntheses based on such different configurations as illustrated above perhaps need to be explicit about the rationale upon which they are derived otherwise the value of any such exercise may be limited and even contribute to further obfuscation.

In searching for the core principles of TQM, it is perhaps worth noting Boaden's (1997) claim that the early authors did not use the term 'TQM'; certainly their key texts do not contain either the anacronym or the term Total Quality Management in the indices (Crosby, 1979; Deming, 1986; Juran, 1988) although Feigenbaum is an exception (1991).

In an interview (Romano, 1994), Deming's comments on the subject, cited below, seem to add weight to Boaden's assertion regarding terminology (1997):

> *'The trouble with Total Quality Management - failure of TQM, you call it - is that there is no such thing. It is a buzzword. I have never used the term, as it carries no meaning'.*

Hackman and Wageman (1995), perhaps rather optimistically in light of this discussion, assert that there is substantial agreement amongst the work of those they describe as *'the movement's founders'* however, others are not convinced (Dean and Bowen, 1994). Table 3.4 summarises the core principles of Deming (1986), Crosby (1979) and Juran (1988); Feigenbaum, however, did not develop such a convenient, pocket-sized encapsulation of his teaching.

Table 3.4: TQM core principles

Deming - 14 Points	**Crosby - 14 steps**	**Juran - 'Trilogy'**
1. Create constancy of purpose 2. Adopt the new philosophy 3. Cease dependence on mass inspection 4. End practice of awarding business on price alone 5. Improve constantly and forever the system of production and service 6. Institute training 7. Adopt and institute leadership 8. Drive out fear 9. Break down barriers between staff areas 10. Eliminate slogans, exhortations and targets for the workforce 11. Eliminate work standards/quotas 12. Remove barriers to pride of workmanship 13. Institute education and self-improvement 14. Take action to accomplish the transformation	1. Management commitment 2. Establish quality improvement teams 3. Introduce quality measurement 4. Evaluate cost of quality 5. Develop quality awareness 6. Take corrective action 7 Establish committee for zero defects program 8. Supervisor training 9. Zero Defects Day 10. Goal setting 11. Error cause removal 12. Recognition 13. Quality councils 14. Do it over again	1. Quality planning 2. Quality control 3. Quality improvement

Dale and colleagues (Dale, Boaden and Lascelles, 1994) take the view that the writings of the 'founding fathers' represent variations on a theme and point out that they were all consultants who sought to differentiate their work from that of others in order to position themselves in the market and attract clients. In the eyes of these authors (ibid; p20) this appears to have been a successful tactic and they suggest that the teachings of four men at least can be characterised by a particular approach: Crosby - company-wide motivation; Deming - statistical process control; Feigenbaum - systems management and Juran - project management.

A number of authors have commented on the similarities and differences within the early work on TQM (Dean and Bowen, 1994; Dale, Boaden and Lascelles, 1994; Beckford, 1998). Others would point to a failure to establish links with the existing management literature (Spencer, 1994; Teixeira, 1999; Scott and Cole, 2000). Consequently, elements in the early work may appear at odds with management theory; a particular example of this is in relation to the notions of reward and appraisal (Hackman and Wageman, 1995). In addition, there are those that point to omissions; for example, there is a sense of rational linearity surrounding TQM which ignores the political nature of organisations (Wilkinson and Witcher, 1993), the notion of universality in TQM application does not recognise contingency theory (Sitkin, Sutcliffe and Schroeder, 1994) and, although there are potentially profound implications for the human resource, little attention is given to how this might be managed (Wilkinson, 1995).

3.3.3 In Search of Theoretical Underpinnings

Whilst there might seem to be little in the way of consensus around what constitutes the core principles of TQM, there is some agreement over the perception that a theoretical basis underpinning the work of the early practitioners was not articulated (Grant, Shani and Krishnan, 1994; Anderson, Rungtusanatham and Schroeder, 1994; Sitkin, Sutcliffe and Schroeder, 1994). Anderson and colleagues (Anderson, Rungtusanatham and Schroeder, 1994) take the view that Demings' '14 Points' evolved over a number of decades and represent generalisations based on his experience as a consultant and, as such, his energies were directed at implementation rather than theory development and empirical testing. In terms of empirical evidence, Anderson and colleagues (Anderson, Rungtusanatham and Schroeder, 1994) argue that there is little available to support the effectiveness of Deming's approach in particular. Others (Dean and Bowen, 1994) look at the broader and varied picture of TQM implementation in general and assert that there is little in the way of theory to explain why TQM is considered a success in some organisations and a failure in others. This apparent lack of a solid theoretical foundation underpinning TQM is attributed to a number of factors which will now be explored.

TQM – A practitioner-led movement

An area of agreement amongst certain academics is an acknowledgement that academia has not been in the vanguard of the TQM movement (Wilkinson and Witcher, 1993; Dean and Bowen, 1994; Anderson, Rungtusanatham and Schroeder, 1994; Boaden, 1996; Scott and Cole, 2000), instead, this has largely been practitioner-led. There have been a number of criticisms of the 'practitioner literature' that has emerged; the

approach has been largely personal anecdotes (Hackman and Wageman, 1995) aimed at managers who, in their desire to believe their efforts are successful, will settle for anecdote (Scott and Cole, 2000). Again, with the managerial audience in mind, some suggest that the publications have been *'long on prescription and shorter on analysis'* (Hill and Wilkinson, 1995) thus promoting a 'quick-fix' for those searching for off-the-shelf solutions or as Deming (1986) has described such products - *'instant puddings'*.

Lack of academic interest

The lack of theory however, is not just attributed to the practitioner focus; the lack of academic interest in this phenomenon has also been acknowledged. According to Powell (1995), *'no other management concept/practice has received so much practitioner attention with so little academic study'*. As a result of this, Yong and Wilkinson (2001) argue that the practitioners and consultants have had a free hand in shaping the formative stages of the movement's development and contributed to the diversity within the field. Boaden (1997) suggests that TQM has been dismissed by some as one in a long line of managerial fads which is likely to have a fairly predictable life-cycle.

Dean and Bowen (1994) suggest that, given the lack of theoretical frameworks, researchers have been reluctant to conduct research based on the consultant-oriented frameworks that were available. The authors (ibid) also suggest that TQM transcends the boundaries of existing theories and, although the field of management theory is populated by multiple disciplines, individual theories are often discipline-bound. As a result, it is argued that existing theories are unlikely to be broad enough to support

research into this phenomenon. This may be true of some theories but perhaps does not take account of systems theory or certain change theories which focus on large-scale organisational change. Also, research should not necessarily preclude the use of single theories if the intention is to bring new insights from existing disciplines. However, the boundary-spanning nature of TQM might pose more of a challenge in practice - as highlighted earlier when even the task of definition appeared troublesome within a particular project team (Boaden 1997). The issue might be more around trying to capture the holistic nature of the phenomenon; an example of which is Deming's (1986) emphasis on the importance of implementing all of the '14 Points'.

Whatever the reason for the apparent lack of earlier academic interest, one outcome of this seems to have been that practice has been *'propelled ahead of theory'* (Anderson, Rungtusanatham and Schroeder, 1994) so much so that, in an issue of the Harvard Business Review, voices from industry called for a greater engagement of the academic community which, it appears, did not fall on deaf ears (Robinson, Akers, Artzt et al, 1991).

In addition to papers appearing across a wide range of peer reviewed academic journals, special issues of journals such as the Academy of Management Review have sought to develop a forum for theory development and, in that issue alone, a number of valuable, albeit different, contributions were in fact made. For example, Dean and Bowen (1994) present their interpretation of the principles and practices of TQM and compare these to the domains included in the Malcolm Baldrige National Quality Award. Spencer (1994) takes three organisational models - mechanistic, organismic,

cultural, as a basis for examining TQM and highlights similarities and differences between each of the models and aspects of TQM. Anderson and colleagues (Anderson, Rungtusanatham and Schroeder, 1994) use a number of methods to identify a theory underlying the Deming approach. Sitkin and colleagues (Sitkin, Sutcliffe and Schroeder, 1994) apply a contingency theory perspective to the implementation of TQM.

Edited texts such as that by Cole and Scott (2000) have sought to make explicit the contribution of existing organisational theory to the work of researchers in the field of quality. Contributors have highlighted a number of related dimensions such as the concept of culture (Cameron and Barnett, 2000; Hamada, 2000), corporate performance (Easton and Jarrell, 2000), and different aspects of Human Resource Management (HRM) (Ichniowski and Shaw, 2000; Kochan and Rubinstein, 2000).

These publications demonstrate the increasing contribution academics are making to the quality movement and to the ever-growing body of literature surrounding it. However, there is the view that the audience of management theorists is essentially academia with the expectation that, in time, there will be a diffusion of the content to the practitioner community through either teaching or consultancy (Dean and Bowen, 1994). Whilst this work may indeed serve to formalise the theoretical context over time as advocated by Anderson and colleagues (Anderson, Rungtusanatham and Schroeder, 1994), one wonders where this leaves action researchers and practitioners in the meantime.

Teixeira, (1999) advises the practitioner to start by seeking out the core principles of TQM but, given the previous discussion, one may question whether there is such a thing. Witcher (1995) takes the view that there is no core, arguing instead that the debate is about its very absence. On the other hand Dean and Bowen (1994) present a very clear core and claim that, far from being '*a hodgepodge of slogans and tools, it is a set of mutually reinforcing principles each of which is supported by a set of practices and techniques*'. Teixeira (1999) suggests that the practitioner's mindset should be a dynamic balance of all contributions, but how realistic is this? Although the notion of 'conventional/received wisdom' has a certain intuitive appeal to the hard-pressed practitioner, it is important to heed the warnings that TQM is not based upon a sound theoretical foundation and any such *'dynamic balance of all contributions'* may lead to confusion with concepts being misunderstood and misapplied or even to what Dale and colleagues have termed TQM paralysis (Dale, Boaden and Lascelles, 1994). Whilst Teixeira (1999) may argue that lack of any universal definition gives a freedom to act, Wilkinson (1995) suggests that a 'fuzzy' understanding of the concept will result in the adoption of a 'fuzzy' model. Table 3.5 outlines a number of ways in which TQM may be conceptualised. These range from a way of managing the business to a tool; operationalisation of either would require very different approaches.

Table 3.5: Degrees of TQM conceptualisation

1. TQM as a program;
2. TQM as human resource management;
3. TQM as quality management;
4. TQM as business process management;
5. TQM as a concept and a tool;
6. TQM as marketing;
7. TQM as a paradigm;
8. TQM as a manifestation of post-modern organisation.

Witcher (1995)

This brings the review round to Hackman and Wageman's question - is there such a thing as TQM or is it merely a 'potpourri' of initiatives under a common banner (1995)? In practice, many of the key elements of the early founders are perceived to have been ignored altogether or sanded down which has left the authors (ibid) to conclude that *'rhetoric is winning over substance'* and that the *'science is fading and the slogans staying'*. In the absence of any definitive 'received wisdom', it seems important that those seeking to implement total quality are explicit about the way in which it is being conceptualised and that the model chosen to translate the concept into practice is consistent with this. The following section will now consider some of the frameworks and critical success factors for and barriers to implementation.

3.4 IMPLEMENTING TOTAL QUALITY MANAGEMENT

As with many other aspects of TQM, the literature on implementation is wide and, for the purpose of this section, the discussion will focus on three main areas: models and frameworks, critical success factors (CSFs), barriers to and problems associated with the implementation of TQM. The aim is to provide a flavour of the literature around these aspects rather than an in-depth analysis and discussion.

3.4.1 TQM Implementation Frameworks

The earlier discussion around policy implementation in Chapter 2 highlighted the difference between two aspects of implementation - that is the end state and the change process. Some have observed that not all authors differentiate accordingly (Yusof and Aspinwall, 2000a) and, in the field, this may lead to confusion and possible inconsistency with regard to the 'what' and the 'how' of TQM implementation; factors

which are considered to contribute to implementation failures (Glover, 1993).

The implementation of TQM is considered by some (Kanji and Barker, 1990; Glover, 1993) as the most complex activity an organisation can undertake and the need for culture change is cited as the main reason for this complexity. Culture change notwithstanding, if TQM is conceptualised as a way of managing the business rather than some sort of localised initiative, then the scale of the change required to deliver the whole system intervention which is intended, over time, to move the organisation from one state to another, will undoubtedly contribute to the complexity of the task. Despite (or perhaps because of) this inherent complexity, TQM implementation, as with implementation per se, has received relatively less attention than other aspects of total quality until recently. Sproull and Hofmeister (1986) suggest that the lack of interest is, in part, because implementation is not generally glamorous or exciting but is, instead, about the *'nuts and bolts, details, and mundane problems.'* Also, because implementation is often not clearly bounded, it does not merely follow on from a decision and it may take place through a large number of actors.

One mechanism for providing a boundary for and increasing the explicitness of the implementation process is to adopt a framework. In fact, the importance of this is highlighted below:

> *'..... one of the most influential factors in ensuring total quality management adoption success is the formulation of a sound implementation framework prior to embarking on such a change process'* (Yusof and Aspinwall, 2000a).

Yusof and Aspinwall (2000b) propose that an implementation framework should

consist of a number of characteristics (Table 3.6).

Table 3.6: Characteristics of a TQM implementation framework

- Systematic;
- Simple in structure; easily understood;
- Clear links between elements outlined;
- General enough to suit different contexts;
- Represent a road map and a planning tool for implementation;
- Answers 'how to' and not 'what is';
- Implementable.

Yusof and Aspinwall, (2000b)

The authors (Yusof and Aspinwall, 2000a) also suggest that the utilisation of a framework will bring a number of benefits: it may serve as a vehicle for raising awareness of the concept and facilitate a common understanding of what is to be achieved and how; it could also enable the organisation to introduce the elements in a *'more comprehensive, controlled and timely manner'*.

At Appendix 1, seven implementation typologies are outlined; the authors have presented these variously as TQM implementation frameworks (Dale and Boaden, 1994; Ghobadian and Gallear, 1997), stages (Kanji and Barker, 1990), steps (Glover, 1993; Stamatis, 1994; Oakland, 1995), or process (Rand, 1994). Across this collection, there is a variation in the level of abstraction, range and focus. As an example of the latter, Stamatis (1994) emphasises the importance of project management whilst Ghobadian and Gallear (1997) aim their framework at small and medium sized enterprises. Some frameworks are written by consultants and others by academics; some are based on experience whilst others have been derived from case studies. Some include what could be considered end state elements but most deal with the process of implementation and also emphasise the central aspect of change within this. Whilst

Dale and Boaden (1994) explicitly state that their framework is not designed as a 'how to', the accompanying text does include 'process' aspects in its discussion of the four main elements.

Rather than presenting a comparison of these typologies which would be of limited value given the diversity referred to above, the intention is merely to demonstrate the variation that exists within. This adds weight to the notion that there are no simple recipes or prescriptions for successful TQM implementation; largely because, as demonstrated previously, there is little consensus over the 'what' and, given the complexity and uniqueness of individual organisations, the 'how' must therefore be adapted to the specific context. Owing to the variation between authors, frameworks must be adopted with caution and adapted with regard to the local context rather than treated as the received wisdom which, in view of the earlier discussion on the 'what' of TQM, seems a matter of interpretation. However, the following discussion of critical success factors and pitfalls should provide valuable insights which may aid this interpretation process.

3.4.2 TQM Implementation - Critical Success Factors

A concept which is related to the notion of the frameworks discussed in the previous section is that of critical success factors (CSFs). Oakland (1995, p25) defines CSFs as *'what must be accomplished for the mission to be achieved.'* In this sense, CSFs serve as an important vehicle for the translation of the goal into practice through the subsequent identification of critical processes, activities and tasks and then the development of key indicators to measure performance. Oakland (1995) stresses that

the CSFs should inform the design stage of the implementation process thus enabling the match of the 'what' to the 'how' and thereby reducing the likelihood of what he terms the *'danger gap'*, a situation in which there are goals but no mechanisms for their achievement.

A number of authors have proposed a set of factors which they consider to be critical to successful implementation. Whilst the title of their papers may refer to successful implementation, it seems one must bear in mind the distinction between implementation as a process and as an end state because both or either may be discussed under this banner. Although some elements such as leadership or senior management commitment may relate to both content and process, their operationalisation will vary depending on how they are categorised (the 'what' and/or the 'how'). By way of illustration, Table (3.7) outlines two examples of mainly 'process' CSFs and Table 3.8 a further two examples of mainly 'end state' CSFs.

Table 3.7: TQM implementation - process CSFs

Porter and Parker (1993)	Yusof and Aspinwall (1999)
1. Management behaviours • clear leadership • vision • commitment to TQM • involved in TQM process • strategic issue **2. Strategy for TQM** • specific objectives • incorporate into business plans • establish means for CQI **3. Organisation for TQM** • organisational structure • team structure • hierarchy for authority **4. Communication for TQM** • Quality awareness • Publish achievements **5. Training for TQM** • All employees • Ongoing process • Scope and depth to meet individual need **6. Employee involvement** 7. **Process management and systems** • Documented quality system **8. Quality technologies** • SPC etc	1. Leadership and support from top management 2. Providing effective and appropriate training for employees 3. Measuring results and performance 4. Conducting continuous improvement 5. Adopting a QA system 6. Sufficient financial resources 7. Providing relevant training for senior management/staff level 8. Favourable work environment 9. Selective application of tools and techniques 10. Involving suppliers in improvement 11. Desirable HR practices

Table 3.8: TQM implementation - end state CSFs

Ahire, Golhar and Waller (1996)	Saraph, Benson and Schroeder (1989)
1. Top Management Commitment 2. Customer focus 3. Supplier Quality Management 4. Design Quality Management 5. Benchmarking 6. SPC Usage 7. Internal Quality Information Usage 8. Employee Empowerment 9. Employee Involvement 10. Employee Training 11. Product Quality 12. Supplier Performance	1. Divisional top management leadership for quality 2. The role of the quality department 3. Training 4. Product/service design 5. Supplier quality management 6. Process management (design and control) 7. Quality data and reporting 8. Employee relations

Other authors have adopted a particular perspective in their quest to increase the effectiveness of implementation (Table 3.9) and have considered organisational factors which affect implementation success (Mann and Kehoe, 1995), organisational factors

which are *'most likely to result in TQM-consistent behaviors'* thereby impacting on implementation success (Shea and Howell, 1998) and factors relating to the *'mind-set'* of senior managers which are also thought to contribute to successful TQM implementation (Taylor, 1996).

Table 3.9: Organisational factors in TQM implementation

Mann and Kehoe (1995)	**Shea and Howell (1998)**	**Taylor (1996)**
1. Process 2. Type of employees 3. Shared values 4. Management style 5. Organisational structures 6. Number of employees 7. Industrial relations	1. Persuasion • Leadership 2. Enactive attainment • Organisation structure • Job design 3. Vicarious experience • Modelled behavior • Training 4. Cognitive mediators • Self-efficacy • Outcome expectancy	1. Understanding of TQM 2. Motivation for implementation 3. Perception of customer satisfaction 4. Perception of financial impact of TQM 5. Perception of extent of employee involvement

Although there are some similarities across the authors cited above either in relation to specific elements such as senior manager commitment/leadership and the more generally expressed management style, the key purpose of presentation has been to display the diversity of approaches and to highlight once again how the duality of implementation may/may not be explicitly expressed and therefore may pose a danger to the unwary.

The CSFs in Tables 3.7 and 3.8 could be perceived as the positive side of the coin - the enablers; the next section will look at the opposite side of the same coin - the potential barriers to implementation.

3.4.3 Barriers, Pitfalls, and Obstacles to the Implementation of TQM

Given the variation in the sets of CSFs presented earlier, it is worth adopting a different perspective and reviewing the other side of the CSF 'coin'; of particular significance given the fact that two in three TQM efforts are not considered successful (Brown, 1993). A number of consultants and academics, either from their own general experience in the field (Brown, 1993; Katz, 1993; Dale and Cooper, 1994; Whalen and Rahim, 1994; Yong and Wilkinson, 1999), based on a review and synthesis of the literature (Davis, 1997) or from case study research (Newall and Dale, 1991; Krishnan, Shani, Grant et al, 1993; Koeslar, 1995; Kanji, 1996) have presented a range of issues likely to impact on the success or otherwise of the implementation effort (Table 3.10). These have variously been described in terms of pitfalls (Katz, 1993; Kanji, 1996), the common mistakes of managers (Dale and Cooper, 1994), barriers (Whalen and Rahim, 1994), obstacles (Yong and Wilkinson, 1999), breakdowns (Davis, 1997), problems (Krishnan, Shani, Grant et al, 1993; Newall and Dale, 1991) and *'reasons why TQ fails'* (Brown, 1993).

The level of detail varies amongst the papers cited above but it is generally a broad treatment of a range of issues; albeit some with a particular perspective such as management mistakes (Dale and Cooper, 1994) or, less commonly, the failings of a particular managing director (Krishnan, Shani, Grant et al, 1993). Others have focused their attention more closely on areas such as organisational politics (Wilkinson and Witcher, 1993), culture and structure (Tata and Prasad, 1998) or the human resource issues associated with TQM implementation (Snape and Redman, 1995).

Amongst the observations cited above which are experiential in origin, there is a sense that implementation failure is generally due to the implementation process rather than the concept itself. The authors tend to recognise that TQM involves 'change'; this may be reflected as the cultural change required to move from a fire-fighting approach to running the business to one which is based upon *'planning, prevention and improvement'* (Dale and Cooper, 1994). Alternatively, the nature of the change may reflect a whole system perception of TQM where implementation will require changes to the way the business itself is run thereby addressing change on multiple fronts (Davis, 1997). However, although the authors refer to TQM, not all are explicit about what 'it' is, or the organisational context in which 'it' has been implemented. Whilst this does not preclude the identification of general themes, it suggests that any comparison of the issues raised by the authors in Table 3.10 on a like for like basis may be of limited value.

Table 3.10: Barriers to TQM implementation

8 TQM pitfalls (Katz, 1993)	Common mistakes made by senior managers (Dale and Cooper, 1994)	10 reasons why total quality fails (Brown, 1993)
1. CEO delegates responsibility for TQM 2. Failing to recognise that every company and environment is different 3. Applying tools of TQM before needs determined and direction established 4. Conducting training before support for TQM 5. Training employees before managers 6. Overemphasis on technical tools over personal skills, leadership and management 7. Failure to incorporate suppliers 8. Not celebrating success	1. Lack of commitment, awareness and vision 2. Failure to commit sufficient time to learn about TQM 3. Failure to become personally involved in planning for its introduction and development 4. Underestimating the resources needed to start and develop a process of QI 5. Not establishing an effective infrastructure 6. Not committing sufficient resources to TQM education and training 7. Treating output and cost targets as the main business priorities	1. Disguising cost control as TQ 2. Measuring too many of the wrong things 3. Lack of support from the top 4. Too much too soon 5. Too little too late 6. Dual structures 7 Focus on activities vs. results 8. Can't get out of phase 1 9. No one gets rewarded for quality and customer satisfaction 10. Total quality as a fad
Breakdowns in TQM (Davis, 1997)	**Obstacles to full TQM (Yong and Wilkinson, 1999)**	**Common barriers to implementation (Whalen and Rahim, 1994)**
1. Failure to execute 6 fundamentals 2. Lack of focus and dissipation of resources 3. Creation of a separate TQM organisation 4. Poorly integrated complimentary management programs 5. Inadequate linkages with financial results	1. Lack of senior level leadership • *Lack of long-term strategy or vision* • *Lack of time* • *Lack of resources and infrastructure* • *Lack of action and consistency* 2. Lack of middle management commitment 3. Fear among front line employees 4. Values and attitudes of organisational actors 5. Barriers between departments/functions 6. High labour turnover 7. Cultural issues 8. Certification and measurement issues	1. Poor planning 2. Lack of management commitment 3. Resistance of the workforce 4. Lack of proper training 5. Teamwork complacency 6. Use of an off-the-shelf programme 7. Failure to change organisational philosophy 8. Lack of resources provided 9. Lack of effective measurement of QI

Table 3.10 contd: Barriers to TQM implementation

Pitfalls to implementation (Kanji, 1996)	**Problems (Krishnan, Shani, Grant, Baer, 1993)**	**Problems (Newall and Dale 1991)**
1. MD undermined creation of constancy of purpose 2. MD failed to adopt new philosophy 3. MD failed to become a leader of change 4. MD would not resource training 5. MD management style relied on fear and intimidation 6. MD created barriers between departments 7. MD inhibited growth of learning culture 8. MD allowed certain people to become overworked 9. MD failed to make decisions based on evidence 10. MD blocked company-wide CQI 11. MD made teamworking and quality improvement second 12. MD created policies in secret	• Confusion from pursuit of multiple quality initiatives • Inability to translate broad quality goals into quantitative targets • Appropriate organisational structure for implementation • Communication difficulties • Managing transition from individual to organisational learning **Kolesar, 1995** • Failure to manage by fact • Initiatives running out of gas • Lack of infrastructure to support problem solving • Lack of understanding • Delegation of implementation • Indicate posturing-implementation gap	• Management commitment • Hostility • Reluctance to change • Outdated working practices • Lack of drive and determination by senior managers • Poor managerial skills • Union relationships • Individual performance appraisal • Emphasis on short term profits • Lack of understanding

Rather than trying to fit the elements in Table 3.10 into a single taxonomy, perhaps the value lies in their diversity. These authors identify a wide range of issues which, collectively, appear to encompass many aspects of the total system. To illustrate this, elements have been selected and aggregated in a whole system framework (Miles, 1997) which illustrates the pervasive nature of the potential barriers to successful TQM implementation.

Table 3.11: A whole system view of the barriers to TQM implementation

1. Vision • lack of vision • total quality as a fad • lack of focus **2. Strategy** • lack of strategy • uncoordinated activity • lack of time • lack of resources **3. Structure** • lack of leadership • lack of management commitment/responsibility • lack of implementation structure	**4. Infrastructure** • poor communications • poor planning • lack of measurement **5. People** • lack of training/education • workforce resistance • front line fear	**6. Competencies** • teamwork issues • managerial skills **7. Culture** • values/attitudes • organisational philosophy

According to the experience of one author (Kolesar, 1995), the issues he has highlighted (Table 3.10) are *'not isolated horror stories unfairly selected from otherwise healthy TQM implementations'*. Thus, as seemingly common occurrences, these issues represent important challenges to the implementation of TQM not only in relation to the process itself but ultimately to the quality of the outcome achieved. Whether an awareness of such challenges originates from the experiences of others or from an internal analysis of TQM initiatives which have failed to deliver the results anticipated, Katz (1993) warns that organisations that fail to identify and address such pitfalls do so at their own peril. These organisations tend to seek *'a fresh TQ Something Else'* (Kolesar, 1995) which Brown (1993) regards as a *'waste of time when we haven't properly applied what we have'*.

Given that CSFs and other aspects of implementation are highly context-specific, Black and Porter (1996) suggest that the nature of TQM has now passed beyond trying to capture it in convenient taxonomies and instead the research effort needs to focus on

the practical experiences of organisations. In light of these comments, the next section will focus on case studies of TQM implementation.

3.4.4 Implementation Case Studies

In the preface to their collection of cases, Oakland and Porter (1994; p xxii) claim that *'the value of illustrative cases in an area such as TQM is that they inject a reality into the conceptual frameworks developed by authors in the subject'*. They go on to argue that cases based on real situations provide a useful basis for analysis, evaluation and comparison with one's own experience. Such cases may also serve as a learning vehicle for groups to work through the issues raised in the safety of a theoretical exercise without the responsibility of actual operationalisation.

Presentation of cases appears to take a variety of forms, not just in terms of single or multiple cases but also a range of approaches within these two variables. Oakland and Porter (1994) have arranged their cases in sequence to illustrate aspects of the 'Bradford Model' of TQM which serves as the conceptual framework. Thus cases are included which highlight specific issues around, for example, the 'foundations' of TQM, the role of the quality systems, tools, techniques and measurement and so on. Olian and Rynes (1991) adopt a similar approach; having identified a set of organisational processes to support the implementation of TQM, the authors (ibid) then present well-known companies such as Motorola and Honda as practical examples of the theory discussed within the text.

In order to follow the implementation of TQM over a period of time, longitudinal case

studies have been undertaken which have enabled researchers to compare and contrast approaches between study sites against selected criteria. A study carried out by Newall and Dale (1991) looked at eight companies, in both manufacturing and service industries, in respect of: quality department organisation, the introduction and development of quality improvement, employee involvement, measurement of progress and problems encountered with TQM introduction and subsequent development. The paper highlights similarities and differences between the cases across these dimensions and concludes that the majority of problems experienced throughout the implementation process were the result of poor planning by the study sites.

Lillrank and colleagues (Lillrank, Shani and Kolodny et al, 1998) researched eight companies in eight countries over a three year period to understand how they organised for continuous improvement. Seven design requirements and seven corresponding design elements are identified. A comparative analysis is presented across these cases together with a discussion exploring the rationale underpinning the design choices made. The authors conclude that there is no *'one best way'* to design for continuous improvement and suggest that whilst it might be wise not to transfer specific programmes from one context to another, the design requirements might in themselves be more transferable (Table 3.12).

Table 3.12: TQM design requirements

1. Is continuous improvement part of ordinary work (integrated) or not (parallel);
2. Is continuous improvement work performed at a permanent group or task group;
3. Are the group members from one or several functions;
4. Are the group members from the same or different levels;
5. Is goal setting made centrally or in groups;
6. Are decisions about implementation made by the management hierarchy or the group;
7. Are incentive and compensation systems to be used to reward effort and results.
Lillrank, Shani and Kolodny et al (1998)

Single cases have included both private and public sector organisations. Some deal specifically with TQM implementation in small and medium enterprises (SMEs) (Goh and Ridgway, 1994; Yusof and Aspinwall, 2000c) and seek to demonstrate that they incur particular problems during implementation due to their size and, consequently, should not be treated as small versions of large organisations. Whilst this may certainly be wise advice, one could argue that some of the specific issues highlighted, such as lack of resources in terms of time, finance and human resources are not confined to these smaller enterprises and this is supported by similar work with large organisations (Dale and Cooper, 1994). Other authors have focused on large corporations and illustrate the challenges of TQM implementation faced by both the private and public sectors. Thus the experiences of a range of companies/organisations are captured and presented as a case study format; these include commercial companies such as an aluminium manufacturer (Kolesar, 1993), a manufacturing company in the oil distribution industry (Snowberger, 1996), a telecommunications company (Krishnan, Shani, Grant and Baer, 1993), oil pipeline and transport (Anderson and Adams, 1997) through to the efforts of federal government (Dobbs, 1994).

Whether multiple or single site approaches are adopted, each provides valuable insights from a variety of perspectives and those of Newall and Dale (1991) and Lillrank and colleagues (Lillrank, Shani and Kolodny et al, 1998) have been cited above as particular examples. From a careful study of cases, the reader is also likely to determine similarities in terms of approaches, issues needing to be addressed, obstacles experienced; however, the depth with which the cases may be explored often varies. Common elements have been included as Table 3.13.

Table 3.13: Common themes from TQM case studies

- Senior management commitment/Leadership;
- Middle managers - their new role as coach/facilitator, threats to their power base, potential or actual obstacles;
- Approaches to training and education;
- Teams - problem-solving; training and support needs;
- Stages/phases of implementation;
- Tools and techniques;
- Change - TQM fundamentally about change;
- Culture - culture to support CQI.

Diversity seems to be a common thread running through much of the TQM literature. In the previous section, it was suggested that this needs to be acknowledged as a pervasive feature. Perhaps it is a function of the lack of any precise definition of TQM and the likelihood that there is *'no one best way'* with regard to implementation (Lillrank, Shani, Kolodny et al, 1998). In addition, issues receiving attention are likely to be highly context specific; their inclusion reflecting the impact relative to other aspects which, although relevant, may be obscured, perhaps not reported, but no less present in the case (Oakland and Porter, 1994). The conceptual frameworks which may have served as the lenses for the inquiry are not always as explicitly stated as in the work of Oakland and Porter (1994) or Newall and Dale (1991) and, irrespective of whether they are explicit or implicit, conceptually they may be quite different. As a related but different point, given the argument that the implementation process is highly context specific (Lillrank, Shani, Kolodny et al, 1998), it is perhaps relevant to note that the level of contextual detail provided as background to the studies also varies. This may have implications for the value of the case study as a learning vehicle where one is hoping to make a comparative analysis between the case organisation and hypothetical or real organisation experience.

The value of a case study could be encapsulated in a statement such as 'interesting as far as it goes'. This should alert the reader to the fact that the case is not likely to be the entire picture but rather a simplification which may bring an associated danger - *'the danger of making implementation seem clear-cut and obvious'* (Oakland and Porter, 1994; p xxi). Although the espoused premise guiding implementation may be that TQM is a philosophy of management, a way of running the business, this does not necessarily mean that the reader will get a sense of the whole system implications of implementation from the cases. For example, Olian and Rynes (1991) address many aspects of not only the 'what' of implementation but also the 'how'. The authors (ibid) argue that the key to establishing TQM as a way of life is to bring all of the key elements into alignment which they sum up broadly in terms of people, processes and outcomes; unfortunately, there is no direct mention of the need to develop a structure and infrastructure to support the processes described.

So far the discussion of TQM generally and cases in particular has largely been confined to the literature from the industrial sectors. This has provided a useful background for the main focus of this thesis and the remainder of this section will now concentrate on TQM and CQI in health care.

3.5 TQM AND CQI IN HEALTH CARE - A GENERAL OVERVIEW

3.5.1 TQM - An Ambiguous and Hazy Concept within Health Care

Although contributors to the field of TQM and CQI in health care recommend that we go outside of this context and investigate alternative models (McLaughlin and Kaluzny,

1990), the decision to start with the literature around TQM in industry largely followed from an earlier sense of confusion generated from an initial scanning of the literature on TQM and CQI in health care. This initial foray was accompanied by growing confusion; terminology such as TQM and CQI is used interchangeably by some authors (Shortell, O'Brien, Carmen et al, 1995; Motwani, Sower and Brashier, 1996; Zabada, Rivers and Munchus, 1998), or defined as separate entities by the some of the *same* authors (Shortell, Levin, O'Brien et al, 1995). There are also multiple definitions of the concepts and characteristics; typologies of the key elements of TQM and CQI appear to vary depending on the writer.

The rationale for looking at the industrial literature went along the lines of - TQM started in industry over a decade before its spread to health care; therefore, there may be greater clarity and consensus in that arena. As the discussion in the previous sections would suggest, this search for clarity in another arena was built on an optimism that turned out to be unfounded. The reality was indeed that a lack of clarity and consensus was not confined to health care giving credibility to the description of TQM as something of a '*quagmire*' (Nwabueze and Kanji, 1997). So as not to add to this lack of clarity, for the remainder of this thesis, the abbreviation 'TQM' will be used to denote the organisational framework that enables the process of 'CQI' to take place; the terms will not be used interchangeably unless during the citation of other authors.

Recognition of the ambiguity described above was an important step forward but it also suggested that many of the issues relating to the implementation of TQM and CQI in health may be similar to those in industry. Although there are those who might

question the validity of this (Arndt and Bigelow, 1995), a degree of similarity is indeed reflected in both literatures. In fact, a number of papers focusing on aspects of implementation in health care seem to present models or sets of CSFs which appear to have a generic flavour. For example, Nwabueze and Kanji (1997) claim that the failure of implementation in the public sector is due to the absence of context-specific models; the authors then present a model to overcome this which could easily be applicable to the industrial setting. Jackson (2001) outlines a set of key actions for achieving successful TQM implementation in health care - here again one could argue that, within this approach, there is little unique to the health service context. These contributions are interesting because they may serve as a challenge to the 'not invented here' mentality described by Pollit (1996) and may even assist in the transfer of learning from one industry to another; particularly with regard to the issues associated with implementation.

3.5.2 The Challenge of TQM Implementation in Health Care

The challenges facing implementation in industry have been highlighted earlier in this chapter; authors considering this notion from the health care perspective raise issues related to a number of features which they regard as specific to this context. Short and Rahim (1995) point to structural elements and comment on complex, bureaucratic organisations which potentially limit cross-boundary working and communication. Others note the presence of a culture of blame which may inhibit openness and cause fear (Arndt and Bigelow, 1995) or the various subcultures (Zabada, Rivers and Munchus, 1998) - related to which there is sometimes tribalism and even turf battles (Wakefield and Wakefield, 1993). Wakefield and Wakefield (ibid) also draw attention

to the complexities of service delivery as opposed to manufacturing and batch production which are considered to be easier to specify, control and measure. Still others note that the complexity is compounded by the fact that the customer is a co-producer of health care (Zabada, Rivers and Munchus, 1998).

Alternatively, one might take the view that the particular structural and cultural challenges outlined above are unlikely to be confined to health care. Customer co-production and the complexity of the service delivery process are a key characteristic of services in general (Lovelock, 1992); however, the complexity is likely to vary depending upon the nature of the service. Contrast, for instance, operative procedures requiring the skill of the clinician with those of the highly regulated and scripted delivery which occurs at some fast food outlets.

Whilst Blumenthal and Kilo (1998) share the view that many of the challenges to implementation are not unique to health care, they also argue that there are exceptions to this and offer two examples to illustrate this belief. The first concerns the wider context in which health care organisations operate. The lack of competition means that, unlike commercial organisations within a market where TQM may be considered a matter of survival, those health care organisations that are meeting their financial targets have little incentive to drive through the profound changes that TQM may require. Attention may instead be focused elsewhere such as on expansion strategies rather than the core business.

Secondly, the authors (ibid) see securing the involvement of medics as a key challenge.

This group is regarded as having considerable autonomy to practice which, before the advent of clinical audit, was considered outside the remit of management. TQM may be perceived as a challenge to both medical autonomy and independence and consequently resisted. The authors also suggest (ibid) that medical training does not prepare the profession for either TQM or CQI; instead, individualism is instilled together with an allegiance to the profession. As a result, many medics find it difficult to adopt the behaviours required to make TQM and CQI a reality - particularly with regard to multi-disciplinary teamwork and notions of internal customer-supplier chains.

The challenge of securing medical involvement in TQM and CQI is a common theme in the literature. Berwick and colleagues (Berwick, Godfrey and Roessner, 1990) point to the fact that in terms of accountability, medics in the past have only, if at all, justified their clinical decisions to each other and then only informally. Many fail to engage with total quality for a variety of reasons; for example: they do not see its relevance to their work believing they are already delivering quality care, thus the time involved in improvement activity is regarded as an opportunity cost (Zabada, Rivers and Munchus, 1998). Some authors see implementation of TQM as requiring a paradigm shift. McLaughlin and Kaluzny (1990, p9) present their perception of the professional and TQM paradigms in Table 3.14 and this provides some indication of the likely 'shift' that may be involved.

Table 3.14: The professional paradigm and the TQM paradigm

Professional	TQM
• Individual responsibilities • Professional leadership • Autonomy • Administrative authority • Professional authority • Goal expectations • Rigid planning • Response to complainants • Retrospective performance appraisal • Quality assurance **McLaughlin and Kaluzny (1990, p9)**	• Collective responsibilities • Managerial leadership • Accountability • Participation • Performance and process expectations • Flexible planning • Benchmarking • Concurrent performance appraisal • Continuous improvement

In addition to the professional challenges, others relating to the health care context have been identified. For instance, the patient as a consumer may now be gaining in terms of 'voice' but is still unable to exert the pressure of the market mechanism and professional knowledge and experience may still disproportionately reflect the shape of service delivery (Wakefield and Wakefield, 1993). In the wider context, several authors have brought to the fore a significant challenge to creating constancy of purpose - the constant threat to goal deployment as a result of policy initiatives which seem to shift the strategic goal posts (Kim and Johnson, 1994; Nwabueze and Kanji, 1997).

There is undoubtedly a vast US literature and an ever growing UK literature relating to the implementation of TQM and CQI in health care to which academics, consultants and practitioners have all made a significant contribution. There is much to be learned from this wealth of writing and especially from the results of large-scale evaluations of TQM implementation. Two such studies are of particular importance; one of which took place in the UK NHS and the other in the Norwegian health care system. Both studies provide a rich picture of the challenges posed by the attempt to implement TQM

and serve as important lessons for those involved in the more recent whole system approach to quality management in the NHS - clinical governance. A brief overview of each research project will now be presented.

3.6 EXPERIMENTING WITH TQM IN THE UK NATIONAL HEALTH SERVICE AND THE NORWEGIAN HEALTH SERVICE

In 1989, a Department of Health initiative to pilot the implementation of TQM was launched. Researchers subsequently evaluated the approach to quality improvement adopted by sites in 12 health authorities over a three year period; eight of these were taking part in the pilot and a further four non-TQM sites were studied as comparators (Joss, Kogan and Henkel, 1994; Joss and Kogan, 1995). In 1993, three Norwegian hospitals were selected by the Norwegian Medical Association to act as test sites for the implementation of TQM and funding was provided. The three pilot sites and three other hospitals (which did not receive additional funding) formed a network and met at regular intervals to share their experiences and learn from each other. The quality journeys of these six were evaluated over a four year period (Øvretveit, 1999; Øvretveit and Aslaksen, 1999).

Table 3.15: Factors predictive of TQM movement

1. Demonstrated senior management commitment to and understanding of TQM;
2. A well-developed and well-documented implementation strategy put in place with clear objectives, time-scales, action plans, and review mechanisms;
3. Strong/persevering TQM co-ordinator - board level appointment or at least direct access to chief executive;
4. Structure overseeing implementation of TQM; strategy for integrating this with normal line-management meetings as soon as managers are trained and continuous improvements have moved out to front line staff;
5. Comprehensive baseline assessment of service quality;
6. Early effort to gain the support of the medical consultants;
7. Sufficient funding for TQM facilitators;
8. Standard setting only as part of strongly monitored CQI;
9. Comprehensive training using mixed classroom/workplace model; tools and techniques not just awareness;
10. Explicit strategy/resources for recognising and rewarding progress;
11. Organisational changes only after evaluation.

Joss and Kogan (1995; p151)

The authors of the final project report on the UK experiment (Joss, Kogan and Henkel, 1994) offered a number of factors which they regarded as predictive of significant TQM movement (Table 3.15). Although the researchers acknowledged that there was an extensive range of quality improvement initiatives taking place in the pilot sites and that there had been a shift towards aspects of TQM practices, this was considered to be variable not only *between* but also *within* sites. Overall, apart from two sites, implementation was considered to have been unsuccessful and the final report documents deficiencies across all 11 of the factors cited above. Those researching the Norwegian TQM pilots (Øvretveit, 1999; Øvretveit and Aslaksen; 1999) do not appear to express any overarching view of the success or otherwise of the initiative. However, the impression gained from their reports (ibid) is that although there were examples of

positive initiatives taking place, this did not constitute an integrated approach to quality management. It would also seem that many of the implementation gaps highlighted in the Norwegian hospitals relate to similar factors as those identified in Table 3.15 which are derived from the UK experience.

Both of these evaluations provide extremely valuable insights into earlier efforts to establish a whole system approach to quality within the UK NHS and within a mainland European health system. Both experiments appear to have suffered, at least in part, from a combination of partial implementation, implementation failure and non-implementation. Progress was not uniform, in fact, it varied between and within sites. The experiences of TQM implementation noted above suggest that many of the challenges facing the pilot sites echo those identified in the earlier part of this review dealing with barriers, pitfalls and so on. It would seem therefore that these are problems not reserved for TQM in commercial settings but are also apparent in the public sector. The identification of the 11 factors described in Table 3.15 should serve as an important signpost for those presently implementing clinical governance in the NHS as should the lessons from the wider TQM literature presented in this chapter. The challenges to the successful implementation of TQM appear pervasive and pose a significant threat to the unwary who do not learn lessons from those who have gone before.

3.7 CHAPTER SUMMARY

This second part of the literature review has focused on quality in general and TQM in particular. The literature has given a flavour of the complex and contested nature of

health care quality and provided an overview of the complexity surrounding TQM both in industry and in the health sector. Far from being able to glean any form of universally supported 'received wisdom', the concept appears hazy and contested and there is certainly no blueprint for the implementation process. Instead what seems very apparent is that TQM is not for the faint-hearted as it poses a significant challenge to the organisation which stems from multiple sources. The risk is that implementation is only partial, perhaps only a watered down version of what the whole approach should be. This lack of attention to the notion of wholeness may result in an initiative that never achieves its full potential; perhaps because of the way it has been conceptualised and/or gaps in the implementation process. The barriers to the successful implementation of TQM are many, varied and well-documented. As such, they should serve as valuable signposts for those wishing to avoid the pitfalls that await the unwary; especially when the change that accompanies total quality is of such transformational proportions.

One aspect of TQM for which there is some degree of consensus, in the literature at least, is that an inherent feature of TQM is the notion of change. This is succinctly expressed by Berwick (1996) who notes that while all change does not involve improvement - all improvement involves change. Given the central role of change in improvement, the next chapter will consider the notions of both change and change management.

CHAPTER 4

LITERATURE REVIEW - CHANGE AND CHANGE MANAGEMENT

'In a changing world the only constant is change'
(Carnall, 1999; p143)

4.1 INTRODUCTION

The phenomenon of change whether at the level of an industry or an individual organisation has attracted considerable interest for decades. Whilst agreeing that concepts of change originating in the private sector should not be *'mechanistically trundled across the sectoral divide'*, Pettigrew and colleagues (Pettigrew, Ferlie and McKee, 1992; p5) suggest a preoccupation with difference and sectoral transfer has limited the extent to which understanding of the change processes observed within the NHS has been informed by the wider literature. The authors (ibid) acknowledge that there are sectoral differences - particularly in terms of politicisation and also the power and social position of the professionals, but they argue that there are enough similarities between the private sector and the NHS for experience gained in the former to illuminate thinking in the latter.

An issue both sectors appear to share is the challenge of effective change management. Tushman and O'Reilly (1996) ask why, when *'organisations are filled with sensible people and usually led by smart managers'* is change so difficult. In the context of health care, the *'implementation deficit'* is a problem commonly identified by researchers (Ferlie, 1997). Ferlie (ibid) argues that the increasing awareness of the sort of difficulties experienced by organisations seeking to deliver the change agenda has, in

part, fuelled the emergence of the change management literature. This has increased recognition that the change process can be facilitated (Iles and Sutherland, 2001) and should be managed (Nadler and Tushman 1995; Anderson and Ackerman-Anderson 2001; Cummings and Worley 2001).

Total Quality Management is considered by some as an important vehicle for delivering large-scale change (Ferlie, 1997). TQM implementation frameworks were presented in the previous chapter; this part of the literature review will continue with an exploration of more generic change models. However, before reviewing the change management literature and, in deference to Anderson and Ackerman-Anderson's warning (2001) that change needs to be understood before it can be managed, theories of change will be presented together with an overview of the more common conceptualisations of change as a phenomenon.

4.2 THEORIES OF CHANGE

It appears that the literature on organisational change is not only diverse but at an early stage of theoretical development (Dunphy, 1996). The author (ibid) observes that there is *'no one, all-embracing, widely accepted theory of organisational change and no agreed guidelines for action by change agents'*. This diversity not only reflects the complexity of the phenomenon but also the range of concepts imported from other disciplines in an effort to increase understanding - punctuated equilibrium (Gersick, 1991), sense making and sense giving (Gioia and Chittipeddi, 1991), even tectonic plates (Reger, Gustafson, Demarie et al, 1994). Given the complexity of the field, Dunphy (1996) asks whether a search for some unitary theory would even be a

legitimate endeavour. On a similar theme, Hawkins (1997) advocates the use of different lenses for organisational analysis arguing that this 'polyocularity' provides a variety of perspectives which will ultimately lead to a more holistic view of the field.

Van de Ven and Poole (1995) make a similar point to those above and warn that applying a single perspective will reveal only a partial account of a complex phenomenon and advocate instead alternative pictures of the same organisational processes. They offer four theories which they suggest might serve as the building blocks for explaining the processes of organisational change; namely: life-cycle, teleology, dialectics and evolution. They suggest the value of this approach is that other theories tend to relate to outcomes rather than the process itself which is of particular interest here, given the intended focus on both aspects of implementation, and therefore worth presenting in a little more detail.

According to life-cycle theory, change is imminent and pre-programmed although influenced by the environment. Change progresses as a unitary sequence of phases/stages which must take place in a prescribed order because each is a precursor to the next. Teleological theory assumes that the entity is purposeful and adaptive; capable of constructing an end state, taking action to reach it and monitoring progress along the way; development is seen as progression towards the goal although the trajectory is not necessarily sequential as in the life-cycle theory. Dialectical theory acknowledges the pluralistic nature of organisations and the presence of competition, conflict and political activity. Change occurs when the status quo is overthrown but the political process may equally sustain the status quo. Finally, evolutionary theory sees

the change process as a continuous cycle of *'variation, selection and retention'* and, in this way, is influenced by the natural sciences. Thus evolutionary change is ongoing, incremental and cumulative. The authors (ibid) suggest that the four theories within this typology offer fundamentally different explanations of the change process but caution that they should be regarded as 'ideal types' and that change within organisations is more complex than any one theory taken alone.

The following section will explore a number of ways in which change may be conceptualised; the reader may recognise shades of the theories presented above in the concepts that will now be considered.

4.3 CHANGE CONCEPTUALISED

4.3.1 Incremental and Discontinuous Change

Whilst acknowledging the theoretical pluralism surrounding the notion of change, Wilson (1992) highlights a certain homogeneity in the language used to describe this pervasive phenomenon. According to Nadler and Tushman (1995), at the broadest level, there are two types of organisational change - incremental and discontinuous. Writers on change seem to adopt a variety of synonyms in differentiating between the two and, in addition to incremental/discontinuous change, references to first order/second order, evolutionary/revolutionary, developmental/transformational, continuous/episodic change may be found in the literature (Pettigrew, Ferlie and McKee, 1992; Van de Ven and Poole, 1995; Weick and Quinn, 1999; Anderson and Ackerman-Anderson, 2001; Cummings and Worley, 2001).

In describing incremental change, Nadler and Tushman (1995) present the phenomenon in the context of organisational effectiveness where modification and improvement is ongoing with the aim of continuously refining the fit between the strategy of the organisation and components of the internal system. Such changes tend to be focused, occur over a finite period of time - usually weeks/months; they are not necessarily small, on the contrary some change may be significant in terms of the resources needed and their subsequent impact. However, incremental changes are usually bounded by the existing values and mission of the organisation and, in this sense, are within the current organisational frame and so essentially concerned with continuity.

In contrast, the focus of discontinuous change is on the creation of new configurations rather than improvements to status quo; thus, a new strategic direction may be the outcome accompanied by a radical reconstruction of the entire delivery system in support of this. According to Nadler and Tushman (1995), discontinuous change requires a complete break from the past; instead of working within the existing frame, the goal is to change the organisational frame completely. This degree of change is often associated with a degree of shock and is even painful and traumatic. Discontinuous change is usually related to major change in the industry in which the organisation operates.

Adding to the perspective outlined above, Weick and Quinn (1999) argue that incremental change is characterised by learning and driven by an organisational alertness and an inability to remain inert which reinforces the previous notion of organisational effectiveness. This type of change tends to take place at the micro-level;

is therefore faster and consists of 'mini episodes' which could subsequently serve as the building blocks for transformational change. In contrast, discontinuous change is characterised by replacement and often triggered by the organisation's failure to adapt incrementally. This type of change is strategic thus wider in scope and slower to achieve.

As highlighted earlier, there is a certain amount of consistency in the literature concerning the basic typology of change and its characteristics at a general level. However, there are those who challenge the notion that discontinuous change requires *'a complete break from the past'* (Nadler, and Tushman, 1995). In contrast, Goodstein and Burke (1991) argue that frame-bending change does not imply wholesale, complete change *'in any and all respects'*, some things inevitably stay the same which is important for those experiencing the change:

> *'... ... the principle here is that for people to be able to deal with enormous complex change - seeming chaos - they need to have something to hold on to that is stable'.* (Ibid).

According to Hamel (2001), it is more the balance between keeping hold of what is still relevant and not being afraid to let go of what may have served the organisation well but is no longer appropriate given the nature of the change.

Anderson and Ackerman-Anderson (2001) present a variation on the two dimensional typology presented above and offer three types of change which are described in terms of developmental, transitional and transformational. Developmental and transformational change appear similar to the notions of incremental and discontinuous change outlined earlier. Transitional change appears more as an interim point in the

incremental - discontinuous continuum and is offered as a response to more complex environmental drivers which require replacement rather than improvement but not in all components of the business. Inclusion of the notion of transitional change is a useful reminder of hybrid forms however, it should not be confused with the notion of *transition.* In the generic change implementation model developed by Beckhard and Harris (1987), transition denotes movement from the current to future state irrespective of the nature of the change.

In addition to this initial deconstruction of change presented by Nadler and Tushman (1995), the authors have added another dimension, i.e. time, to that of continuity (incremental/discontinuous). They reason that by differentiating between reactive and anticipatory change and combining these with the continuity dimensions, a further four types of change may be identified; each of which they regard as characteristically different (Table 4.1).

Table 4.1: A matrix of continuity and time (Nadler and Tushman, 1995)

	Incremental	**Discontinuous**
Anticipatory	**TUNING**	**REORIENTATION**
Reactive	**ADAPTATION**	**RE-CREATION**

4.3.2 Planned and Emergent Change

Another perspective on change relates to the extent to which it occurs as a result of a deliberate effort or whether it emerges over time; these aspects are generally referred to as planned and emergent change respectively. A recent review of the change literature (Iles and Sutherland, 2001) touches on both of these notions and defines planned change as *'deliberate, a product of conscious reasoning and actions'* (ibid, p14). Others, such as Cummings and Worley (2001) present a more detailed treatment of planned change. In particular, they draw attention to the role of Organisation Development (OD) in planned change efforts which, they argue, has moved from an earlier concentration on incremental changes to one which increasingly incorporates large-scale, discontinuous change. The authors (ibid, p39) are at pains to debunk the criticism of planned change as a *'rationally controlled, orderly process'* and highlight instead:

> *'... ... (its) chaotic quality, often involving shifting goals, discontinuous activities, surprising events and unexpected combinations of changes.'*

This chaos is often compounded in their opinion by managers who initiate change without having any clear idea of either their goals or strategies for achievement. In contrast, emergent change is described as a phenomenon which *'unfolds in an apparently spontaneous and unplanned way'* (Iles and Sutherland, 2001; p14). The process is characterised by drift rather than design and presumably without the deliberate intent which characterises planned change.

4.4.3 Ideal Types and Composites of Change

The body of literature surrounding change is massive and yet the phenomenon itself is

one which is often poorly understood and managed (Goodstein and Burke, 1991). The preceding discussion has attempted to present just some of the conceptualisations of this subject and, because of the vastness of the literature, this constitutes a small proportion of the thinking in the field around how change might be viewed. Different approaches offer different perspectives and insights and most of that which is presented here takes the form of what Van de Ven and Poole (1995) refer to as *'ideal types'*. These serve not only as a valuable simplification tool but also as a mechanism for organising thinking around change (Ferlie, 1997). Ideal types contrast with the reality of the change process which is infinitely more complex whether at the level of an industry or an individual organisation.

The reality of complex change is not bounded by either/or decisions but represents composites of some/all of the elements outlined within the depictions of ideal type. For instance, with regard to the notions of planned and emergent change, Pettigrew and colleagues (Pettigrew, Ferlie and McKee, 1992), Iles and Sutherland (2001) and Cummings and Worley (2001) are keen to dispel the 'myth' of the linear change process which seems to form the basis of criticisms of planned change. Even planned change is likely to demonstrate emergent properties; Klein (1995), concerning the 1991 NHS reforms, comments that *'the dynamics of change once unleashed, created their own side effects and surprises.'* This is perhaps to be expected given the author's earlier observation that: *'the plans as initially announced were little more than outline sketches. The details were filled in during the course of implementation'* (Ibid). Given the emergent nature of clinical governance as a policy, it seems that Klein's comments are as relevant today as almost a decade ago.

Continuing with the theme of composites, Wilson (1992) suggests that change is a relative concept and therefore, it is more appropriate when considering organisational change to think in terms of the degree of change taking place rather than conceptualising it as the antithesis of stability. Nadler and Tushman (1995) make a similar point - even when organisations appear to be going through a period of inertia, they are not standing still. In this, Tushman and O'Reilly (1996) see the seeds of a dilemma for managers. In the short term they are constantly struggling to increase the degree of internal and external alignment but this evolutionary change is not enough for sustained success. In the long run they may be required to destroy the processes which have delivered the very alignment that has made the organisation successful. Organisations need to become *'ambidextrous'* and operate in a world that is characterised by periods of stability and incremental change whilst at the same time remain alert to the triggers for revolutionary change. As Pettigrew and colleagues (Pettigrew, Ferlie and McKee, 1992; p299) observe, there is *'no respite from the ever present duality of holding together an organisation whilst simultaneously reshaping it'*. Given this enduring challenge, it is perhaps timely to explore the principles of change management and identify models which might assist managers in the delivery of the change agenda.

4.4 CHANGE MANAGEMENT

Whilst clichés such as the one cited at the beginning of this chapter are seemingly abundant (Goodstein and Burke, 1991), they are still likely to strike a chord with those currently working in the NHS - despite the New Labour promise of evolution not revolution in the health care arena (Department of Health, 1997). Whilst the NHS

reforms of 1991 brought change within the existing structure, the more recent reforms have heralded a new configuration of the health economy. The scale of this change serves as a challenge to Klein's comment (1995) on the Thatcher Government reforms about which he observed that *'the exhausting convulsions precipitated by Working for Patients have dampened the appetite for further change'*. It seems that Klein (ibid) was a little premature in making this observation.

To facilitate the management of this most recent programme of NHS reform, a review of the literature on change management was commissioned (Iles and Sutherland, 2001). This document aims to provide an introduction to a range of approaches, models and tools and presents each using a uniform format - description, use, evidence and commentary. Certain elements such as culture, organisational politics and leadership were apparently outside the scope of the review which seems a lost opportunity as these often present the biggest challenge to the management of change. As an introduction to change, the review makes a valuable contribution to the literature in that it highlights a number of concepts and tools; particularly those that will assist organisational diagnostics and planning. However, practitioners will need to look elsewhere for a guide to actually leading and managing the transition from the present to the future state because, apart from Soft Systems Methodology (Checkland and Scholes, 1990), the review does not appear to include much in the way of models that deal with the actual process of change.

4.4.1 Models and Frameworks for Change Management

Although the literature does not tend to distinguish between frameworks and models and these terms are often used interchangeably, Anderson and Ackerman-Anderson (2001) see these as two separate phenomena. They argue that a change framework essentially highlights the areas which will require attention during the change and cite the Peters and Waterman (1982) '7-S Framework' as an example of this. In contrast, they see change process models as offering guidance on the 'what', 'how' and in 'what order' change needs to happen citing the Kotter model (1996) as an illustration. Whilst the frameworks are regarded as static representations, the process models are considered to be dynamic; serving as roadmaps and a *'thinking discipline'* rather than a *'prescription for action'* or a check list (Anderson and Ackerman-Anderson, 2001).

The distinction between models and frameworks will not be emphasised in this thesis in deference to other authors cited such as Miles (1997) whose framework will be utilised for the case study (Appendix 2). Although Miles refers (ibid) to his construct as a framework, it is dynamic and captures the what and the how and therefore would constitute a model under Anderson and Ackerman-Anderson's (2001) criteria.

Anderson and Ackerman-Anderson (ibid) argue that frameworks have a place as educational tools but have little value in the field other than as an *'organising construct'*. From experience in the field I would argue that, in itself, is of value given the complexity of the change process and the omissions that may occur in the absence of either an explicit framework or a model of the change process. Perhaps it is more about how frameworks are utilised; as the review by Iles and Sutherland (2001)

demonstrates, frameworks in themselves may have limited value outside of a change process model.

Given the breadth of the field of change management and the different disciplines that contribute to the ever expanding literature, it is not surprising to discover that change process models abound (Kotter, 1996; Miles, 1997; Pendlebury, Grouard and Meston, 1998; Anderson and Ackerman-Anderson, 2001; Cummings and Worley, 2001). Perhaps the most famous change model is the notion of unfreeze-move-refreeze presented by Lewin (1951); upon which most of the subsequent models seem to be based. The sheer choice within the field makes the selection of a model a somewhat daunting activity, particularly when used in an action research setting where the research process includes on-going feedback to the organisation as well as data collection. Given the variation in conceptual content found by the review cited earlier (Iles and Sutherland, 2001), it seems unlikely that a single model could capture the full complexity of the change process.

In light of the above comments, three change process models have been selected for inclusion in this review (Kotter, 1996; Miles, 1997; Pendlebury, Grouard and Meston, 1998). Although the models vary in terms of emphasis, detail, and level of abstraction, taken together they appear to cover much of the complex ground relating to the practical aspects of making change happen in real organisations. Kotter (1996) seeks to provide an 'action plan' for the change effort (Appendix 3) and is the more abstract of the three models whilst Pendlebury and colleagues (Pendlebury, Grouard and Meston, 1998) seem to have developed more of a blueprint and reach a level of detail which

includes individual tasks (Appendix 4). Miles (1997) seems to be in the middle of this continuum and offers a *'framework for transformation'* which gets across the messiness of real world organisational change (Appendix 2). The remainder of this chapter will consider each of these models in greater detail.

4.4.2 Change in Eight Steps

Kotter (1996) presents an eight step change process which has been derived from the common errors he has observed over time spent working with organisations to bring about major change. He argues that each of the eight steps must be followed: steps 1-4 are concerned with *'defrosting'* the status quo, 5-7 putting new practices in place and stage 8 is about making the change *'stick'*. Each stage needs to be completed so that a solid foundation is gradually established and later built upon which gives the impression of sequential movement. However, Kotter (ibid) acknowledges that the presentation of this step model of the change process is a simplification of reality; given the complexity and messiness of real world change, the steps are more likely to be operationalised as multiple phases. One of the key concerns appears to be that, under pressure to deliver results, there is always the temptation to address stages superficially or even miss them out altogether. In this event, it is unlikely that a solid framework will become established; consequently early progress may soon lose momentum or any change achieved ultimately may not become institutionalised.

4.4.3 Ten Keys to Effective Change Management

Pendlebury and colleagues (Pendlebury, Grouard and Meston, 1998) have identified what they have termed 'The Ten Keys to Successful Change Management'. They

propose that this approach constitutes a coherent whole; each of the keys fulfils a different function and should not be regarded as a one-off activity. In fact, to maximise the likelihood of success, they advocate that the keys are *'applied not only simultaneously but continuously throughout the change process'* (Pendlebury, Grouard, and Meston, 1998; p41). Although it is acknowledged that each key may be more active during different phases of the change process, this sense of simultaneousness and the continuity of these components is rather contradicted by the detail around implementation which appears later in their text. Here there is a recognition that, certain, if not most of the keys need to be in play prior to delivery. There is a logic to the fact that some keys will need to be applied in sequence and will ultimately overlap perhaps intermittently, perhaps continuously; this lends itself to the notion of a critical path which highlights/predicts how and when these overlaps may occur. The core message is that all of the keys are considered to be essential to the success of the change effort; omitting one will cause problems, the authors (ibid) argue that omitting more than one will cause failure.

4.4.4 A Framework for Transformational Change

Miles (1997) moves away from the 8/10 taxonomies presented above. He offers a framework which outlines the fundamental attributes of transformation which deal with energy, vision, alignment and what is termed *'process architecture'* and presents within these main headings, clusters of activity which must be performed in order to achieve the transformation required.

Miles (ibid) stresses that the effectiveness of the framework relies on two important

factors; the initial change condition and leadership. He argues for an assessment of the initial change condition along the axes of readiness for change and resources available. Anything other than a state of high readiness and high resources (which he acknowledges to be *'a largely vacant space where only a few notable companies manage to reside for long'* [Miles, 1997; p11]) needs to be addressed before the framework may be implemented. The other factor concerns the issue of leadership which Miles (ibid) argues needs to be of a transformational nature in order to successfully catalyse and steer the organisation through the complexity of the change process.

Although a total system perspective is regarded as a vital ingredient of the process generally, perhaps it should be considered as a third factor of the initial change condition. This demands the transition to the future state takes place, not in a piecemeal way, but through the simultaneous articulation of all elements which are then orchestrated to deliver the vision. As with the two earlier models cited here, success relies on the implementation of the whole approach; if the initiative lacks more than one of the significant elements, once again failure is predicted.

Although each of the models discussed above may present the management of change in different ways, there is a certain internal consistency amongst several areas of content; these will now be considered under the heading of common themes.

4.4.5 Common Themes

Vision-led change

In the event of large-scale, complex change which is characterised by long time-scales and unanticipated events, it is unlikely that the whole change process will be knowable let alone controllable. In such circumstances, by defining and making explicit the fundamental goal of the organisation, the vision can serve as a compass by which the organisation may steer a course through the turbulent time to come and, ideally, provide a common sense of purpose behind which the organisation may unite. The key challenge is the translation of this broad goal into tangible objectives capable of being operationalised over a defined timescale.

With the exception of Pendlebury and colleagues (Pendlebury, Grouard and Meston, 1998) who refer to the re-engineering work at Leicester Royal Infirmary, many of the examples cited in the models discussed in this section are taken from industry. As with any generic approach, they need to be adapted and implemented sensitively according to the individual context; this applies equally when the transfer is from one industry to another or from organisation to organisation. As an example of the different industries; the visioning process in a commercial organisation is closely aligned to the strategic management process which seeks to address fundamental questions such as 'what business would we like to be in given the current competitive climate'. In contrast, the visioning process of an NHS organisation is likely to be determined largely by central policy. As another example, lowering complacency and raising the sense of urgency may be in response to the threat to the survival of a commercial organisation. In contrast, the sense of urgency in the NHS is often generated by the time-scales that may

accompany the introduction of a new policy and failure to meet these is not so much a threat to the survival of the organisation but often career-limiting for the Chief Executive. Nevertheless, whilst the triggers for visioning sometimes differ between the private and public sector, the process of developing the vision and defining how it is to be operationalised is often similar.

Leadership and management

Leadership is a recurring theme both within the models discussed here and also in the wider literature. However, successful change is not just a matter of effective leadership; it also requires effective management - change does not 'just happen' and as Kotter (1996; p129) notes - *'a balance of the two is required'*. Deliberate management intervention across the whole system is required if 'implementation drift' is to be avoided. This refers to both the long term objectives and the short terms gains for which management should actively plan; to passively hope for the achievement of either is an unreliable tactic (Kotter, 1996). Whilst visioning is regarded as a leadership function, Pendlebury and colleagues (Pendlebury, Grouard and Meston, 1998) suggest that the responsibility for change management lies squarely with the managers. This not only entails the translation of the vision into reality through the definition of tangible objectives which are prioritised according to the resources available, but also the operationalisation of these objectives through the management process; the essence of which Kotter (1996; p128) describes as:

> *'..... systematically targeting objectives and budgeting for them, creating plans to achieve those objectives, organising for implementation, and then controlling the process to keep it on track'.*

Energy and capacity for change

Each of the three models refer to the energy required not only to shift the organisation away from the status quo (synonymous with Lewin's notion of unfreezing [Lewin, 1951]) but also to sustain the momentum for what is likely to be a long haul. This emphasises the need for the creation of a sense of urgency and an associated lowering of complacency - a state secured by what Miles (1997) terms the process of *'confronting reality'*. This involves an assessment of the current state which accurately identifies the gap between that and the vision state; mechanisms to achieve this include benchmarking, industry analysis and a review of internal strengths and weaknesses. Although it is Miles (1997) who explicitly addresses the notion of the initial change condition, the other models also highlight the need to create the capacity for change through the allocation or re-allocation of resources which sends powerful signals down into the organisation about what is considered to be important. There are also issues around meeting the needs of the organisation in relation to knowledge and skills, not only in terms of the new roles that might be needed but also with regard to the change process itself in order to secure participation and involvement.

Organisational politics and political behaviour

Each of the models described in this section address the issues of politics and political behaviour albeit under different headings; for instance, as the need to handle the power dimension (Pendlebury, Grouard, and Meston, 1998), as the creation of powerful coalitions (Kotter, 1996) or as the need to deal with the personal dynamics of change as part of early energy generation (Miles, 1997).

Holism and alignment

A common theme running through the change models is the notion of wholeness; that success relies on the application of the whole approach leaving no scope for a 'pick and mix' attitude. Another important and related theme is the notion of internal alignment; that is, ensuring that *all* elements of the system are aligned and mutually reinforcing of the vision. According to Miles (1997), the total organisational system consists of the vision, strategy, structures, infrastructure, people, culture and competencies; given the scale of the change required to move all of these aspects from the current to the future state, it would be unreasonable to expect the new internal context to emerge in what Miles (ibid, p48) refers to as *'a moment of cosmic creation'*. Therefore all of these elements need to be carefully orchestrated (a term used by both Pendlebury and colleagues [Pendlebury, Grouard and Meston, 1998] and Miles [1997]) to create and maintain dynamic alignment in a way that builds up the organisational capacity to take forward the change effort given the resources available.

Each of the models deal with the core components of the alignment mechanism slightly differently. Pendlebury and colleagues (Pendlebury, Grouard and Meston, 1998) and Kotter (1996) seem to present them either as separate keys or separate steps. In contrast, Miles (1997) presents these activities together as a cluster which he terms *'process architecture'*. These components are regarded as key requirements if alignment is to be dynamic and responsive to the changes that will be needed if the organisation is to navigate through the fluidity of the transition state. It is recommended that all these elements are put in place at the earliest opportunity and remain so as appropriate throughout the life of the change initiative. This suggests that

alignment is not regarded as a one-off activity but as an on-going process which adapts in response to the feedback from the whole system as the change process itself proceeds. As with all aspects of the implementation process, it seems the clusters of activity which make up the process architecture need to be deliberately designed and executed in a manner which, once again, is consistent with and mutually reinforcing of all other aspects of the total system. A certain added value may be perceived in the way that the Miles model (1997) highlights these components as an important cluster. Practical experience suggests that these activities often get overlooked in the flurry to change the 'hard' elements of organisational design.

Continuing with the themes of alignment and deliberate intervention, the 'hard' or more formal elements such as strategy and structure are those which tend to be addressed first. These are perhaps more tangible and generally respond quicker than the 'softer', less tangible elements such as culture and people issues. Miles (1997) suggests that there has been a mind set that if the 'hard' elements are changed, then the 'softer' design elements such as organisational culture will automatically come into alignment; however, the author (ibid) warns that this is not necessarily so and this will shortly be expanded upon further in section 4.4.6.

Resistance is to be expected

Not only should there be deliberate action to align the system but each of the models cited here concur that there needs to be deliberate action to confront and, where necessary, remove any obstacles to this alignment. Resistance to change is regarded as a normal response, and, as such, should be anticipated and addressed. More usually,

this is through enabling people to contribute effectively to the change process but, where efforts fail to get people on board, it may then be more appropriate to move people on or out rather than allow them to serve as obstacles/barriers during the transition. Power issues are also considered as an inherent part of any change process. Power seeks to be increased rather than decreased (Pendlebury, Grouard, and Meston, 1998) and organisational change threatens to disturb the existing balance of power whether this arises from formal or informal power bases.

4.4.6 Culture Change

Another of the 'softer' elements of the whole system is that of corporate culture; a term which can sometimes obscure the fact that most organisations consist of a variety of subcultures (Kotter, 1996). Pendlebury and colleagues (Pendlebury, Grouard and Meston, 1998; p30) describe the culture of an organisation as *'the set of lasting values shared by its entire staff'*. Values and beliefs are, in themselves, invisible, but their expression in the form of behaviour is often all too apparent.

There is a consensus amongst the models that culture change, for a variety of reasons, is extremely complex but essential nevertheless as corporate culture is regarded as the 'anchor' which serves to institutionalise the change once implemented (Kotter, 1996). Cultural change may take years to achieve in contrast to structural change which sometimes take weeks or months; despite this, the cultural components of the change need to be considered at the outset if alignment is to be achieved. Whilst culture may, because of its very nature, be difficult to address directly and values are difficult to change, an important mechanism to achieve alignment is the translation of the vision,

not only into specific business objectives, but also into behavioural outcomes; the modelling of which is monitored and for which people are held to account (Miles, 1997). Whatever deliberate intervention is advocated, it seems that culture change is about the long haul rather than a quick trip and occurs last not first. Kotter (1996; p156) offers the following as *'good rule of thumb':*

> *'... Whenever you hear of a major restructuring, reeingineering, or strategic direction in which step 1 is "changing the culture", you should be concerned that it might be going down the wrong path'.*

4.5 CHAPTER SUMMARY

The aim of this chapter has been to provide an overview of change and change management. This third and final part of the literature review has sought to highlight the complexity of large-scale organisational change. Attention has been drawn to the theoretical pluralism which surrounds the notion of change and is reflected in concepts of incrementalism, transformation, emergence and intention (this latter referring to planned change). It would appear that, in practice, organisational change is often poorly understood and poorly managed. That it could and should be managed is attracting increasing attention in the literature which is often practitioner/academic-practitioner generated; the need for leadership and management is presented in terms of 'both/and' rather than 'either/or' components of the design process.

A number of change management frameworks have been included for discussion which have varied in terms of detail and also in the level of abstraction. Common themes within these have been identified; namely that large-scale change involves the whole system, it is not entirely controllable, the destination is not always identifiable but may

unfold as part of the journey, transformational change of this kind is a complex and often a messy undertaking. It is worth remembering that models/frameworks are a simplification of reality but, as such, may serve as a useful tool in guiding the change programme.

This chapter concludes the literature review per se; the following chapter will describe in detail the process of translating the research questions into research findings.

CHAPTER 5

RESEARCH METHODOLOGY

'The biggest enemy of your learning is the gnawing worry that you're not doing it right...but any given analytical problem can be approached in many useful ways'
(Miles and Huberman, 1994; p14)

5.1 INTRODUCTION

Earlier chapters have attempted to provide a flavour of the 'newness' of clinical governance as a *concept* and highlight the fact that, although many of its key components have been in existence for some time, the introduction of an integrated framework for quality improvement constituted an innovation for the NHS when first presented in the White Paper of 1997 (Department of Health). Although a number of initial 'must do's' were made explicit in subsequent guidance (Department of Health, 1999), the absence of any definitive 'blueprint' meant that the interpretation of both content and implementation at the local level was left largely to individual NHS Trusts. A number of surveys have been published which provide a snapshot of clinical governance across various regions (Conduit, Morgan and Willetts, 1999; Firth-Cozens, 1999; Latham, Freeman, Walshe et al, 2000; Walshe, Freeman, Latham et al, 2000). In contrast, the aim of this research study was to uncover, in rich detail, what clinical governance looked like in one NHS Trust in terms of content and to describe how this policy was being turned into practice over a period of time.

This thesis provides an insight into the journey of one large organisation as it faces the complex tasks of both translating clinical governance from words on paper into something tangible and also implementing this in the real world setting. The purpose of

this chapter is to describe the rationale for the research design selected, to provide a detailed description of how the research strategy has been operationalised, and to give some insights into the methods used to ensure the quality of both the research process and the results obtained.

In writing this chapter, I have been influenced by the comments cited below and have tended to use the first person in order to give a sense of the choices I have made from research design through to the delivery of this work:

> *'Many is the time I have ploughed through a desperately boring methodology chapter, usually written in the passive voice..... usually your readers will be more interested in a methodological discussion in which you explain the actual course of your decision-making rather than a series of blunt assertions in the passive voice'* (Silverman, 2000; p235).

5.2 RESEARCH DESIGN

5.2.1 A Qualitative Framework to Provide a Flexible Approach

The newness of clinical governance and the requirement for local interpretation suggested that an exploratory study would best reflect the fact that this particular field of enquiry is still relatively unknown (Hedrick, Bickman and Rog 1993), constituting what Marshall and Rossman (1998) regard as new territory. Under such circumstances, where the phenomenon itself or variables of interest cannot be defined precisely in advance, it is considered entirely reasonable for the research questions to be expressed in broad terms (Maxwell, 1998; Marshall and Rossman, 1998). In Maxwell's (1998) experience, it may even be the case that a significant part of the research needs to take place before one can get any real sense of what the specific questions should be. This study began with two primary research questions and these have guided subsequent

design decisions; namely: *what* constitutes the local clinical governance agenda (content)? and *how* has clinical governance been implemented (process)?

The questions outlined above are both exploratory and descriptive. Their main purpose is to discover and describe, as far as possible, 'what is' as opposed to 'how many'; the ultimate aim being to present what Hedrick and colleagues (Hedrick, Bickman and Rog, 1993) describe as a *'rich picture'* of both content and process in relation to clinical governance. The overall approach needs to serve a number of purposes: to capture the 'real world research' which Marshall and Rossman (1998, p21) describe as *'often confusing, messy, intensely frustrating and fundamentally non-linear'*; focus on events taking place in their natural settings (Miles and Huberman, 1994); go beyond the snapshot and capture complexity (ibid); remain flexible enough to allow the precise focus of the study to evolve (Marshall and Rossman, 1998); and thereby capture emergent insights (Maxwell, 1998). Consequently, in light of these requirements, I decided that an overarching qualitative framework would be most appropriate for this study. Whilst a qualitative framework has the capacity to address the kind of challenges of an exploratory real world inquiry described above, the manner in which research questions are translated into results is a function partly of design. Owing to the newness of the phenomenon to be researched - clinical governance - this raises an issue concerning the degree to which this design should be pre-structured.

5.2.2 Qualitative Designs

There is support in the literature for the proposition that qualitative designs do exist and, in fact, it is argued by some that all research studies are based on a design albeit

some are more deliberate and explicit than others (Miles & Huberman, 1994). This is proposed on the premise that, as soon as decisions and choices are made within the research process, whether in relation to sampling or data collection, the focus of the study is becoming defined and must therefore be based on some form of design. The degree to which this may be implicit or explicit appears variable (Miles & Huberman, 1994; Maxwell, 1998).

An ongoing debate seems to be taking place amongst writers on the extent to which the research design should be structured prior to field work (Miles & Huberman, 1994; Maxwell, 1998). Patton (2002) points to the emergent nature of design which partly unfolds during fieldwork and this is echoed by Maxwell (1998). Miles and Huberman (1994) suggest that a case can be made for loosely structured, highly inductive, emergent designs on the one hand and highly structured designs based on a clear conceptual framework with well-developed research questions on the other. However, the authors argue (ibid) that looser designs can mean that everything looks interesting and, as a result, may lead to massive amounts of data collection which might yield little in the way of real insight. Tight, pre-structured designs may not be sufficiently sensitive to the reality of the situation and the research questions could turn out to be the wrong ones. Their own preference seems to rest near the centre of the qualitative design continuum; a preference shared by others such as Robson (1993, p20) who points out that *'free range exploring is seldom on the cards'* and the skill, therefore, is to have a general view of what is being sought whilst being open to the unexpected. A similar approach is advocated by Bickman and Rog (1998) who recommend the development of a 'tentative' plan with the proviso that this will be revised should

emergent insights indicate this is necessary.

The views referred to above tend to add weight to the proposition that qualitative design should be regarded as an iterative process in which modifications are made throughout the study to incorporate new developments (Hedrick, Bickman and Rog, 1993). This unfolding and emergent approach to inquiry requires that the researcher remains open to a degree of ambiguity and uncertainty (Patton, 2002); however, this may prove extremely daunting for the novice and, for this reason, others advocate (Miles and Huberman, 1994) that the 'beginning' researcher adopts a tighter design to provide greater clarity and focus.

5.2.3 A Conceptual Framework

With this debate in mind, I decided to take a more structured approach to the design which would require the development of a conceptual framework. This sets out to describe the main variables that will be the focus of the study (Miles and Huberman, 1994). The framework may be derived in a variety of ways: from the knowledge and experience of the researcher, from existing theory and research, from the findings of pilot and exploratory studies and from speculative approaches that consider 'what if' (Maxwell, 1998).

Just as with the earlier discussion around explicit/implicit qualitative designs, there is a view that all studies are based on some form of conceptual framework, acknowledged or otherwise (Hedrick, Bickman and Rog, 1993; Miles and Huberman, 1994; Maxwell, 1998). What seems to be important in terms of exploratory, qualitative research is that

although the framework forces the researcher to be explicit about the variables for attention, it does not have to be definitive (Robson, 1993). Conceptual frameworks can change particularly if regarded merely as a map of the current terrain (Miles & Huberman, 1994) upon which one's position presumably changes over time.

Marshall and Rossman (1998) warn that, in exploratory studies, the existing literature may not entirely address the initial research questions and, to overcome this gap, the researcher needs to look at new ways of connecting existing knowledge with the new concept or phenomenon which is the focus of the current study. As the earlier literature review of clinical governance demonstrates, the empirical work in this area is very much of an emergent nature and thus there was little to shape this research in the early stages of the study. However, there is a massive literature surrounding quality and change which has influenced both the development of the conceptual framework for this study and the design in general. Although the TQM literature provides valuable insights into implementation and clinical governance may, in fact, be TQM by another name, I thought I would be on 'safer' ground to choose a generic change management model to serve as the conceptual framework and, in time, selected one developed by Miles (1997). The general themes of this model have already been discussed in Chapter 4 and a diagram of the adapted version is at Appendix 2.

The value of the Miles model (ibid) as a conceptual framework to guide this study is that is appears comprehensive and accommodates both the 'what' (content in the form of transformation initiatives) and the 'how' (process). The model also supports a whole system perspective and a dynamic, non-linear approach which seems consistent with

the 'messiness' of real world research referred to earlier. It can be seen from the framework (Appendix 2) that the whole system view of content is nested within the change management model itself; compartmentalising the framework in this way serves as a reminder that variables may be duplicated under the content and process categories - for instance, communication which could be part of the implementation process or as an element of the end state.

The intention from the outset was to remain flexible and open to the need to adjust the conceptual framework. In practice, the choice of framework proved to be entirely appropriate; it was specific enough to provide a focus and yet broad enough to accommodate inductively generated insights. In this way, the Miles framework (1997) provided a consistent structure not only for data collection but also for analysis and subsequent reporting. Articulating a framework is one thing, what is also needed is a mechanism for getting from the research questions to the findings and this requires a research strategy.

5.3 RESEARCH STRATEGY

5.3.1 Case Studies, Surveys and Experiments

Once the general purpose, broad research questions and a tentative conceptual framework had been developed, the next step was to formulate the research strategy. Robson (1993) outlines three main strategies: the experiment to measure the effects of manipulating one variable on another variable; the survey which permits the collection of standardised information from groups or individuals; and the case study which is

defined as:

> *'.....a strategy for doing research which involves an empirical investigation of a contemporary phenomenon within its real life context using multiple sources of evidence'* (Robson, 1993; p52).

The choice of a strategy should reflect the research questions to be answered. Robson (ibid) suggests that experiments will answer how and why questions but the researcher needs to be able to exert control over the variables in the study; surveys will answer questions concerning who, what, where, how many/much whilst the case study is best suited to how, what and why questions. These strategies are not regarded as mutually exclusive; however, Yin (1994; p8) argues that the case study is preferred in *'examining contemporary events... when the relevant behaviours cannot be manipulated'*. Patton (2002) adds that case studies are particularly valuable where the phenomenon is individualised; clinical governance is a good example of this as implementation is reliant on the local interpretation of policy and the translation of this into practice. Thus, the views of Robson (1993), Yin (1994) and Patton (2002) would seem to point to the adoption of the case study as the primary strategy although with the caveat that there would need to be enough flexibility to allow the incorporation of a survey if subsequently indicated. An experiment was not considered to be appropriate given the aims and context of the research.

5.3.2 The Single Site Case Study

For the purpose of this thesis, the research focus is on the single case which, as is generally the norm, was selected purposively (Robson, 1993; Miles and Huberman, 1994; Bickman and Rog, 1998); the main criteria being that it is likely to be what Patton (2002) describes as 'information-rich'. Patton (1999) suggests that final selection

is best preceded by pre-study fieldwork of some sort before committing to an intensive period of study. In this respect, I was fortunate to have been involved in an earlier study of NHS Trusts (Latham, Freeman, Walshe et al, 2000) and consequently had some prior knowledge of the target site. In reality, any of the Trusts would probably have been data-rich; whether the case study suggested non-, sub- or exemplary implementation, this would constitute an important finding given the newness of the clinical governance agenda per se. However, I considered the Trust selected to be of particular interest because it conceptualised clinical governance as a vehicle for learning, espoused a reluctance to follow a 'tick box' approach to implementation (thus aimed at gaining hearts and minds commitment and culture change) and, finally, articulated a strong focus on service users.

It was envisaged that the case study would be 'nested' (Yin, 1994) which would allow me to follow clinical governance at both the corporate and divisional level; this latter would provide a cross-sectional view down to the front line of service delivery.

There is a certain danger in selecting a single site. Hart and Bond (1995) point out that internal circumstances may change in some way which make continued study unfeasible with the result that permission to access the case site is revoked. In light of this potential precariousness, data collection would be designed and conducted to provide both an ongoing picture of the implementation process but would also be phased in targeted cycles that would secure particular outputs; thereby giving some insurance against any premature termination of the study.

5.3.3 Generalising from Case Studies

A particular concern surrounding the case study approach generally and the single case in particular appears to relate to the notion of generalisation which is described by Robson (1993) as the extent to which findings from one inquiry may be applied more generally. There is a consensus amongst a number of authors that, in the qualitative paradigm, any generalisation may only be theoretical as opposed to statistical (Hart and Bond, 1995; Bickman and Rog, 1998; Marshall and Rossman, 1999; Yin, 1999). The nature of qualitative findings are highly context and case specific (Patton, 1999); the changing context of real world research means that exact replication is unachievable (Marshall and Rossman, 1998) and the onus for determining generalisability seems to rely on those seeking to make the generalisation rather than on the primary researcher (Robson, 1993; Marshall and Rossman, 1998). The responsibility of the primary researcher appears to revolve around ensuring that there is enough rich description from design to reporting to allow the reader to assess whether there are sufficient parallels to his/her own context/agenda (Robson, 1993).

5.4 ACTION RESEARCH

5.4.1 Origins and Applications

Early in the development process, I found it very reassuring to read the words of Miles and Huberman (1994) quoted at the start of this chapter. It was also helpful to see this sentiment echoed by others such as Marshall and Rossman (1998) who observe that there is no one perfect research design. In fact, in order to capture the complexities of real world research, it is often necessary to develop what Hedrick and colleagues

(Hedrick, Bickman and Rog, 1993) call a hybrid strategy. With this in mind, it appeared entirely reasonable to incorporate an action research (AR) approach into the case study design.

The reason for my considering the action research approach was twofold: firstly there was a concern for reciprocity (Patton, 2002); NHS Trusts face multiple challenges of which clinical governance is, by necessity, one of several. Thus, participation was likely to be more attractive if the target site perceived that it would derive some sort of benefit from engaging in the project. Secondly, as the overall approach was conceived as formative rather than summative, there would need to be an agreed mechanism for feeding back the data to avoid the risk of the sort of dilemma faced by others. Studies by Joss and Kogan (1995) and Bate and Robert (2002) describe instances where the research process had yielded information that might contribute positively to the change process; however, neither study had been designed to incorporate real-time feedback. Although this was subsequently negotiated in both cases, Bate and Robert's (ibid) perception was that their intervention was construed as *'meddling'* rather than *'helping'* whereas a formal action research approach would have allowed for feedback to take place as a legitimate part of the research process.

Action research has been a distinctive form of inquiry since the 1940s (Elden and Chisholm, 1993; Hart and Bond, 1995). It is practised in a variety of settings such as education (McTaggart, 1994), health care (Hart and Bond, 1995; Bate, 2000), industry (Pasmore and Friedlander, 1981; Ledford and Mohrman, 1993), local communities (Greenwood, Whyte, Harkavy, 1993), international communities (Brown, 1993) and at

a variety of levels: individual, group, small and large-scale organisations. A review of the literature suggests that AR is a somewhat amorphous approach. Greenwood and Levin (1998) point to a mounting confusion in the field as AR increasingly comes to mean different things to different people. The apparent lack of clarity over what is meant by AR has led to a wide variety of activity being labelled as such (Dash, 1999) to the point where any cyclical process of research could be included (Hart and Bond, 1995) or even sloppy research justified (Eden and Huxham, 1996).

5.4.2 Definitions and Principles

Given the observations above, it does not come as a surprise to find that there is no consensus over a definition to describe AR; however, a number appear to capture the essence as these two examples seek to demonstrate. According to Eden and Huxham (1996):

> *'AR involves the researcher in working with members of an organisation over a matter which is of genuine concern to them and in which there is an intent by the organisation members to take action based on the intervention'.*

Elliot (1991) provides a somewhat shorter definition:

> *'(Action research is) the study of a social situation with a view to improving the quality of action within it'.*

An area where there is some agreement relates to certain common principles. Firstly there is an emphasis on AR as an approach which aims at research *with* rather than something *done to* the participants and, as a result, collaboration/participation is a key component of the research process (Eden and Chisolm, 1993; Hart and Bond, 1995; Bate, 2000; Meyer, 2001). Hart and Bond (1995) argue that participation cannot be mandatory - for example, in the event that the context does not support participation

due to the prevailing culture and/or resource issues. In any case, there is the sense that some authors regard *genuine* collaboration as an objective which proves rather difficult to achieve (Foster, 1972). Thus, although one may start with the intent and deliberately try to build in activity that will enable participation/collaboration to take shape, the operationalisation of this is more likely to be emergent rather than pre-determined.

Secondly, AR may be seen as an approach which is capable of generating knowledge whilst at the same time attempting to change or improve the phenomenon which is the focus of the research (Hart and Bond, 1995; Bate, 2000; Meyer, 2001). This focus is often described in terms of a problem and yet Cunningham (1993) cautions that this implies that 'something' is wrong which might not necessarily be the case. The author (ibid) suggests that a problem in AR terms might mean that there is a recognition of the need for change in some form which may be corrective in nature but may equally be value adding.

5.4.3 The Researcher Role in Action Research

One area where there is rather less consensus relates to the role of the action researcher. Hart and Bond (1995) have developed a typology of action research which spans from the experimental at one end of a continuum to empowerment at the other. The further toward the experimental end, the more likely that the role of the researcher is of a research-consultant/expert; the further toward empowerment, the greater the collaboration and the role will more likely represent that of a co-researcher/co-change agent. Ledford and Mohrman (1993) suggest that the more typical approach is that of 'co-experimenter' which may lead to democratic power sharing over the research design

and process itself. This could entail the researcher providing the means for the system itself to act (Bate, Khan and Pyle, 2000) or, in the case of Greenwood and colleagues (Greenwood, Whyte and Harkavy, 1993), this involved teaching research skills to those who would participate as inside-researchers. The researcher-consultant who generally retains control over the research process and decision-making within seems a less common occurrence. However, Hart and Bond (1995) offer a number of examples of this role and Ledford and Mohrman (1993) provide an account of their experiences as content and process experts in a large-scale organisational change process.

5.4.4 A Model for Action Research

In terms of the practice of AR, several writers refer to the cyclical nature of the approach in action (Elliott, 1991); however, Bate (2000) usefully depicts this as a model (Appendix 5) which emphasises an iterative rather than a linear sequence of activities - diagnosis, analysis, feedback, action, evaluation. Bate (ibid) regards action research as having a number of different levels of application: the research process itself, the intervention and the change process. At the level of intervention and change process, the actions in the Bate model (ibid) have a resonance with the 'Plan, Do, Check, Act' (PDCA) cycle of continuous quality improvement outlined by Deming (1986) which provides a sense of consistency particularly when the purpose of the AR approach is improvement.

In selecting a model to serve as a guide to the action research element, I decided to use Bate's (2000) for a number of reasons. Firstly, the elements of the model described above were consistent with the change/improvement focus of the study. Secondly, the

apparent simplicity of the model would facilitate discussions of the proposed approach with the case study site and add a certain sense of tangibility to what can seem a rather amorphous approach. Thirdly, the flexibility of the model meant that it was consistent with other design choices such as the case study and qualitative framework and would also accommodate the apparent unpredictability of AR. Finally, because the model may be applied at multiple levels, it would support a variation in cycle times. According to Elliot (1991), the higher the level of organisational focus, the longer and more open-ended the AR cycle; the lower the level (for example: specific department, group and so on), the cycle tends to be shorter and more focused.

5.4.5 Collaboration and Participation as Key Components

Decisions regarding the role and level of collaboration/participation of the case study site were more problematic. I subscribe to the view that involvement is likely to bring a greater commitment to the study findings (Hart and Bond, 1995) and have, what has been described as, an *'ideological leaning'* (Meyer, 2001) towards a democratic approach. However, in practice the degree to which these considerations were incorporated into the research design largely came down to pragmatism in view of the resources available; an important consideration in any research design. Firstly, as the only researcher, there was a real issue about what could be achieved in the time available and it did not appear feasible, at the outset at least, for the study to support the researcher input required to make this a genuinely collaborative study. Secondly, at the start, the AR approach felt quite ambitious and I did not feel able to commit to a role as expert or teacher in terms of the research process itself although I did feel comfortable as a resource in relation to the quality and change processes. Consequently, I thought it

might be prudent to start as what Hart and Bond (1995) describe as a researcher-consultant but remain open to the possibility that both the role and the level of site involvement might change over the course of the project. Although this starting point was negotiated with the Trust, I did not raise the issue of a possible shift in the role of either myself as researcher or the organisation as the feasibility of this would probably only become clear as the research progressed.

5.5 DATA COLLECTION AND DATA MANAGEMENT

5.5.1 Data Collection Methods - Interview, Observation, Document Analysis

According to Robson (1993), once some of the initial decisions about what, why, where and who have been made, the major question of how the data is to be obtained needs to be addressed. Patton (2002) suggests that there are three main kinds of qualitative methods of data collection; namely: interviews, observation and document analysis. The benefit of using multiple methods is emphasised in the literature (Robson, 1993; Yin, 1999; Patton, 2002); a multi-method approach is recommended partly to provide a comprehensive perspective from a number of sources and partly to compensate for the potential limitations of individual methods. The use of multiple methods will also enable triangulation; this may be interpreted as a means of checking the consistency of findings (Yin, 1999) or another perspective relating to the opposite side of the same coin which looks for divergence - often the source of valuable insights (Patton, 2002).

Each of the above methods may be pre-structured to varying degrees depending on the nature of the inquiry. Robson (1993, p157) offers two extremes of advice. If it is an

exploratory case study with little upon which to base a conceptual framework and only very general research questions then it is inappropriate to have much in the way of pre-structuring. However, *'if you know what you are after'* then plan ahead. The intention in this case is to use all three methods and keep the design flexible enough to accommodate a survey should the emerging findings suggest this would be appropriate. Also, although the research questions are broad, the initial conceptual framework has identified a number of clear variables thus the level of pre-structuring of instruments will vary depending on whether the exploratory shifts towards confirmatory.

Interviews

Given the type of information required, interviews based on open-ended questions will be used throughout the case study to allow the respondent to use his/her own words based on his/her perspective rather than being required to use a category constructed by the interviewer. Patton (2002) outlines three approaches to interviewing: the informal conversational interview which is largely unstructured, the general interview guide approach which is semi-structured and the standardised open-ended interview where the questions are specified in detail. At the outset, it is more likely that the interviews will be less structured but may become more so with a desire to confirm emergent findings.

Observation

Whilst interviews allow the researcher to hear what people say, observation provides direct evidence not only of what they say but also what they do which is not always one and the same. Observational methods provide the researcher with an opportunity to

experience the context and see the key stakeholders in action. In addition to observing action, behaviour, activity and so on, it also gives the researcher an opportunity to obtain a sense of what is not happening which can be of particular value when the objective is to provide feedback for improvement. The role of the observer may vary considerably from participant observation at one end of the continuum to complete spectator at the other (Patton, 2002). This may vary from event to event or over the course of the research project and it is difficult to predict how this will unfold at the outset; yet another emergent aspect of the design.

Document analysis

Documentary analysis is a less direct and relatively unobtrusive form of inquiry in which the data may be extracted away from the field. Organisations are often a rich source of documentation which includes the minutes of meetings, policy/strategy documents, memos. Access to a range of documents is likely to provide insights into who has been involved with the decision-making process that has surrounded the phenomenon. It also allows the researcher to track back through the history of the phenomenon where this pre-dates the study and follow its development to the start of the research process. It is always of interest to look at the official statements and compare this with what is subsequently seen and heard during fieldwork (Patton, 2002). However, it is important to remember when undertaking content analysis that the documents were likely to have been written for purposes other than the research process which may have implications for the inferences that can be drawn from such sources.

5.5.2 Data Management

It seems to be the norm that a consistent aspect of most qualitative inquiries is the large amount of raw data accumulated from the fieldwork (Miles and Huberman, 1994; Patton, 2002). At the outset it is difficult to predict how much data will ultimately be collected; however, it is possible to plan the recording format and also the storage arrangements. In this study, all fieldwork notes would be recorded sequentially in A4 booklets and stored according to units of analysis and cycle of inquiry. Detailed notes of tapes would be made and illustrative quotes extracted. In view of the number of participants, tapes from focus groups would be transcribed in full to assist subsequent analysis. A decision regarding the use of qualitative software would be deferred and reviewed as the data collection process progressed. In practice, time pressures precluded the early investment in training needed to use this software and so its incorporation into the research process was not an option.

5.6 RESEARCH IN ACTION

5.6.1 Phase One - Gaining Entry

As indicated earlier, I decided that the Bate model (2000) would be used to guide my approach to the action research cycle. This is a dynamic and iterative model of diagnosis, analysis, feedback, action and evaluation which will be illustrated through the following account of the research process. Before the cycle could be initiated, however, it was first necessary to negotiate entry into the organisation. The initial agreement to participate in the study was obtained through a third party who had also been involved in the earlier research and who was known to the Trust Chief Executive.

Once the Chief Executive had agreed to take part, I arranged to meet with him and the Clinical Governance Lead. The purpose of this meeting was to provide greater detail on the purpose of the research and the AR approach proposed. The Trust representatives regarded participation as an opportunity to receive external feedback on their efforts. This was considered of particular value as, at some stage, the Trust would undergo a routine review by the Commission for Health Improvement.

This initial meeting was followed up by a series of exploratory interviews with the Clinical Governance Lead so that I could obtain a more detailed overview of the Trust (key stakeholders, structures, services, geography) and a sense of the history of clinical governance implementation in the organisation to date. It was also an opportunity to develop a rapport which I considered to be extremely important as the Lead played a pivotal role in the Trust not only in terms of clinical governance but also in her capacity as an Executive Director. In addition, the Lead would effectively be my sponsor and, if necessary, might need to sanction and facilitate access to people and services within the organisation.

These exploratory interviews were semi-structured and the questions were open-ended; this was to ensure that I could cover the areas I thought were important initially but would also allow the interviewee to bring other insights and perspectives that could be followed up subsequently. These initial interviews were not taped as I thought a more informal approach was indicated at this stage. However, once data collection began in earnest, all subsequent in-person interviews were taped, all telephone interviews were taped once the appropriate equipment was obtained; taping followed explicit consent

from interviewees.

The early interviews outlined above helped develop a map of the organisation and from this I was able to identify the key meetings I would need to attend either as a one-off or on a regular basis; the documents such a relevant strategies/policies that needed to be obtained; the minutes of past meetings that would need to be retrieved plus arrangements needed for my inclusion on the circulation lists for future minutes.

This initial entry period began in May 2000 and, in the months that followed, the interviews with the Clinical Governance Lead continued. I was also able to meet and present the proposed research to the Management Team and thereby made early contact with Executive Directors, Divisional and other functional managers. In addition, I observed a Trust Board meeting, started to attend the monthly meetings of the Clinical Governance Sub-committee and the quarterly meetings of the Risk Management Team. In that time I also undertook a preliminary analysis of the Trust documents relating to clinical governance which included strategies and the minutes of earlier meetings.

5.6.2 Phase Two - Rapid Appraisal

The data from this entry phase formed part of the initial diagnosis and, in time, the interview set was broadened to include the Chief Executive, the Non-executive Chair of the Clinical Governance Sub-committee, the Executive Team and the Divisional Managers. In this way, I was ensuring access to those who were likely to have been involved in the development of the Trust approach to clinical governance and also those who were responsible for its implementation. The purpose of phase two was to

undertake a rapid appraisal of clinical governance at the corporate level.

All of these interviews (except one which was conducted via telephone due to the fuel crisis) were conducted in person. This was a deliberate decision to facilitate the development of a rapport with respondents as we would be coming into contact with each other for some time to come either in meetings and/or through the reports I would be producing. Once again, these interviews were semi-structured and consisted of open-ended questions which provided the flexibility to probe and follow up issues raised by the interviewees.

By November 2000, this first round of interviews was completed; whilst I continued to attend and observe routine meetings, I now withdrew from the field. As far as possible, I had followed recommended practice with regard to early analysis of raw data (Miles and Huberman, 1994) but, given the large amount of data already gathered, I needed protected time to undertake a more formal analysis and write the first feedback report.

5.6.3 Feeding Back to the Trust - Report One

This initial round of data collection and analysis (which included the rapid appraisal September –November 2000) lasted eight months. In AR, there are inevitably a number of audiences for the feedback of results (Robson, 2000) and the timing of such feedback inevitably contributes to its perceived relevance. So, in order to ensure that analysis and feedback would follow as soon as rigour permitted, this interim report was kept succinct and framed as an internal briefing paper for the Trust rather than for any external audience. The paper focused on a number of key aspects of clinical

governance implementation and concluded with a series of recommendations offered to the organisation for consideration (Appendix 6).

The briefing paper was initially sent to the Chief Executive and Clinical Governance Lead with the understanding that it would be circulated to the Management Team and the Clinical Governance Sub-committee. I subsequently presented the findings and recommendations to both of these corporate-level groups. Although there was some discussion of the report and content in both arenas, the Trust did not provide a formal response, neither was any explicit action plan formulated in light of the findings, nor evidence of further discussion in any detail. According to Hart and Bond (1995), this is not an uncommon occurrence following feedback but I was aware that this could be a precursor to further access being denied if it was an indication that my analysis and recommendations had not been well received.

5.6.4 Phase Three - Widening the Corporate-Level Interview Set

Thus, with no action plan to monitor, I decided to maintain a lower profile for a period of time and continue with a general focus on corporate level activity but, at the same time, concentrate more on establishing a rapport with key stakeholders. Consequently, I continued to observe the relevant meetings and also maintained an ongoing contact with the Clinical Governance Lead. Often this was in the form of what Patton (2002) describes as a conversational interview; highly unstructured but this approach allowed me to keep in touch with new developments. I also broadened the interview set to include the Chair of the Trust and two further members of the Clinical Governance Sub-committee, a Non-executive Director and a Medical Officer (the other members

had been interviewed earlier in their capacity as Executive Directors/Divisional Managers). In addition, I invited all Non-executive Directors (excluding the Trust Chair) to participate in a focus group; three out of a possible five attended. Of the two who were not available, I had already interviewed one Non-executive Director in her capacity as member of the Clinical Governance Sub-committee.

As time went on and a level of trust developed between the Clinical Governance Lead and myself, I was able to provide feedback on a more opportunistic and informal basis. This had a number of benefits: firstly, the Lead was now getting ongoing feedback which would ensure that nothing in the final report would come as a surprise. Secondly, it allowed me to check out findings and the interpretations I was making as a result of ongoing analysis. Thirdly, it allowed space for a dialogue and, in this way, the Clinical Governance Lead was able to participate in some of the more emergent design decisions. Finally, in time, my role as an observer at meetings shifted from pure spectator to participant observer where I offered feedback on what I was observing within the Trust or responded to requests for an opinion on the issues under discussion.

5.6.5 Phase Four - Primary Care Division

In April 2001, whilst maintaining the focus at corporate level, I began preparations to incorporate the Division and Locality as units of inquiry and analysis. The Mental Health Division was the preferred option as it would provide the widest access to a range of professional groups and also to both secondary and community based services. However, at that time, the Acting Divisional Manager had just stepped down and the Clinical Governance Lead and I decided not to focus the research spotlight on a service

which was just about to get new leadership. Each of the learning disability services were specialised in some way, consequently we were concerned that other audiences within the Trust might not relate to issues raised in these areas. This meant that the research focus would incorporate the Primary Care Division. Although we were aware that there had been little deliberate clinical governance activity in this area, it was hoped that feedback gained through the research process would facilitate future progress. Ironically, just prior to the start of data collection in this Division, its senior manager was moved to Mental Health which meant that Primary Care now had a new Divisional Manager in an 'acting' capacity; however, the research went ahead as the initial approaches and preparation had already been made. Within the Primary Care Division, the Northern Locality was selected for closer study as funding had been identified by both the Trust and the Primary Care Group (PCG) for the appointment of a Clinical Governance Facilitator to work across the Locality and the PCG.

The AR approach in Primary Care followed a similar pattern to that undertaken at the corporate level. Although access had been approved by the Clinical Governance Lead, I met initially with the Acting Divisional Manager (ADM) and two of the three line managers (the third was unable to attend) to provide details on the purpose of the research and to discuss the AR approach proposed. Following this initial meeting I conducted preliminary interviews with the ADM to gain an overview of both the context and clinical governance activity to date. I was able to identify the key stakeholders, documents needed, meetings of interest. I attended several of the meetings of the Clinical Governance Forum and my role was generally that of an observer although, occasionally, I provided feedback from the field. Participation was

much less than at the corporate level as the timescale was considerably shorter and consequently the opportunities to develop a rapport were less. However, I did attend a meeting of the Clinical Leaders so that I could get a sense of the agenda as it proved difficult to get a comprehensive set of previous minutes because of the chairing arrangements. Also, because of the timescale issue, I thought it would provide the managers with an additional opportunity to meet with me and, in this way, become familiar with both the researcher and the research process.

Interviews took place with the ADM, senior and junior managers (district nursing and health visiting; Division and Locality) and managers from the Professions Allied to Medicine. The geographically dispersed nature of the Division and the timescale available meant that, after the first meeting, the most efficient method of interviewing tended to be via the telephone which was not entirely satisfactory for either the interviewees or the researcher but it represented a seemingly inevitable trade-off. All interviews were taped with permission. In addition, a separate focus group was held for district nurses and another for health visitors; five and nine members of staff participated respectively. Both sessions were taped with permission and subsequently transcribed in full. The decision to undertake focus groups with front line staff was made so that data collection could take place in a more relaxed manner. In this way, it was hoped that the interaction of group members might surface new issues/insights and would also encourage discussion around the clinical governance agenda generally and Trust activity in particular thus facilitating a certain amount of awareness raising .

The fieldwork at the corporate and divisional levels was completed in October 2001.

This end-date had been made explicit and thus my withdrawal from the Trust was expected. Once again, analysis of the raw data had been ongoing throughout the study but the end of data collection signalled an intensive phase of analysis necessitated by the sheer volume of data and the timescale for reporting; it was agreed that the final report would be distributed by the end of December 2001.

The final phase of analysis drew heavily on the conceptual framework outlined earlier. This had been developed as an initial guide to the variables for attention and had proved broad enough to serve as a guide for data collection, analysis and informal feedback throughout the period of fieldwork. Thus, using the same framework to guide analysis overall seemed entirely appropriate.

5.6.6 Phase Five - The Final Report

The final report was considerably more substantial than the earlier briefing paper. On-going, informal feedback to participants ensured that there would be no surprises for the key stakeholders of the Trust. In the end, the report summarised what most of the key participants had heard already and dealt with findings at both the corporate level and the level of the Primary Care Division and Locality. In addition, the report made a number of recommendations concerning the content of the clinical governance agenda as conceptualised by the Trust and its future implementation (Appendix 7). The report was released firstly to the Clinical Governance Lead and the Chief Executive and then disseminated to key managers in the Division. In January 2002, I met with the Clinical Governance Lead, Chief Executive, ADM, line managers and the Clinical Governance Facilitator for the Division to gain feedback on the report and the research experience.

The Trust was complementary on both counts.

5.6.7 The Action Research Cycle

In terms of the AR cycle, the most overt stages at both levels of the study appear to be diagnostics, analysis and feedback; the way in which this has contributed to action and hence the opportunity for formal evaluation has been less apparent. It is important to note, however, that action has taken place albeit not always as a discrete stage flowing from an explicit declaration of intent. Owing to the ongoing informal feedback provided at both the corporate and divisional levels, there was evidence of Trust responsiveness in the form of real-time action. In addition, the Trust incorporated many of the recommendations in its clinical governance plan for the new PCT. How far this plan has been translated from policy to practice in the PCT was unfortunately beyond the scope of this study.

5.7 RESEARCH QUALITY

5.7.1 Quality Criteria for Qualitative Inquiry

The issue of quality in qualitative research is part of a long and contested debate (Mays and Pope, 2000). Robson (1993, p66) suggests that establishing the trustworthiness of research lies within the realms of common-sense - whether the researcher has done a thorough and honest job and has tried to *'explore, describe or explain in an open and honest way'*. However, the author (ibid) is also of the opinion that good intentions are not enough to ensure the quality of research irrespective of whether this is of a qualitative or quantitative nature and, in this sentiment, Robson echoes the view of

another seasoned qualitative researcher (Silverman, 2000).

Whilst checklists for quantitative studies are apparently common, there is no definitive set of guidelines for delivering quality in a qualitative approach; and, according to Mays and Pope (2000), any attempt at prescription is to be avoided. Lincoln and Guba (1985) argue against the qualitative application of quality criteria derived from the quantitative paradigm (internal and external validity, reliability and generalisability) and suggest as alternatives the notions of credibility, transferability, dependability and confirmability. These alternative criteria are commonly cited in research texts and there is no shortage of additional criteria offered for consideration (Mays and Pope, 1995; Marshall and Rossman, 1998; Mays and Pope, 2000). Although it is clear that there are no easy solutions to the limitation of error in qualitative inquiry, I have tried to address this throughout the research process from design to reporting and an overview of the steps taken will now be provided.

5.7.2 Research Strategy: Design and Operationalisation

The case for a qualitative study has been clearly stated at the outset of this chapter thus the reader is immediately aware of the paradigm within which the work is situated. The rationale for the overall design has been presented together with the strategic choices relating to this. Although the research questions have been expressed in broad terms, the conceptual framework has been described in detail which allows a judgement on whether the strategy and methods are, in themselves, appropriate for the purpose of the study. Multiple methods have been selected to allow for triangulation and, in attempting this, the search was for both convergence and divergence of evidence. Also,

by using more than one method, it was possible to compensate for any potential weaknesses that might have served as a threat to validity if a single method had been applied (Robson, 1993; Yin, 1999). The methods themselves were entirely consistent with a qualitative approach and the literature attests to the fact that a combination of interview, observation and document analysis had been adopted in similar studies (Yin, 1994; Hart and Bond, 1995; Bate, Khan and Pyle, 2000).

5.7.3 Sampling Strategy

Purposive sampling has ensured that data has been obtained from a variety of sources. Although the sampling strategy had not been formulated prior to entry into the field, I had identified the Clinical Governance Lead as a key informant. This led to the evolution of, what has been described as, a 'snowball' approach (Robson, 1993) as I met with other managers and staff. The relatively flat organisational structure and the fact that the senior groupings were small provided the opportunity to purposefully select whole populations such as the Executive Team, the Management Team, the locality management structure which contributed to the comprehensiveness of the study. In addition, I was allowed unrestricted access to key meetings over a long period of time and to all relevant documentation and therefore did not rely on snapshots.

5.7.4 Generalising from Case Studies

The issue of generalisability has been outlined earlier in this chapter where it was argued that the responsibility of the primary researcher was to provide enough rich description to enable the reader to identify any potential parallels with his/her own research context/agenda. With regard to generalisation, I will simply state that I have

attempted to provide a rich picture throughout and invite the reader to make a judgement on whether this has been sufficient for his/her purposes.

5.7.5 Rigour in the Field

The application of methods in the field was a rigorous as possible. For the most part, interviews were semi-structured and a selection of interview schedules are included as Appendix 8 which will allow the reader to assess the validity of the instrument. In addition to contemporaneous notes, the majority of interviews were taped; detailed notes made from these and illustrative quotations extracted. Owing to the presence of multiple participants in the focus groups, the tape recording of each session was transcribed in full. Observation was conducted without any form of pre-structuring and extensive contemporaneous notes were made in the setting. In these records, annotations provide a clear distinction between evidence, interpretation and intervention (Yin, 1999). As most of the observation took place around specific events such as meetings, there are also minutes of the meeting taken either by a participant or secretary to the group which adds another perspective to the proceedings. Documentary analysis was largely guided by the original conceptual framework. All raw data has been stored in a manner that will ease retrieval if challenged. Field notes and tapes are in date, level of analysis and collection cycle order.

5.7.6 Analysis and Reporting

Analysis and reporting has been guided by the conceptual framework. This has served to focus the research throughout but has been broad enough to accommodate emergent insights. The aim of the research was to provide rich description and the sustained

association with the organisation has provided the opportunity to confirm my own interpretations.

5.7.7 Participant Feedback

An extremely important test of validity was embedded in the AR approach itself and the commitment to provide ongoing informal and periodic formal feedback to individual participants and the organisation itself. The Trust response has been very positive and confirmed the reports presented as fair representations of clinical governance in the organisation.

5.8 CHAPTER SUMMARY

The purpose of this chapter has been to provide a comprehensive account of the research process from the initial design to the presentation of the results. The rationale for the various choices made in the design of this project is discussed; these choices have led to the selection of a qualitative framework which has been flexible enough to sustain a case study strategy and an action research approach. Details of data collection methods and data management have been provided together with information highlighting the action research process 'in action'. Finally, the notion of research quality has been discussed together with the various steps taken by the researcher to assure the quality of the entire research process. The design and implementation of the overall research strategy have served as the focus of this current chapter; the results of this effort will now be presented in the following three chapters.

CHAPTER 6

RESULTS - CLINICAL GOVERNANCE IMPLEMENTATION - CORPORATE ACTIVITY: CONTENT

6.1 INTRODUCTION

Qualitative methods frequently give rise to massive amounts of data (Patton, 2002) and this case study certainly adds weight to Patton's observation (ibid). Organising and analysing this data so that the results could be presented in a coherent format was always likely to be a challenge. However, this task was facilitated considerably by utilising the same conceptual framework for the presentation of the results as that which guided data collection and subsequent analysis. This framework is outlined in detail in Appendix 2 and encompasses notions of both content and process or the 'what' and 'how' of implementation. There has been frequent reference to the duality of meaning within the term implementation; the following results chapters will clearly demonstrate this difference. The aim of this chapter is to present the clinical governance initiatives of the Emerald Trust which correspond to corporate level content activity. Each of these elements will now be presented using the Miles framework (1997) as sub-headings.

6.2 A VISION AND A STRATEGY FOR CLINICAL GOVERNANCE

6.2.1 The Clinical Governance Report

One of the first key clinical governance documents prepared by the Trust was the briefing paper dated June 1999, the 'Clinical Governance Report' (Internal Trust Document, 1999; unless otherwise stated, all future references to the 'Clinical

Governance Report' or the 'Report' will relate to this document). This document introduces the Trust's conceptualisation of the clinical governance agenda and distils this into the six key components; the rationale for these elements is also presented and each is deconstructed further into a number of sub-elements (Table 6.1).

Table 6.1: The main components of clinical governance (Internal Trust document, 1999)

CULTURE	HUMAN RESOURCE MANAGEMENT	KNOWLEDGE
• Trust-wide commitment • Board level focus • Clinically focused management strategies	• Training • Continuous professional development (CPD) • Appraisal • Performance Management	• Evidence based health care/clinical effectiveness/audit • R&D • Libraries/research resource centres
CORPORATE LEARNING	**USER INVOLVEMENT**	**INFORMATION**
• Complaints • Risk Management • Adverse incidents	• Advocacy • Consultation • Individual ownership of health	• Clinical information systems • Knowledge management • Patient information

A key message contained within this Report is that clinical governance is not entirely new to the NHS and earlier initiatives such as clinical audit, care pathways, risk management and so on have been incorporated. However, the Report does highlight the fact that there are a number of new aspects to this policy which are identified as: an organisational focus for quality improvement; corporate accountability for and the involvement of management in clinical quality; and the need to integrate new and existing systems for quality improvement. The Report identifies a key role for the Trust Board in refocusing the culture from financial to clinical issues and also explores what clinical governance might look like at different levels, for instance: the organisation, division, team and the individual practitioner.

Although a vision of what the organisation might want to see in place once clinical governance is established is described, the Report does not include a comprehensive overview of the present organisational situation in relation to this future state. Instead, there is a brief reference to the challenges currently being experienced in relation to several of the existing components such as clinical audit and risk management. Thus, it is difficult to get a sense of the scale of change required in order to make this transition merely from the information contained within the Report. Nevertheless, the Report serves as a useful introduction as to how clinical governance has been conceptualised at the corporate level. The stated intention was that the framework outlined in the document would form the basis of future discussions with the divisions as part of the process of formulating a development plan.

6.2.2 The Clinical Governance Development Plan

The 'Clinical Governance Development Plan' (Internal Trust Document, 2000a; unless otherwise stated, all future references to the 'Clinical Governance Development Plan' or the 'Development Plan' will relate to this document), was subsequently approved by the Trust Board in January 2000 and has formed the basis of the corporate approach, without revision, since that time. The Development Plan reiterates the framework for clinical governance outlined in the earlier Report and specifies a series of short-term objectives under each of these headings, identifies the managers with a key responsibility for the achievement of these objectives together with the timescale for completion.

In total, the Development Plan identifies a set of 39 objectives; of these, 36 are

described either as ongoing or to be achieved in year one. Many of the objectives refer to an end state such as the aim *'to achieve CNST level 2'*, the establishment of a corporate focus for clinical audit, the development of a policy for the reporting of poor clinical practice. Other objectives address certain process issues such as communicating the agenda and providing training. In addition, a subset of the objectives are targeted specifically at the divisions with Divisional Managers clearly identified as having the lead responsibility for their achievement. In spite of this, a series of interviews which took place with senior managers during September - November 2000 (9-11 months after the Development Plan had been approved by the Trust board) revealed that, whilst all interviewees knew that the Development Plan existed, there was little evidence to suggest that it had become a living document within divisions or that it was explicitly guiding local approaches to clinical governance implementation. In fact, four out of the six divisions did not have an action plan to take forward the clinical governance agenda.

In light of the apparent lack of goal deployment described above, a review of progress against the Development Plan was a key recommendation of the research feedback provided to the Trust in December 2000. At that time, a period of 12 months had elapsed following the approval of the Development Plan by the Trust Board which suggested that it would be timely for the organisation to evaluate its achievements to date and assess the amount of work outstanding. However, the Trust view was that the movement towards PCT status would have implications for the shape and operationalisation of clinical governance in the new organisation; therefore, it preferred to focus on consolidating rather than revisiting the existing objectives.

The 'Clinical Governance Development Plan' represented an action set for development rather than a comprehensive strategy for clinical governance implementation. Taken together with the 'Clinical Governance Report', these two documents formed the basis for the Trust approach to clinical governance implementation; however, during the research period, these documents were not augmented by a comprehensive implementation strategy.

6.3 STRUCTURES TO SUPPORT A DEVELOPING AGENDA

Early development activity within the Trust has included the establishment of structures to support clinical governance. Committees and groups at both corporate and divisional levels have been formed and an important first step has been the appointment of the Clinical Governance Lead.

6.3.1 Clinical Governance Lead

In line with the guidance issued in 1999 (Department of Health), a senior clinician was nominated to act as the Trust lead for clinical governance. In addition to leading the clinical governance agenda, the Lead is also an Executive Director of the Trust with the Research & Development (R&D) brief. Within this combined role, the implementation of clinical governance forms a significant part of the Director's portfolio and this has allowed the Clinical Governance Lead to protect time in order to focus on the development of this agenda. Making this appointment at a senior level is regarded by this Non-executive Director as an indication of the Trust's commitment to clinical

governance:

> *'Having a director almost working full time (on clinical governance) has given clinical governance more kudos'.*

Over time, the Lead's brief has expanded in line with the growing agenda at a rate not anticipated at the outset. No formal Terms of Reference have been developed to focus the role; although the Clinical Governance Lead has line management responsibility for the library services, there is no functioning operational structure to support her in the discharge of the wider clinical governance remit. As Clinical Governance Lead, she either chairs or is a member of a number of the key groups/committees which are either directly/indirectly associated with the clinical governance agenda. Partly because the lack of a supporting operational structure, and partly because of the apparent difficulty in engaging some of the key players with the implementation process, the Lead has become increasingly embroiled in operational clinical governance and this activity is in danger of displacing the strategic aspects as the following comments illustrate:

> *'There is a problem with being the clinical governance lead because the issue is, if you don't lead things... ... The job is about trying to get things actioned and a lot of this takes my personal time because maybe some people aren't as engaged as they might be, that's maybe one of the reasons why everything continuously comes back to me. If I haven't done it, has it actually happened? I don't want clinical governance to be something that I do but at this stage in the development, I often have to be the person who kicks it off and how much time is there as the clinical governance lead to do that. The problem is that if you have a lead everyone thinks you are leading so it's a double whammy in a way'.*

> *'That's one of the things I have been going on at the Chief Exec recently to; I said I can't do this job unless I have time to think and for several months this has just not been possible; I appreciate I generate this stuff myself, but I can't even fit it in within very long working days, five days a week; therefore the temptation is whenever you're in the office I have got loads of things I've got to get out, got to get done, therefore there is no time for reflection which I actually think is a weakness in my current role at the moment... I don't have enough time to reflect. You're in danger then of ending up being busy and I do get a lot of things just like*

producing stuff for meetings ... because I haven't got anyone who can produce that sort of thing for me'.

'Also, just about trying to think; You've come to me and asked me what is my agenda for next year, and I must admit because you had e mailed me... it did make me think but I have got to sit down and put some time into that question. It's about finding the time to do that'.

6.3.2 Clinical Governance Sub-committee

In addition to appointing the Clinical Governance Lead, a new sub-committee of the Trust Board was established in February 1999 - the Clinical Governance Sub-committee. The intention was that the Sub-committee would meet monthly and, apart from one or two exceptions to this, has met on that basis. The Sub-committee is chaired by a Non-executive Director of the Trust and the meetings have been consistently attended by most of its members.

The Sub-committee's Terms of Reference suggest that it is responsible for ensuring that arrangements are in place to deliver the overarching objectives of clinical governance and for co-ordinating the activity required to support this which implies a responsibility for both an assurance and a steering function. The Development Plan provides the main vehicle for delivering both functions; and, in the absence of an implementation plan, the objectives contained in this document provide some indication of the direction of travel which will go some way to enabling the Sub-committee to discharge its steering role. The Sub-committee did not go on to develop a work plan to focus its attention in the first or subsequent year.

Whilst the Terms of Reference made clear that the minutes of the Clinical Governance

Sub-committee meetings would be circulated to members of the Trust Board and the Sub-committee, there was no formal arrangement to disseminate these to a wider audience for quite some time. Although several members of the Management Team are also members of the Sub-committee, not all are represented and the minutes of the Clinical Governance Sub-committee meetings are not a standing item on the agenda of that key operational group or, for that matter, on the agendas of the Clinical Governance Development Team or the Risk Management Team. Thus, in the absence of an operational structure, the Clinical Governance Lead is the only mechanism for taking the recommendations of the Sub-committee out into the wider organisation.

Initially, membership consisted of two Non-executive Directors (one of whom chairs the Sub-committee), the Trust Chief Executive, the Clinical Governance Lead, the Nurse Director, and the Medical Director. Later a consultant psychiatrist joined the Sub-committee to represent the Division of Psychiatry. In September 2001, after it had been in existence for over two years, the membership of the Sub-committee was revised and extended dramatically to include a representative from each of the divisional clinical governance fora and representatives from each of the three Primary Care Group (PCG) clinical governance committees. The rationale for this was to increase the effectiveness of communication between the Clinical Governance Sub-committee and the other clinical governance groups both within and outside of the organisation.

The absence of any representation from the Human Resource (HR) function, Information Management and Technology (IM&T), User Involvement, Finance and the Divisional Managers is perhaps curious given the centrality of these functions in the

conceptualisation of the Trust's clinical governance agenda and the stated aim of delivering greater integration: - *'to integrate and identify clear links between the developed policies related to Human Resources Management, Information and Knowledge Management'* (Internal Trust Document, 2000a, p5). Although the Sub-committee had, for some time, been considering how best to incorporate the perspective of service users and carers into the clinical governance agenda, there was also a determination to avoid tokenism and to ensure that the users were enabled to contribute effectively whilst maintaining their unique perspective. Although the Sub-committee appears committed to the concept, this is an issue which is yet to be resolved, as one Sub-committee member put it:

> *'Within the Trust we do quite a lot of specific user involvement, particularly with mental health. It's how to bring that all together and see how it informs clinical governance? It's just too easy to say we'll have two users on the committee and that's cracked it because it obviously doesn't..... ....I've been on other committees where you have the representatives of the users and before you know where you are they've become quasi professional and they are not doing what they are supposed to be doing. We need to find proper methods of working with the public outside the clinical governance arena and bring in the results of that back into the clinical governance structure'.*

From the minutes of the Clinical Governance Sub-committee, the breadth and content of the agenda has developed over time; however, the agenda itself is generally compiled by the Clinical Governance Lead – apparently it is rare for other members to put forward items for inclusion. In the early days, the focus of attention was on defining its Terms of Reference, considering the linkages with other groups, discussing the format for reporting to the Trust Board. Over time, the Sub-committee has received a greater amount of information upon which to base discussion; included as regular items are the quarterly risk management reports and the Significant Clinical Incident

Review reports.

The establishment of the reporting system has contributed to a feeling amongst some of the original Sub-committee members that they are getting to grips with the agenda; this may also be a function of sitting on a variety of committees:

> *'(Agenda) seemed huge at first and every meeting we went to it got bigger and more worrying because you couldn't really see how it would begin to work because it was all terribly complicated but over the last quarterly report that went to the Board, there you can see the various strands come together and things beginning to interrelate - I'm on the Complaints Committee and the Audit Committee and the Mental Health Committee and all those things feed in to it'.*

Another member noted that the presentation of information in the current format enabled those reading the report to identify trends:

> *'We obviously look at quarterly returns; those things you see we didn't look at before; now we've got all these quarterly returns, bringing all this different information together so we can spot trends, we didn't do that before... ... ... we are bringing from all these different areas of the Trust all this information together in a very simple tabulated form, all the different groups that meet - prescribing, complaints etc; all coming together and we can simply look at it every quarter and spot trends... ... ... we've always had these floating around but they are coming together in a more user-friendly, manageable form so we can quickly look at them'.*

The researcher has been a regular attendee at the Clinical Governance Sub-committee meetings and has observed the lively discussion that is often a feature of the proceedings. However, much of the information provided in the consolidated report is operational data and primarily produced for other audiences. It is generally existing data rather than information based on an assessment of what the Sub-committee actually needs to be able to meet its Terms of Reference with particular regard to its assurance and steering functions. Whilst the report does give an update against aspects

of the Development Plan, the existing reporting framework is yet to capture the full range of clinical governance activity in detail; for example, the coverage of appraisal and Personal Development Plans (PDPs); the progress of clinical effectiveness or clinical audit; the progress of the IM&T strategy. The information is essentially passively received rather than actively sought. Members of the Clinical Governance Sub-committee seem to appreciate what they receive but do not generally appear to recognise gaps.

Whilst some of the more established Sub-committee members seem to think things are coming together nicely, some of the newer members quoted below are not even clear why they are on the Sub-committee or the implications of being a member of a formal Sub-committee of the Trust Board:

> *'I'm not sure (why I'm here), I've just been told to come'.*

> *'I just got a letter from (my manager) saying that she put my name forward... ... ... I didn't get a chance to read them (the minutes before the first meeting)... ... ... well I sat there and was thinking - obviously he is accountable as the chief exec but he was trying to say that the group as a whole was responsible - and I sat there and thought so how responsible does that make me and I don't know, I don't know... ... ... I did actually think if anyone actually questioned it how far would they take it. If there was an issue would it come down to me, little me, would it really and I couldn't really believe it'.*

The issue of establishing tangible linkages with other structures has also proved a challenge for the Clinical Governance Sub-committee. From the outset, an explicit objective was to establish formal links with a number of existing sub-committees and groups which included: Complaints Sub-Committee, Training and Development Group, Risk Management Team, Professional Advisory Groups, Clinical Directors, Heads of Therapy Services, and the Information Strategy Group. Although, as indicated earlier

in this section, individual members of the Clinical Governance Sub-committee may attend one or more of these groups, the link appears more in the form of the individual as opposed to a formalised system of information exchange. Although recognised by some in the Trust, this matter was not resolved during the 18 months of fieldwork.

6.3.3 Divisional Structures

In addition to developing a structure to support clinical governance at the corporate level, an important objective in the 'Clinical Governance Development Plan' was the establishment of a clinical governance forum in each of the clinical divisions. It was envisioned that each forum would provide direction, co-ordination and support to the division as it took forward the clinical governance agenda. The forum would also perform a monitoring and reporting function.

The divisions have been encouraged to develop a forum model that would reflect local circumstances. All but one is chaired by a clinician or a manager with a clinical background and the professional background of the chair understandably differs from division to division. The rate at which these fora have been established has varied with one local forum meeting for the first time as recently as February 2001 - 12 months after the Development Plan identified this as an objective for all Divisional Managers. The findings of the rapid appraisal, which took place towards the end of year 2000, indicated that the divisions had not undertaken a baseline audit of the coverage or effectiveness of existing quality improvement systems such as clinical effectiveness or risk management processes; four out of six divisions were still to develop a local action plan for clinical governance. In fact, there was little evidence that the Trust

Development Plan had diffused into the organisation and become a living document.

By early 2001, each division had established a forum although they appeared to be at different stages of development and performance. This appears to be a function of a number of factors which include the length of time the forum had been operating, local priorities and even the corporate style which has a tendency towards 'shaping' initially rather than prescription but seems to become more directive and prescriptive in the absence of progress.

Whilst there has been a growing emphasis on sending information upwards, there has been less attention to the mechanisms for disseminating information downwards; reliance has been on the Divisional Managers although the Management Team does not routinely receive the minutes of the Clinical Governance Sub-committee meetings. It was only when the membership of the Clinical Governance Sub-committee was expanded to include representatives from each division that all local fora had access to the minutes.

6.3.4 Clinical Governance Development Team

From the outset, the Trust anticipated the need to provide support and facilitation to the divisions to enable them to take the clinical governance agenda forward. It was proposed that this role would principally be fulfilled by a new team, the Clinical Governance Development Team (CGDT).

Initially the role of CGDT was to focus largely, although not exclusively, around the

'Knowledge' component of clinical governance; however, over time, a greater emphasis on the wider clinical governance agenda appears to have emerged. This is reflected in the notes to the meetings which have taken place on a fairly regular basis for more than 18 months. Since the inception of CGDT, membership has gradually expanded to ensure that all clinical divisions have access to a named CGDT member. Mid 2001, a joint appointment was agreed for a facilitator to work across one of the PCGs and the corresponding Locality of the Primary Care Division. Recruitment to a part-time post of Care Pathway Facilitator is also planned but has not yet taken place.

Part of the role of the Clinical Governance Lead is to co-ordinate the work of the Team; the characteristics of which indicate a project rather than functional group given that several members have substantive, operational posts within the divisions for which they also act as facilitator. Other Team members have broader, Trust-wide remits; for example: one manager has specific objectives relating to areas such as clinical audit and management responsibility for the Library services; another manager has a specific remit in relation to R&D activity. Still others have functional roles within either the Library Services or Formulary Pharmacy Audit and, as such, act in a more central-resource capacity.

So far, the Team's input to the divisions appears to have been variable in terms of both content and quantity. Activity has included the provision of general support to the local divisional clinical governance fora and facilitation of the local reporting process in relation to the Trust annual clinical governance report. The variability observed is due to a number of issues which will now be considered. There has been a long delay in

getting all of the members into post so the CGDT, as an entity, has been slow to develop:

> *'Think that we have been forming and re-forming and forming and re-forming so we have never really got to storming, haven't got near norming'.*

Related to the delay in establishing the Team, most members expressed a lack of clarity around this role. Although objectives for the CGDT itself had been developed and there had been some move to translate these to the level of individual team members, a work plan setting out priorities in-year had not been developed. For some Team members, the broad objectives need refocusing:

> *'My personal opinion is that we could do with vision and focus again. We had a meeting last week at which that person, that person and that person were there for the first time in their current roles. So over the last 12 months the group hasn't stayed the same..... could do with looking at the team and roles and whether they are clear enough'.*

> *'My personal feeling is that there is a sense of confusion about specific detail of roles within the team so I think we still have some work to do clarifying exactly what our responsibilities are and how they interface because there is going to be a lot of overlap..... other people have role extensions..... we need to revisit our role as a team and individuals..... need to revisit our objectives and what we have achieved and where the gaps are'.*

> *'Don't really know what my role is on that (CGDT). I am pretty clear what my role is in relation to clinical governance, I think; I don't know - I suppose I am probably a bit thick, but I don't know where the Clinical Governance Development Team stops and clinical governance begins or the other way around. I've looked often at the aims of the Clinical Governance Development Team and they don't give me any direction really'.*

There is also a capacity issue for some individuals whose Team role is performed in addition to the operational requirements of the division. Although this dual role has been negotiated with the respective Divisional Manager, the additional Team responsibilities are not always reflected in the core role objectives and, in some cases,

the part-time Team role has become an 'add-on' to full-time divisional duties:

> '*(Recent IPR) ... All my ongoing stuff was left out and I said, I'm sorry but that is a big job, that is going to have to go in as well. The ongoing stuff we leave out(of the IPR) because there is other stuff that needs to be tackled... ... You obviously have a good idea of what the Clinical Governance Development Team is set up to do; I don't have any idea at all because I just spend my life running between divisional objectives and the stuff coming out of the clinical governance forum. I inherited that role at the same time as I linked into the Clinical Governance Development Team. So if the Clinical Governance Development Team is very different to what I am doing, I don't know how I would fit it in anyway*'.

6.3.5 Risk Management Team

The Risk Management Team has been meeting regularly within the Trust for around three years. More recently it has been chaired by the Clinical Governance Lead and membership includes senior managers of both clinical and support divisions, representatives from professional groups, staff-side representation and managers from specialist areas, for example Health & Safety, Complaints. The Risk Management Team reports to the Clinical Governance Sub-committee, the Trust Board and, in terms of Controls Assurance, to the Audit Sub-committee.

In January 2000, the Terms of Reference of the Team were reviewed and amended to reflect the need to incorporate clinical risk management into what had previously been a non-clinical risk focus; thereby developing a more integrated approach to risk management within the Trust. It was also intended that the Risk Management Team would adopt a more proactive approach to the risk management process. The Team's original dataset was therefore augmented to support a greater degree of both analysis and also corrective/preventative action based on this analysis. One example of this is in

the area collectively known as 'slips, trips and falls'. Previously, incidents would have been discussed locally but the practise of reviewing an integrated dataset has meant that the Risk Management Team was able to identify a shared and recurring problem. A working group has subsequently been formed to explore the issue in greater depth, identify root causes and propose action to manage the risk to both service users and, in some cases, staff.

An intended function of the Risk Management Team is the co-ordination of elements deemed to sit beneath the risk management umbrella. Therefore, this has become the forum for taking forward the Clinical Negligence Scheme for Trusts (CNST) accreditation at level one and, more recently, Controls Assurance.

The Trust has recently reviewed and revised its 'Risk Management Strategy' which was approved by the Trust Board in September 2001. In addition to providing strategic direction, the document also sets out a detailed plan designed to take the risk management agenda forward over the next two years. The strategy not only makes explicit the corporate and divisional/directorate responsibilities for delivering this agenda but also defines the specific responsibilities of the Trust Board, divisional managers, departmental/service managers and also those of staff within the Trust. Discussions are currently taking place with regard to the mechanism for launching the strategy and cascading the corporate objectives to and within the divisions/directorates. This appears to be a very different approach to the implementation of clinical governance per se in that it appears highly structured and deliberate.

Risk management within the Trust is evolving with the intention that it will become increasingly systematic and integrated. However, although there are managers leading on a limited number of individual risk management components, there is a sense that the only strategic and operational overview rests with the Clinical Governance Lead. The Lead not only has the overview but also provides strategic leadership for risk management and is engaged in delivering operational aspects of this agenda. This latter has included: leading workshops, leading Significant Clinical Incident Reviews, Significant Event Audits, providing facilitation and support to divisions/directorates. Within the Trust structure, there is no provision for a risk manager post; the Health & Safety officer collates and compiles reports on risk data quarterly for the Risk Management Team but reports in a line management capacity to the Finance Director. Thus, although the Clinical Governance Lead is heavily involved in the risk management agenda, she does not exercise a line management role in this area.

It has been interesting to observe the development of this group over a period of time; specifically the evolving agenda and the growing use of regular information as a basis for further enquiry and action upon which a number of its members have commented favourably:

> *'There has been a change in focus since (the Clinical Governance Lead) has been chairing the meetings. Previously we just reported the numbers but didn't go beyond this'.*

> *'We have become much more focused around the issue of risk management. We've become more aware of the fact that we've got to learn and take action from the risks that have been identified. In its early days, it was very much a reporting mechanism with very little direct action resulting from the risk management committee, that's the area where we have started to build on. Once we started to identify common risks we've then tried to commission action to try and address*

those risks'.

'We've become a lot more proactive and we're working more as a team now whereas before we had pockets of different people doing different things - not saying people doing all bad but we didn't have a forum where we could discuss best practice... ...people can see not just a paper chase (now)'.

The developments described above are part of an on-going process but significant gaps in the present dataset such as clinical audit, complaints, and the Significant Clinical Incident reports inevitably limits the ability of the Team to integrate the risk management agenda and discharge its monitoring function. Also, there does not appear to have been a systematic baseline assessment of the risk management process per se or an assessment of manager/staff training needs around this agenda.

6.3.6 Training and Development Group

The Trust's 'Clinical Governance Report' highlighted education and development as a central element in the establishment of clinical governance in the organisation:

'Effective clinical governance needs to be underpinned and supported by the education and training of clinical staff that is relevant, up to date, flexible in its delivery and meets the needs of individual practitioners as well as the needs of the Trust'. (Internal Trust Document, 1999; p9)

The Development Plan identifies a number of specific objectives around the education and training agenda; these include action around appraisal and Personal Development Plans (PDPs), best practice in user involvement, training staff to access best evidence. There is also a reference to the *'newly established Training Strategy Group'* whose brief includes the review of education and training needs across the organisation.

Membership of the Training and Development Group reflects the membership of the

Management Team; essentially, the group is Management Team meeting to focus on specific issues relating to the training and development agenda. Although the budget is administered by an Executive Director of the Trust, training and development appears to have been devolved to divisions; it is not part of the remit of the HR function. Eighteen months after the Development Plan was produced, a strategy for education and training had not been formulated. In the absence of a strategy and given that employee appraisal is still not universal, it is not clear how priorities for education and training are determined. Although there is training in appraisal and incident reporting, there is no evidence to suggest that an *integrated corporate approach* has been adopted to equip staff with the range of knowledge and skills to engage effectively in clinical effectiveness, risk management, quality improvement and other specific elements of the clinical governance agenda.

There is a sense amongst some interviewees that, apart from budgetary control, current arrangements concerning accountability and responsibility for the delivery of training and development within the organisation are less than clear. Some members of the Training and Development Group did not necessarily feel they had an overview of the whole agenda and were not entirely sure who amongst them would have:

> *'We used to have a training manager who reported to (the ED) ..... we have come right away from that now and apart from the assessment centre there is no centralised training function at all. I don't care who leads the training function but my concern is that there is no overview ..... I don't think there is a feeling that it is being pulled together at all ..... this is not a criticism of (ED) because I don't think this is what her role is envisaged as being. Think it is an area where you do need an overview'.*

6.3.7 Libraries

Another key component of the Trust's clinical governance framework concerns 'knowledge management' which has, in theory, if not yet established in practice, a strong connection with the education and training agenda. The geographical dispersion of Trust services presents a particular challenge when considering how to facilitate staff access to the knowledge for practice. The Trust provides library services from three sites. Initiatives to improve these services have focused on a number of areas: an increase in staffing to raise the level of professional input, the development of library systems and processes to enhance the service and meet the needs of a multidisciplinary workforce. As a consequence, there has apparently been an increased investment in staff, IT equipment, electronic resources, books and a rationalisation of journals.

Access issues due to the geographical dispersal of services have been recognised by the Trust which has acknowledged the need to provide 'virtual' library services. However, discussions with a number of front line staff suggest that, whilst physical access can still pose a problem for some, there may also be a cultural barrier - this clinician described how she felt guilty about accessing the library 'in work time':

> *'I'm just saying it is a luxury, and I often feel very guilty if I go to the library in work time because they are all so far away ... ... you can't just pop in and pick a book up or drop a book off. It's couple of hours to go there to look for something and then to follow it up; you tend to do all of that in your own time. Feel there is a stress factor there - if you're doing that there's something you're not doing; back to down to the bones again in terms of time'.*

The service has been working towards accreditation under the 'Linc Health Panel Accreditation Scheme' and recently achieved level three; in her report, the assessor paid tribute to the hard work of the team involved. Although more work is needed, the

content and tone of the accreditation report suggests that, in achieving level three accreditation, the Trust has established a sound basis for future development.

6.3.8 Related Structures

Given the complex and far-reaching nature of the clinical governance concept, there are, of course, a large number of groups within the Trust which contribute to the delivery of the clinical governance agenda. Just some examples would be the Audit and Complaints Sub-committees, committees and groups taking forward the work in the areas of Health & Safety, Nursing Practices, Drugs and Therapeutics, Information Management and Technology (IM&T). Many of these groups have been functioning for some time and the need to establish formal links between new and existing structures to achieve a greater degree of integration between systems was identified early in the clinical governance implementation process. Although the Trust recognises that progress has been made in some areas, there is an acknowledgement that more work is needed and discussions have been ongoing in relation to mechanisms for increasing the level of integration required but, as indicated earlier in this section, this is an issue which is yet to be resolved.

As highlighted earlier in this report, individual managers sit on a number of groups or committees but sharing information from one structure to another often relies on the individual rather than an explicit system. As an example, although IM&T systems underpin much of the work of the Trust, whether as clinical information systems or in providing internet access to related information, it is difficult to see from the minutes of the Clinical Governance Sub-committee how the strategy for IM&T *explicitly*

influences/informs the agenda of this group. The minutes record little in the way of discussion around this aspect of the Development Plan.

6.4 SYSTEMS AND PROCESSES

As new structures were being introduced and, in some cases, the work of existing structures re-focused, development of the supporting infrastructure was also taking place with the introduction of new and the re-focusing of existing systems and processes. Many of these initiatives are intended to 'capture the learning' either from within the organisation itself, the users of its services, and/or from external sources.

6.4.1 Dissemination and Implementation of Good Practice Guidelines

In order to strengthen existing mechanisms for capturing the increasing amount of evidence-based information received by the Trust such as National Institute for Clinical Excellence (NICE) Guidelines, Technology Appraisals and Effective Health Care Bulletins, the Trust has developed a system for the 'Dissemination and Implementation of Good Practice Guidelines'. This new approach was introduced mid 2001 to ensure that all relevant documents entering the Trust are either received directly by or sent on to the Clinical Governance Lead. These documents will then be logged, reviewed by the Clinical Governance Development Team and allocated a priority rating which ranges from 'immediate consideration', to 'planned review' and 'for note only'.

Once the initial review has taken place, a course of action for each priority is specified which may include dissemination to the local clinical governance fora and/or other Trust groups for consideration. In each case, responsibility for the process within the

target group is accorded to a named individual. High priority will require a local/Trust review of existing practice against that which is specified in the guidelines, recommendations to address gaps identified, report on findings/action proposed to the Clinical Governance Sub-committee - all within pre-determined time-scales.

The Trust recognises that, in addition to NICE guidance etc, it will also need to consider how the reports arising from other external sources will be incorporated into the system for explicit processing. Potentially, this will include the reports from national inquiries (e.g. the Kennedy Report on paediatric cardiac surgery at Bristol Royal Infirmary), Commission for Health Improvement reviews, external clinical incidents (e.g. problems associated with the administration of Vincristine) other guidance/information such as that issued by the Royal Colleges and Department of Health.

The system provides a clear framework for capturing, disseminating, discussing and acting upon key information coming into the Trust. A mechanism is in place to track these processes and a key challenge will be to incorporate this system within the broader clinical governance agenda by, for example, informing the Trust clinical effectiveness and audit programme, risk management etc. By the end of the fieldwork period, the system had been in operation for approximately five months and a review was planned of the process itself, the nature of outcomes arising from the process, and the progress of any subsequent action (divisional or Trust-wide).

6.4.2 Clinical Audit

Clinical audit is a component of the clinical governance agenda which has been undertaken within the Trust for a number of years. Despite this, the Trust acknowledges that a number of factors have presented a challenge to its efforts to *'maximise the benefits of the programme'* (Internal Trust Document, 1999; p11). These factors have apparently included: a less than multi-disciplinary approach, fragmentation, issues around the implementation of change where indicated and also perceptions and attitudes around the importance of clinical audit. A small number of Trust-wide projects have been undertaken which focused on consent and record keeping however, clinical audit activity has been devolved to the clinical divisions. The local clinical governance fora are responsible for developing a programme for audit as part of the local clinical governance plan but there is no corporate plan for clinical audit which would guide the fora on the key issues facing the Trust from both a national and more local perspective. However, as part of the system for the 'Dissemination and Implementation of Good Practice Guidelines', it is intended that audit against the national guidance will contribute to the Trust programme of clinical audit where there are Trust-wide implications. Alternatively, where guidance is more locally relevant, it should inform the divisional programme.

Prior to the establishment of the Clinical Governance Development Team, clinical audit was co-ordinated and facilitated centrally. Whilst members of the Team have provided support around aspects of audit to divisions and latterly the local clinical governance fora, the extent of this support has varied depending on the other operational aspects of the Team member's remit and also the number of divisions for whom the individual has

been acting as facilitator. It is anticipated that the recruitment of new members to the Team will mean that support and advice around clinical audit becomes available to all areas.

The level of clinical audit activity taking place is perceived as low overall although some areas are doing more than others. Organisational changes are thought to have created capacity issues but changes in arrangements for support and a lack of data are also regarded as contributory factors as this manager commented:

> *'There probably isn't (a lot happening). This is what disappoints me - there has been a lot of audit going on and in the last 18 months it has really rather withered and they really need to regenerate their focus. The people who have been there are wanting to do it, it's just that they have been applying for posts, re-organising, setting up new teams. They are now at the point where they can start to think about quality..... the problem with audit work is that it is very time-consuming, just so labour-intensive because we don't have the data. So one of the reasons why I think we don't do a lot of re-audits is that people are so exhausted'*

> *'I could weep; if I look at some of the stuff I am doing, it is small beer, it's not changing practice because it is too small, it is not consistent enough, we haven't got the data, we can't show things consistently enough so we might do a bit of tinkering round the edges; but the time for tinkering round the edges is gone'.*

In December 2000, the Trust introduced a new summary report form to capture key details of the audit work being undertaken in order to build up a profile of clinical audit activity in the Trust. This not only gives an indication of coverage and methodology but also seeks to establish the changes which have been made to practice and any subsequent benefits to patients resulting from this audit activity - i.e. that the audit cycle has been completed. Information on clinical audit is collated by the Clinical Governance Support Manager. In addition to the summary sheets which are returned centrally, the divisions have recently been required to include an overview of their

clinical audit activity in their annual clinical governance reports; the data from which has been incorporated into the annual clinical governance report of the Trust. These centrally collated summary sheets provide valuable information on clinical audit activity; however, it is not clear from the datasets currently available how this informs the routine clinical governance monitoring and reporting system. The lack of a deliberate integration mechanism means that clinical audit results are not considered with other elements of the clinical governance agenda such as risk management, complaints, Significant Clinical Incident Reviews etc thus there is less opportunity for each to inform the other.

Whilst training in literature searching has recently been available, training around the wider clinical effectiveness and the clinical audit agendas has not been provided in-house for some time due to changes in the arrangements for facilitation. Whilst it is important for staff and managers to have the relevant knowledge and skills if they are to undertake this activity and many staff have apparently acquired this through post graduate study, this is not the case for all.

6.4.3 Raising Issues of Concern

Continuous improvement in the quality of services for patients and clients is a central aim of clinical governance and opportunities for improvement may be identified in a number of ways. In addition to the group and committee structures described earlier, the Trust has developed a policy and procedure to assist individual staff should they identify gaps in service quality or wish to share concerns regarding service delivery. Through its policy 'Raising Issues of Concern', the Trust has made explicit the

responsibility of all staff to bring any such concerns to the attention of their managers. A procedure for raising issues has been outlined which provides details of the multiple avenues open to staff together with information on the action to be adopted by the Trust in response. Both the policy and procedure have been incorporated into the Trust Policy and Procedures Handbook.

Since the introduction of the policy in October 2000, the procedure has been invoked on one occasion. Investigation revealed that the matter was already being addressed locally although the individual who had made the report was apparently not yet aware of this. It is anticipated that the investigation process will be similar to that established for incidents in general or, if it meets the criteria for Significant Clinical Incident Review, the latter approach could be considered more appropriate.

The Trust recognises that staff may find it difficult to report concerns, particularly where the issue involves the actions of colleagues, some of whom may be in a more senior position. The usage of this mechanism will continue to be monitored, and, if the low level of reporting persists, an assessment of the underlying reasons for this will be made.

6.4.4 Incident Reporting, Trigger Events and Significant Case Reviews

A mechanism for reporting incidents associated with the Health & Safety agenda has been operating within the Trust for a number of years. The need to increase the reporting around clinical incidents has been recognised and efforts are ongoing to raise awareness of this; however, training courses have apparently been suspended due to

low numbers. A workshop for senior managers took place in July 2001 and was well attended, apparently well received and should, therefore, provide a positive starting point for further efforts to raise the profile of clinical incident reporting and, indeed, risk management in general.

As part of the development of clinical incident reporting, a pilot project is taking place to develop the use of 'trigger events' which, should they occur, will indicate to staff that an incident report is required. A process of 'significant case reviews' is also being piloted. This process is intended to focus on complex clinical cases or cases where the boundaries of practice are being extended to address the specific needs of the clients concerned. Each of these pilots is at a relatively early stage of implementation and the intention is that an evaluation will take place in due course.

6.4.5 Significant Clinical Incident Review

When a clinical incident occurs, there may be important lessons to be learned which, if acted upon, may minimise or, in some cases, even eliminate the risk of such events happening again. The seriousness of such incidents often varies as does the outcome for the patient/client, carer and the Trust. To address this issue, a system for the investigation of significant clinical incidents - 'Significant Clinical Incident Review' - was introduced early in year 2000. The aim of the review is to take a whole-system approach to investigating the incident, determine the root cause and effect appropriate remedial action. The procedure is clearly defined and extends from the notification of the incident, rapid appraisal to determine whether it should be dealt with under the Significant Clinical Incident Review procedure, through to the conduct of the investigation, remedial action and the reporting mechanisms intended to support the

monitoring of progress against the corrective action plan arising from the incident.

In an effort to signal a commitment to openness, to make explicit the lessons learned and the subsequent action to be taken, the Trust has introduced a mechanism for disseminating the Review report both internally and externally to the wider health community. Depending on the audience for the report, the detail and format will vary; full reports of the incident are sent to and discussed at the Clinical Governance Sub-committee and Management Team meetings. The Clinical Governance Lead will visit the patient and/or family to discuss the findings of the report before sending a copy to them. Anonymised summaries are also distributed to divisional clinical governance fora, to the Trust Board, and to external organisations such as the PCGs and the County Quality Board. A follow up audit is undertaken after an agreed period of time to confirm that the required remedial action has taken place.

By the end of the fieldwork period, 18 Significant Clinical Incident Reviews had taken place over a period of approximately 18 months. Although Divisional Managers felt that such incidents had been taken seriously in the past, there was the sense that this recent approach had provided those whose division was directly involved in the incident with an explicit framework for investigation and action.

The Significant Clinical Incident Review is an important initiative and has started to signal a change in the 'way we do things here'. However, observations in the field suggest that there are still a number of issues to be addressed; in particular, those relating to assumptions about the level of openness at the front line of service delivery,

the perceived transferability of lessons learned and the report dissemination process. As outlined earlier, reports are disseminated widely and the level of detail varies depending on the intended audience. The effectiveness of dissemination relies on a number of factors, one of which is the degree of openness within the different levels of the organisational hierarchy. The openness at the corporate level may not be matched by local approaches to complaints, significant incidents and so on. A number of front line staff commented on the tendency to keep complaints and incidents as a local issue involving only those staff directly affected; they see this as a cultural phenomenon. Within the context of formal staff meetings, it does not appear that complaints or incidents are discussed even in broad terms such as the numbers received on a quarterly basis. Local staff are filling in incident forms but are not apparently receiving feedback on their efforts which may lead to cynicism:

> *'I think it's about culture. We are looking at culture changes, ...from a culture that hid away and didn't discuss it at all (to) a culture that allows you to discuss critical incidents, near misses, significant events in an environment where you expect positives as well as negatives; it is this sharing of information across divisions which could put you in a negative light... ... and that is very embryonic but it's starting'.*

> *'Feedback is really important but when you don't get any it's demoralising; we've done this, we've sent in this form and you get nothing back from it that's perhaps going to improve something - (that) this, this and this has been done - you get a bit cynical - you think what's changed?'*

Feedback from several of the divisions suggests that, in some cases, where an incident has occurred in a specialised part of the service, there is a risk that the relevance of the lessons learned may not be appreciated in other areas. This has led to a situation where local circumstances are less likely to be reviewed to determine whether similar corrective or preventive action is indicated. In addition, whilst some managers are

acting on the reports, not all managers know what to do with them once received:

> *'Significant Clinical Incident - this information cascading down to us; how many of us in that room this afternoon know what to do with that? Where do we take it, what do we do with it. Do we think about it or are we just going through the motions. I knew about the (particular) incident, I didn't cascade it anywhere - should I have? It's around - should we? There's one or two who probably think, I know what to do with this, I know how to learn from it and get my staff to learn from it to show my staff that clinical governance is working; but not all of us would'.*

Whilst the Significant Clinical Incident Review reports are widely disseminated, they do not appear on the agenda of certain key committees such as the Risk Management Team meetings. Members of the Risk Management Team who are also part of the Management Team will receive the report through the latter group but other members currently find themselves out of the loop. How far down into the divisions the Review reports are communicated is variable; some of the junior managers and practitioners only became aware of the existence of this system at the Risk Management Workshop held over 12 months after the first of these incidents had been investigated.

6.4.6 User Involvement

User involvement is another core element of the Trust's clinical governance framework. The Development Plan contains a number of objectives under this banner and makes specific reference to the work of the Trust Board and to the divisions. The Development Plan preceded a review and report on user involvement in the Trust. This report concluded that although there was enthusiasm for developing this important component of the clinical governance agenda, there was no mechanism for sharing good practice across divisions. Initiatives often relied on the enthusiasm of individuals rather than being an integral part of service delivery. Based on this assessment, in

October 2000, the Trust developed an action plan to take user involvement forward. The focus of this work is on three levels: care planning, service provision and development and organisational development. Each of the clinical divisions was required to identify an opportunity for piloting initiatives to address one or more of these three levels; coverage has apparently been patchy and progress, overall, described as variable. Although a number of initiatives are regarded as progressing well, one division is yet to get any under way.

Operational monitoring of these initiatives has been undertaken by the lead manager; however, there are no mechanisms for regular, formal reporting of the progress of these pilots to the Management Team. Despite the fact that user involvement has been devolved to the divisions and Divisional Managers are responsible for driving the agenda forward, this key component of the clinical governance framework does not appear as a regular agenda item on the Management Team meetings. Instead, updates appear to take place on a more informal, one-to-one basis between individual managers. Thus no mechanism has been established in the forum with explicit responsibility for taking this agenda forward to enable collective monitoring of progress, discussion of barriers to effectiveness and the institution of remedial action to address the current lack of progress in these initiatives. Essentially, there is no corporate structure to drive user involvement in the Trust other than the efforts of the User Involvement Lead. The Lead has been trying to work with the staff on the front line but is moving more towards trying to engage the Divisional Managers in an effort to develop a more top down *and* bottom up approach.

Although the User Involvement Lead has presented the topic to the Clinical Governance Sub-committee and the issue of user input to this particular Sub-committee has been under consideration for some time, little progress has been achieved in establishing user representation onto the Sub-committee either in the form of service users or the lead manager.

6.4.7 Appraisal and Professional Development

Monitoring the performance of staff and promoting life-long learning are key themes within the national clinical governance agenda. The appraisal process is one of several mechanisms proposed for highlighting and addressing performance and development issues (Department of Health, 1999) and the Trust objective in this regard is as follows (Internal Trust Document, 2000a; p6):

> *'By April 2000: To ensure all staff have regular appraisal and have identified personal development plans which are linked to the business plan'.*

In December 2000, the Trust undertook a staff attitude survey; 2927 questionnaires were sent out with payslips and 1170 were returned - a response rate of 40%. Of those who responded to the statement *'my manager gives me regular feedback on how I am doing in my job'* - 47% agreed. Of those who responded to the statement *'I have a Personal Development Plan (or Training and Development Plan) which has been agreed with my manager'* - 35% agreed. Clearly the Trust has some way to go in order to meet its original objective. To facilitate this process, training sessions have been provided for managers prior to appraisal of staff. There has apparently been an increased corporate emphasis on the need to move forward with the appraisal system. A number of managers interviewed now have this as a personal objective and

consequently are requesting training in this area.

Apparently there have been a number of discussions in a variety of arenas around the challenges of delivering the targets set for appraisal and Personal Development Plans (PDPs). Contributory factors are thought to include, in some cases, negative perceptions around the purpose of appraisal:

> *'(I) think that managers tend to use it as a whipping tool rather than an opportunity to sit down and discuss things... ...sounds as if we may have some staff who think it is a telling off session rather than what it should be which is completely the opposite'.* (Senior manager)

For some managers appraisal is perceived as a time-consuming extra rather than an integral component of the management function. Current training courses not only provide information on the appraisal process itself but also recognise the need to overcome some of the negative perceptions surrounding appraisal and CPD that currently exist.

Prior to the staff survey, there have been a number of ad hoc initiatives to monitor the percentage of staff receiving appraisal however it is unclear how the progress of this agenda is monitored on an ongoing basis, how a Trust overview is maintained or how the development agenda informs business planning.

6.4.8 Communicating the Clinical Governance Agenda

During February 1999, the Trust undertook a series of road shows with the aim of raising awareness around the emerging clinical governance agenda. These were held in four locations and comprised; leaflets, posters, short presentations on clinical

governance and clinical effectiveness. Staff also had an opportunity to try electronic search facilities. Two hundred and seventy one (271) staff attended which represented around 9% of the workforce. Feedback on this initiative was, apparently, complementary in the main although some staff would have appreciated more time and for the content to be have been more specific. Some interviewees suspected that the majority of those attending the road shows were managers rather than staff:

> *'The road shows were put on for the directorate - not well attended. It was well publicised but I think people thought it wasn't important - the managers came but they were told to come'.*

> *'My hunch is the types of staff who attended were the more senior staff who thought this is going to be something that my manager's going to ask me about in my IPR rather than the untrained and the more clinical staff who cannot as yet see how this is going to affect them when they go and see Mrs X'.*

A small number of articles have since been published in the in-house newsletter and the Trust Annual Reports have included information on progress against components of the Development Plan.

Since the early Trust-wide initiative, awareness raising has continued on a more opportunistic basis with presentations by the Clinical Governance Lead to divisional meetings and meetings of the local fora. In addition, where members of the Clinical Governance Development Team have been active within a division, they have engaged groups and individuals often on a similarly opportunistic basis. In reality, the implementation of clinical governance has not been supported by a communication plan and, in this managers' opinion, communication of the clinical governance agenda is essentially left to the Clinical Governance Lead:

> *'Everyone will leave it to (the Clinical Governance Lead) as the lead to*

think how do I make sure this (clinical governance) issue gets communicated thoroughly across the Trust; that's how it will be left. (Clinical Governance Lead) might say I think it will be a good idea if we have a road show and that will happen. If she said today, I think it will be a good idea to send out an update to staff in pay packets, that would happen; but I don't think as a separate entity there is anybody sitting down and saying this is a very important issue, what should our communication strategy be on it?'

Although the responsibility for external communication has been assigned to a named manager, the responsibility for internal communications is unclear; whilst there is a framework for external communications, a corresponding framework for internal communications has not been developed.

The Clinical Governance Development Team is currently reviewing the issue of awareness raising in the Trust and is considering options for taking this forward. One approach is the development of a standard presentation to provide managers and staff with consistent, core messages around the clinical governance agenda that can subsequently be adapted to reflect the needs of local audiences. Also under consideration is the possibility of developing a resource/training package that will have a Trust-wide relevance. In the meantime, a workshop is scheduled to take place to look at the roles and responsibilities of the groups/committees and individuals; the target audience is members of the Clinical Governance Sub-committee, the local clinical governance fora and Divisional Managers. Whilst this is a positive initiative, it will only connect with a small proportion of the organisation and there is currently nothing planned for the wider audience.

The apparent gap in disseminating clinical governance is also highlighted by the

arrangements for the distribution of the minutes of the Clinical Governance Sub-committee which, as mentioned earlier, tends to be to the Trust Board. The formal Management Team membership does not routinely receive minutes and neither does the Risk Management Team; latterly, however, the chairs of the divisional fora have been included in the circulation. Some members of these groups will receive this information by virtue of the fact that they are also on the Trust Board but there is a lack of consistency in the dissemination process. Under the circumstances it was not surprising to discover that levels of awareness and understanding around the clinical governance agenda were variable. These trained staff when asked to say what clinical governance meant to them had some difficulty in explaining the concept:

> *'I don't really know anything about clinical governance although I feel I ought to'.*

> *'Clinical governance - what is it? Is it about enlarging on topics and finding out weaknesses? I don't really know'.*

Some staff saw clinical governance as lists of elements such as evidence based practice, clinical supervision etc; others articulated the agenda as a more integrated approach to quality improvement:

> *'Government initiative to maintain, improve and monitor standards of practice and care in the NHS - response to things that went wrong'.*

> *'Responsibility to clients/patients to provide best practice possible and research based..... allowing staff to develop and discuss best practice via clinical supervision and personal development..... initiation of NICE and clinical excellence'.*

> *'Providing a better service, value for money, more accessible, meets health needs'.*

> *'Clinical governance is everybody's concern. It is an umbrella term for areas of practice which can be continuously reflected upon. For example, team working, communication, to see if improvement is required. Can also provide frameworks and strategies for quality*

improvement'.

'A framework aiming to deliver a quality, standardised service to patients; using evidence-based practice is a vital part of that'.

Many of the professionally qualified staff interviewed perceived their knowledge to have been gained through professional publications, associations or professional training rather than from Trust-based initiatives. The quotations above suggest quite a range in trained staff awareness; in contrast, managers specifically commenting on staff awareness generally perceived this to be on the lower end of the knowledge spectrum:

'Will be some (staff) who have a fair understanding and others who are completely in the dark'.

'Clinical governance were two words that were talked about a lot but their understanding of clinical governance was "it isn't going to affect me; it's not going to have an impact on me, why should it impact on my practice; I think that I do deliver the best service I can"..... you have an individual responsibility but I don't think that has been taken on board either; so if you like they are actually saying - well clinical governance, that's (the manager's) problem because she is the manager... or clinical governance, well that's the PCG clinical governance forums problem... that's not my problem, not my area because I have no responsibility'.

'There is no point doing (a questionnaire on understanding),..... they do not understand clinical governance, it does not, as yet inform their practice'.

'We all know about clinical governance (managers) but whether the staff at ground floor level actually know..... if you walked up to a member of staff and say how is clinical governance affecting your work - I don't know whether they would know exactly what you are talking about'.

Despite the above perceptions of their staff, it seems that few managers initiated any deliberate awareness raising initiatives within their own sphere of influence. Whilst staff would likely benefit from more input, it would apparently be welcome to some

managers too:

> *'There has been no awareness raising around the agenda or training for clinical governance or CQI. Would welcome some myself - feel as if I am fumbling in the dark'.*
>
> *'It (clinical governance) is still woolly. One of the problems about the adoption of it is there is a lot of work already been taking place but its not tangible. Can't see it and feel it on a daily basis. Having looked at the Trust action plan on clinical governance my first response was - how on earth do you apply this to practice? Now I am sure I am not alone there..... is it tangible, is it real; it will only make an impact if it's real and tangible..... '.*

6.4.9 Monitoring and Reporting Progress

The establishment of monitoring and reporting systems designed to capture clinical governance activity within the Trust has been an evolving process. A template for quarterly reporting has been introduced which collates data from a number of existing quality systems into a single report format. Thus, data and information from Risk Management, Control of Infection, Significant Clinical Incident Reviews and progress against the Development Plan objectives has been presented for some time. More recently, information on Complaints and Staff Sickness Absence has also be included in an ongoing effort to present the wider and expanding picture.

The availability of data in this format is relatively recent but has already highlighted trends within and across services. This has brought managers and staff together to look at specific issues and, where appropriate, formulate corrective action which may be appropriate for wider application across the Trust. This has been less evident in the past when there was a feeling that the geographical dispersal and the diversity of services often precluded such a joint approach; however, collective analysis of the

collated data has, in some cases, identified common themes indicating that collaboration might be appropriate.

A schedule has been developed which indicates the timing and sequence of reporting. Reports by division are to be considered at Management Team and the Risk Management Team. This data is then consolidated into a Trust report for consideration at the Clinical Governance Sub-committee prior to being presented to the Trust Board where it is received in the public part of the meeting.

Another mechanism for determining progress has been the development of an explicit reporting framework to inform the Trust clinical governance annual report for 2000-2001. This provides a clear indication of the areas which should be receiving divisional attention and action as clinical governance is implemented. The framework has been developed to ensure consistency in the annual returns in order to facilitate collation. However, it could also provide a valuable mechanism for reporting progress against objectives in-year rather than year end which would considerably augment the information currently available to local groups, to the Clinical Governance Sub-committee and ultimately to the Trust Board.

Although the above constitutes important progress, it has already been highlighted that there are still gaps in the clinical governance dataset which means that those receiving the reports are unlikely to have a full picture of clinical governance within the Trust. Whilst the reporting process is evolving this must be appreciated so that the Sub-committee understands the extent to which it may discharge its assurance function

given the information at its disposal.

The IM&T implications of supporting the delivery of clinical governance are far reaching; some of this diversity has been highlighted in the Clinical Governance Development Plan. The Trust has developed an Information and Communication Technology (ICT) Strategy to take forward the national and local agendas for IM&T. The strategy is supported by the ICT Implementation Plan and progress is monitored through the IM&T Development Board. Updates on progress against the objectives outlined under the 'Information' component of the 'Clinical Governance Development Plan' are incorporated into the quarterly clinical governance reports; however, the objectives themselves are broad and give little specific information around the progress of the IM&T agenda. Apart from this quarterly report, it is not clear how the IM&T agenda explicitly informs the work of the Clinical Governance Sub-committee and vice versa given the nature of the existing reporting framework and the absence of a specialist as part of the Sub-committee membership. At times, verbal updates are provided by the Clinical Governance Lead who is a member of the IM&T Board however, it seems that this input is not systematic but tends to represent an individual transfer of information rather than a formal monitoring and reporting mechanism.

6.5 PEOPLE

6.5.1 The Human Resource

At an aspirational level, the 'people' element within the clinical governance agenda, both nationally and locally, is an important key to the achievement of quality in health care. As indicated in Chapter 3, the nature of services, whether in health care or

commercial settings, is such that the quality of the service offering is highly influenced by the individuals engaged in the delivery process. The guidance document issued in 1999 (Department of Health, p6), explicitly reinforces the connection between quality and the workforce:

> *'Closing the gap between the present service and the desired new level of quality will often not be possible without addressing workforce issues'.*

6.5.2 Linking HR and Clinical Governance

The document (ibid) continues by stressing the importance of a local human resource (HR) strategy to ensure that the connections between the numerous strands are made to facilitate an integrated approach to HR's contribution to quality improvement in general and the delivery of the clinical governance agenda in particular. Despite the explicit reference to HR in the Trust clinical governance framework and the identification of key objectives in relation to this, the realisation that HR underpins much of this agenda has been rather slow to dawn on some managers and this important element has not received as much attention as it might have:

> *'Essentially what you're talking about is quality where, clearly because you need to do that through the staff, then there will be some HR implications but not all the HR initiatives that have come from the Centre (are about clinical governance)... ...I suppose you could say that staff involvement is about clinical governance because there is a requirement to try and involve staff in the delivery of health care... ...now you've said that there might be more overlap than I had even thought about before... ...I suppose at the end of the day, if you are trying to do something through your staff then everything you do (in HR) is going to have an impact on the quality of health care that they actually deliver - but whether or not you could lump it all under the umbrella of clinical governance or that would make it too big, I don't know. You might even talk of harassment I suppose, policies on that; if someone is feeling harassed they are not delivering a good service are they, they are not improving their work - but would you put that under the clinical governance umbrella?... ...I suppose clinical governance is something that affects everybody, it's the whole organisation so in some*

ways possibly it would'.

'There hasn't been as much connection with HR as one would want - because we haven't particularly focused on that'.

At the close of the fieldwork period, the HR strategy was still in draft; the explicit and perhaps only reference to clinical governance is made in the section 'Quality Workforce' (Internal Trust Document, 2000b). In this section there is a brief paragraph documenting that a clinical governance lead has been appointed, a Clinical Governance Sub-committee established and that performance review has been introduced. However, there is little to link clinical governance with the rest of the HR strategy and it is not clear from the document how other elements, such as clinical supervision, are specifically related to the clinical governance agenda. The implementation of the HR strategy will be devolved to the divisions; however, it is unclear how this process will be monitored.

The issues discussed above reflect the devolved nature of the HR function; the role of which appears primarily to be one of providing operational advice and support to the divisions. Accountability for delivering the overall HR agenda is unclear. Of particular significance in terms of clinical governance is the lack of HR input into the Clinical Governance Sub-committee - there is no mechanism for regular updates to the Sub-committee although some aspects of the HR agenda are included in the quarterly reports. Sub-committee membership has not included a representative from the HR function either at the outset or later on when the membership was expanded which seems rather a surprising omission given the centrality of the human resource in the delivery of the clinical governance agenda.

6.6 ORGANISATIONAL CULTURE

6.6.1 The Need for Culture Change

A fundamental objective of the national clinical governance agenda is the introduction of a new culture into the NHS; one that is open and participative, demonstrates a commitment to quality, works with users and carers, supports multi-disciplinary team working and so on (Department of Health, 1999). To reflect its key role in the national picture, the Trust has incorporated 'culture' into its clinical governance framework. In fact, culture takes prime position as the first element in both the 'Clinical Governance Report' and the 'Clinical Governance Development Plan', two key Trust documents referred to throughout this chapter.

In relation to culture, the 'Clinical Governance Report' highlights some of the barriers to change within professional organisations and alerts the reader to the need for culture change but stops short of stating explicitly what this change might entail relative to the current culture of the organisation. From the excerpt below, culture appears to have been conceptualised as a variable which must be addressed so that the rest of the proposed change may follow on:

> *'Change implementation in the NHS is often seen as threatening to health professionals. The concept of clinical autonomy and clinical freedom, fear of failure and blame and often a lack of comparative information and the non-identification of effective levers for change all mitigate against the establishment of a culture of change within health service organisations. Changing that culture is difficult but it is a pre-requisite to the delivery of clinical governance. Once the culture is changed, then challenging, reviewing and altering practice becomes second nature'.* (Internal Trust Document, 1999; p8)

6.6.2 Culture conceptualised

The concept of culture has been interpreted within the Trust clinical governance framework in terms of: a Trust-wide Commitment, Board-level Focus and Clinically Focused Management Strategies. These have been translated into more tangible objectives such as the development of an implementation plan for clinical governance; the establishment of structures; and the development of a number of the systems described earlier in this chapter. A great deal of the work undertaken by the Trust and described throughout this section could be related to the cultural variable in some way. For example, in setting up a system of reporting for clinical governance activity, the Trust is indicating how one aspect of a 'reporting culture' will look in very practical terms. Similarly, with the introduction of Significant Clinical Incident Reviews, a powerful signal is being sent to the organisation around 'the way we do things here' - indicating the sort of cultural shift that may need to take place in some areas in order to integrate this new approach.

Despite the central role given to the cultural element, the data does not suggest that the initial baselining work undertaken at the outset included any systematic assessment of the existing culture per se or that of its various subcultures; for example: professional cultures, non-professional cultures, an improvement culture, an incident reporting culture, a blame culture, a fair culture, an open culture, a culture of trust and so on. As a result, in documentation and conversation, culture is generally referred to in abstract rather than specific terms but there are exceptions to this as indicated by the initiatives described above and the change in focus expected of the Trust Board; this latter will now be considered.

6.6.3 A Culture of Trust

One of the policy objectives surrounding the introduction of clinical governance is to ensure greater clarity around corporate accountability for quality. The intention is that accountability will ultimately rest with the Trust board; the chief executive identified as accountable officer on its behalf. Although the local documentation does not state the accountability issues as explicitly as this, the Report suggests that, in order to deliver the agenda, the Board will have to change the way it works and:

> *'... ... move away from (a culture) that is financially driven and focuses predominantly on administration and contractual requirements to one that has a clinical focus'.* (Internal Trust Document, 1999; p8)

The Development Plan outlines specific objectives which identify the Trust Board as having a key role in their achievement; these address such fundamentals as the development of a clinical governance strategy and implementation plan. In addition, one of the centrally mandated objectives for year one of implementation was the clarification of reporting arrangements to the Trust Board. This led to the development of the consolidated reports referred to in an earlier section which are submitted to the Board on a quarterly basis after consideration by the Clinical Governance Sub-committee. As a result of these reports, some Non-executive Directors believe that Trust Board meetings now devote more time to the quality agenda than previously:

> *'There has been a shift in our whole approach - when I first came, half the Board meeting was taken up with finance but I think now it (clinical governance element) is still not big enough but clinical governance is becoming much more important for us (the Board)'.*

These perceptions are particularly interesting as the minutes of the Trust Board demonstrate that finance and activity is reported monthly whilst clinical governance reports are quarterly; also the minutes do not reflect a high level of discussion/debate

around the clinical governance submissions. Apart from initial briefings, there has been no real development work with the Trust Board so that, as a body, it may clarify its role and identify the information which will enable it to fulfil its new responsibilities. Instead, as with the Clinical Governance Sub-committee, information seems to be passively received and the gaps in the dataset appear to go unchallenged. Nevertheless, there is a belief that systems are in place albeit a recognition by some of the Non-executive Directors that determining the effectiveness of these is another matter:

> *'Optimistic that the systems are rigorous but to be frank I wouldn't know'.*
>
> *'Believe that it happens because there is good management'.*

The lack of detail in relation to system effectiveness seems to be compensated for by the sense of trust surrounding the Executive Team as individuals and also as a collective as the following quotes demonstrate:

> *'(Lack of detail) I suppose I have implicit trust in the directors here; that is a value judgement of mine. I suppose if I was (a non-exec) in a Trust where I didn't trust the equivalent of the Clinical Governance Lead and Chief Executive then that would be a problem wouldn't it?..... (the agenda is) devolved down and fed back up and the board sees the headlines, believes it happens because of good management..... question (how robust are the systems in place) shows how much I rely on my faith in top management; in a way I suppose that shows up a weakness in a sense because one of my jobs should be making sure that the top management work through the system, because I have such a good feeling about this Trust I would feel that those systems are in place - my feeling would be that they are, I trust that they are because we have been looking at incidents and picking things up'.*
>
> *(The executive team) it's an established team, people had been working together for a long time, trusted one another..... working with this mature team, there are other things you don't have to worry about so much about because systems are up and running and they run well..... if I have any concerns or worries I would ring up (Clinical Governance Lead) and ask,..... a lot of respect for her abilities'.*

The high level of trust suggested by the sentiments above is not confined to the Executive Team but also extends to other Non-executive colleagues who play a more direct role in the clinical governance agenda:

> *'I've got to be honest, I am not on the sub-committee and I've got enough on so I haven't pushed myself..... why stick your nose in where you are not required yet'.*

> *'I would get much more involved if I wasn't confident of those two people (Trust Chair and Chief Executive)..... we get regular feedback anyway and we get feedback on clinical incidents for example - so I am comfortable'.*

> *'I know that (x) has got really involved in it and have the highest regard for (x) abilities and consequently there doesn't seem to be a great deal of point us poking our nose in - you are right to point out that we have collective responsibility for it and the reports we get from (x) and (Clinical Governance Lead)to the committee keep us sufficiently informed so we don't have to get too involved'.*

> *'We all trust each other too much'.*

Thus the culture of trust appears strong at the corporate level at least; but trust can also be a heavy burden particularly for those further down the hierarchy who are committed but do not necessarily have the capacity to deliver; as one junior manager explained:

> *'He (line manager) knows it doesn't matter if it's in my job description, if he suddenly had something to be done by the end of the week, something that he could pass it on to me, then I would pick it up and run with it. That's how we work. If we didn't we'd never get the improvements to practice that we want to see. He has said - "I could employ several people full-time for 12 months and give them one of your objectives each and it would be a full-time job but there are things we need to do and we haven't got the bodies to do them"..... you see we do it because we are committed to the service as well. That's how they have got people isn't it'.*

6.7 CHAPTER SUMMARY

The aim of this chapter has been to present the clinical governance initiatives undertaken by the Emerald Trust that correspond to the 'what' or the content element of

implementation. The whole system framework adapted from that of Miles (1997) has proved to be a useful mechanism for organising the results coherently. The use of the framework also highlights the fact that each aspect of the whole system has been addressed in some way by the Trust. Whilst the initiatives described here are an important step forward for the organisation, a number of gaps have been identified in its conceptualisation of clinical governance. Although there has been an element of interpretation within this chapter, the main discussion of the significance of the Trust's approach will be deferred until Chapter 9.

CHAPTER 7

RESULTS - CLINICAL GOVERNANCE IMPLEMENTATION - CORPORATE ACTIVITY: PROCESS

7.1 INTRODUCTION

Given that the previous chapter has addressed issues of design and content, the aim of this current chapter is to describe the process elements of clinical governance implementation within the Emerald NHS Trust. This is not intended as a chronological account of process initiatives; instead clusters of activity are presented which have either been inductively generated from the data or are reflective of elements contained within the Miles change management framework (1997) (Appendix 2)

7.2 LEADERSHIP AND MANAGEMENT

As stated earlier in the introduction to this thesis, one of the key steps to be undertaken by all NHS Trusts by April 2000 was the establishment of leadership arrangements for clinical governance. The advent of clinical governance means that the Trust Board now has an explicit responsibility for the quality of clinical services and the national policy requires the chief executive to assume the role of accountable officer (Department of Health, 1998). The Emerald Trust was ahead of the national deadline in appointing its Clinical Governance Lead which provided her with an opportunity to shape and lead this agenda from the outset. Whilst the Chief Executive is a member of the Clinical Governance Sub-committee, much of the development work around this initiative has been taken forward by the Clinical Governance Lead.

The Trust philosophy surrounding implementation suggests that some elements of the

clinical governance agenda will need to be driven from the top whilst others will be devolved for local development; therefore, it will be important for people with the responsibility for taking forward clinical governance to know and understand what they are accountable for. This transactional approach is set within what appears to be a predominantly transformational style of leadership; a feature of which is the constant articulation of Trust values such as a commitment to service. This style seems quite pervasive and is generally espoused throughout the management hierarchy. Traditionally, within the Trust, there has been less of an emphasis on systems and processes and more on organisational culture; summarised by one Non-executive Director as *'strong on culture, weak on systems or perhaps weaker on systems'*. One outcome of this is, being trusted to deliver, Divisional Managers do not appear to be directly performance managed, and, until recently, have not been appraised on a regular basis.

The Clinical Governance Lead also articulates these transformational aspirations and demonstrates transformational attributes; however, there is also a strong sense of the transactional in her style which seems more apparent when it is perhaps culturally acceptable to act in this way. The transactional element is very apparent in some of the new systems described in the previous chapter. Although this is often couched in terms of 'capturing the learning', the reality is that formal feedback and control mechanisms are being incorporated to determine whether the required change is, in fact, being implemented. In the areas over which she has direct control, the Clinical Governance Lead appears to drive the clinical governance agenda forward; in other areas she must rely on influence and persuasion but seems willing to move to a more prescriptive and

directive style if required in order to achieve the objective.

7.3 CONFRONTING REALITY

Part of the early work in the Trust consisted of mapping the existing system. This does not appear to have been documented explicitly in a public format, at least a copy was not seen by the researcher; and the process and scope of this remain rather unclear. There does not appear to be any explicit evidence of benchmarking against other Trusts although a routine external review of the Trust clinical governance arrangements was undertaken. The findings from this review and from the internal mapping have apparently informed the development of the 'Clinical Governance Report' outlined in the previous chapter. Although the Report alludes to a number of issues relating to existing systems within the Trust, the document does not provide a thorough overview of the current state of clinical governance or its component parts. Given the experience and the extensive local knowledge of the Clinical Governance Lead, it is likely that, with or without a written document, she has an overview of the performance of the key building blocks such as clinical audit, risk management and so on. Nevertheless, it is not evident from the minutes of either the Trust Board or Clinical Governance Sub-committee how this has been shared in any detail with a wider audience, or, in fact, how this assessment has explicitly informed the development of the objectives outlined in the Development Plan.

7.4 CREATING A VISION OF CLINICAL GOVERNANCE

Another early activity was a visioning exercise undertaken with the fledgling Clinical Governance Sub-committee at its second meeting in April 1999. Members of the group

were asked to consider what clinical governance might look like in the organisation two years hence. It is not clear from available documentation how this visioning initiative was replicated in other arenas but the process preceded the publication of the 'Clinical Governance Report' and, as highlighted previously, the draft publication of this document was apparently followed up by discussions with a variety of divisional groups to obtain their input.

7.5 PLANNING FOR IMPLEMENTATION

Although the process and scope of the baseline assessment does not appear to have been documented in detail, the culmination of this early activity was the 'Clinical Governance Development Plan'. The objectives outlined in the Development Plan were a mixture of end state and change process; for example: the achievement of CNST level 2, the development of a system for managing significant clinical incidents, the creation of the Clinical Governance Development Team, and the introduction of structures and systems to support the implementation of clinical governance. Thus, the Development Plan appears as a mixture of the 'what' and the 'how'. It is interesting to note that the first objective assigned to the Trust Board, Clinical Governance Lead and Divisional Managers was the development of an implementation strategy by February 2000 - one month after the publication of the Development Plan itself. This had not been achieved either before or during the fieldwork period; thus, the change process which needed to take place to deliver the clinical governance agenda was not made explicit neither were the key objectives embedded in a comprehensive, documented implementation plan. Despite the fact that the implementation plan was an explicit objective, this particular approach was apparently not the norm within the Trust as this

senior manager indicates:

> *'We don't go big on implementation plans and documentation. That's not the way we do things here and you (the researcher) won't change us'.*

Certainly the approach to the draft HR strategy and clinical audit seem to bear this out:

> *'(Implementation plan to accompany HR strategy) - not something I would dignify with the word implementation plan; more a sort of lets get on and do this bit although the business plan will pick up aspects of it and will have time-scales and responsibilities..... (picked up by divisions) - I suppose in a very opportunistic, incremental way rather than any sort of plan saying we must incorporate that bit into what we are doing..... I don't think there is a very clearly defined way of getting them (Divisional Managers) to implement it, it is rather opportunistic'.*

> *'We said that all departments must do clinical audit but still left the topics to them. Then moved on to say after some time, you can do anything as long as it fits in with the Trust's objectives..... there is more emphasis now on the corporate plan'.*

Other than a date for the completion of individual objectives, the Development Plan does not give a sense of the priorities for action apart from the fact that some objectives are scheduled for completion in 2000 and others in 2001. Within these parameters there is no indication of the sequence in which the objectives need to be delivered or the mechanism for monitoring progress.

7.6 CREATING AND REALLOCATING RESOURCES

A reallocation of resources has taken place to support the appointment of an Executive Director into the Clinical Governance Lead post. The fact that the Lead has an executive role and clinical governance forms the main, although not only, part of her remit was seen by some Non-executive Directors as a significant investment in the

clinical governance agenda:

> *'A lot of the resource has gone into (the Clinical Governance Lead)'.*
>
> *'Having a director almost working full time (on clinical governance) has given clinical governance more kudos'.*

Additional investment has also been made available for other new appointments, for instance, an R&D manager, and library staff. Resources have also been allocated for equipment; training has been provided in evidence-based literature searching. Developments are also taking place, in parallel, around IM&T although it is not clear how specific objectives in this area have been integrated with the clinical governance agenda.

Whilst the Development Plan outlined the objectives to be delivered, these have not been explicitly costed. This not only has implications for the operationalisation of the clinical governance agenda generally but also for decision-making with regard to the resourcing of this activity. Without a costed plan, it is difficult to see how priorities for action are decided or how they will be funded given that some elements will not be cost neutral; for example the provision of education and training and the setting up of the Clinical Governance Development Team.

7.7 FROM VISION TO OPERATIONS

The majority of the objectives outlined in the Development Plan identified the Divisional Managers as or amongst the key stakeholders and, in the absence of a clinical governance group at the operational level, the Management Team was expected to pick up the Plan and take it forward. In addition to the general objectives for the

Trust, there are a number of specific ones aimed at the divisions, all of which have year 2000 time-scales or are classified as on-going. However, despite the fact that the rapid appraisal took place 9-10 months after the Development Plan had been approved by the Trust Board, the progress in the divisions was found to be highly variable. Although the Clinical Governance Lead spent time discussing the implications of the Development Plan with individuals, no development work was undertaken with the Management Team as a collective. The rationale for this is described below:

> *'There has been no work done with them (Divisional Managers), we suppose they know what to do... ...send them the document and let them get on with it... ...there was an expectation that they would go out and find out more what clinical governance is about'.*

Given that the Divisional Managers had the Development Plan outlining their clinical governance objectives, the Clinical Governance Lead focused on a number of organisational design components - the 'what' elements outlined in the previous chapter. Early efforts were made to bring existing systems such as risk management into greater alignment and also to introduce new systems such as Significant Clinical Incident Review; this latter serving, perhaps, as the most significant lever in the attempt to re-shape the corporate culture. The rationale for much of this alignment has been couched in terms of 'capturing/sharing the learning' – in particular trying to identify the root causes of problems before finding solutions and making changes to the system as appropriate.

Generally, progress in relation to alignment appears to have been incremental. Between-system linkages are often dependent on the multi-meeting attendance of the individual rather than routine information flows. Whilst the Trust is endeavouring to

bring a greater emphasis to the identification and correction of the root causes of problems, a whole system approach is yet to develop. An example of this relates to the Risk Management Team. There has been a considerable amount of work undertaken to bring together the risk agenda; and yet, no thorough assessment of the risk management process per se has taken place. Also, there has been little attention given to the development of an appropriate risk management structure in support of the growing risk management agenda.

7.8 ENERGY FOR CHANGE

Areas which have achieved the direct attention of the Clinical Governance Lead such as Risk Management Team and Significant Clinical Incident Review have been perceived within the Trust as having made progress. Other areas such as Human Resources, Training and Development have received less direct attention from the Clinical Governance Lead and there appears to be less in the way of explicit integration with the clinical governance agenda; the Lead's attention and energy having been focused on different areas. There is a sense that, in some cases, the progress of clinical governance is relative to the capacity of the Clinical Governance Lead to drive this agenda forward. Although progress has undoubtedly been made with specific initiatives, there is little evidence that this is the result of a total system approach. Miles (1997) argues that in order to achieve the latter, a process architecture consisting of a set of mutually reinforcing mechanisms must be deliberately created to support large-scale organisational transformation (Table 7.1). The Trust activity which reflects each of these elements will now be presented although ordered differently from the list below.

Table 7.1: Process architecture

- Education;
- Involvement;
- Co-ordination;
- Feedback;
- Communication;
- Consulting support.

Miles (1997)

7.8.1 Education and Involvement

Education

Early in the development process, a workshop had been planned for the Trust Board members; unfortunately, this was postponed and, although rescheduled, the new date was effectively two years after the publication of the Trust Development Plan. The Trust Chair and two of the Non-executive members of the Clinical Governance Sub-committee have attended the occasional regional workshop/seminar on clinical governance. There have been no specific initiatives for the senior teams to ensure that members have a similar knowledge base in areas such as: the concept of clinical governance, the implementation process within the Trust, the roles and responsibilities of managers and their staff, monitoring and reporting arrangements.

A number of more widely targeted initiatives did take place and these included the early road shows, training sessions focusing on searching the clinical evidence base, a workshop on clinical risk management and appraisal. Since appraisal has been included in middle/junior managers' objectives, demand for training in this area appears to be outstripping supply. In sharp contrast are the training sessions around incident

reporting; some of which have had to be cancelled because of the lack of uptake. Although staff are starting to be appraised and complete PDPs, there has been no large-scale assessment of training needs in relation to the clinical governance/change agendas per se.

Knowledge for implementation is not just about dealing with the specifics of clinical governance. An important component of the National Clinical Governance Support Unit programme deals with the management of change; in contrast, this area does not appear to have been addressed by the Trust. The level of manager knowledge and know-how in terms of change management was not assessed as part of this research; however, it is interesting to note that there has been no demand from the field for education and training in this discipline. On a related issue, neither does it appear that the formulation of the Development Plan was informed by an explicit change management framework.

During the research process, it was apparent that a wide variation in the awareness and understanding of clinical governance existed and this could be observed at all levels of the organisation. Trust Board Non-executive Directors who were not members of the Clinical Governance Sub-committee cited briefings from the Clinical Governance Lead and also the NHS Confederation as the main sources of their clinical governance knowledge. Many of the professionally qualified staff interviewed perceived their knowledge to have been gained through professional publications, associations or professional training rather than from Trust-based initiatives.

Involvement

The process leading up to the development of the Trust Clinical Governance Plan provided senior people with a number of opportunities to shape this emerging agenda. The Clinical Governance Sub-committee members were engaged in an early visioning exercise. Discussions were held with the Trust Board and Management Team; in addition, a variety of unspecified groups within the Trust also took part in the shaping process.

The phrase 'clinical governance is everybody's business' is an oft expressed cliché however, perhaps less heard is the fact that the extent of one's knowledge base is an important determinant (albeit one of a number) of a person's capacity to become involved whether this is on an individual basis or as part of a group. In relation to the clinical governance agenda, there have been a number of opportunities for manager involvement: shaping the Trust approach, delivering the agenda and modelling behaviour. Involvement may take place on a number of levels. Whilst the Clinical Governance Sub-committee had the opportunity to shape the content at the outset, for others within the Trust involvement has been a matter of commenting on what has already been drafted. This latter situation constitutes a very different level of involvement; the extent of which depends on how far into the process these discussions have taken place.

A lack of understanding of what is expected might result in non-engagement; an example of this arises in relation to the Significant Clinical Incident Review process. A manager at a separate site from that at which the incident occurred took no action on

receipt of a copy of the report as she was unsure about what to do with it. Thus, the findings were not shared with the manager's own staff and no assessment was made of the local situation in light of the report's findings. Whether this was an isolated occurrence was not assessed but the individual referred to here manages a significant number of front line staff; they might have heard of the incident through the 'grapevine' but not, apparently, through any formal process.

One observable aspect of involvement is the modelling of desired behaviour, an important role for managers in particular. Whilst two of the Divisional Managers demonstrated a comprehensive grasp of the agenda and appeared to be taking it forward proactively, another colleague had apparently initiated little in the way of deliberate activity with regard to clinical governance implementation. In addition, although some of the key components of clinical governance appeared on the agenda of Management Team meetings, the progress of the implementation process itself was not a standing/regular item for update/discussion. It was not surprising therefore to find this non-action replicated at the front line and the quotes from clinical staff cited in the previous chapter seem to confirm this.

Whilst understanding might be adequate at an abstract level, it appears that translating this into individual behaviour is more problematic. If the desired behaviour is not modelled at the senior level, the chance of others moving forward regardless does not appear universally likely. One manager, when asked why she had not taken the agenda forward herself given the lack of action from her own manager, responded '*it hadn't been high on my agenda*' and that clinical governance didn't feature in her objectives.

Interestingly, the Trust has apparently experienced a huge demand for training in appraisal since it has been incorporated into individual IPRs. This suggests that one mechanism for securing involvement is to translate corporate objectives into personal objectives and assess performance against these as part of the subsequent appraisal process; in a sense it seems that 'what gets measured gets done'. In reality, neither the Divisional Managers or the middle/junior managers have been performance managed on delivery of the clinical governance agenda per se. In fact, systematic appraisal seems to have been as much a new experience for the Divisional Managers as it has been for their staff. Other than the requirement to appraise their staff, a number of middle and junior managers reported that they had no clinical governance objectives in their personal objectives.

The Clinical Governance Lead appeared to be well aware of the spectrum of Divisional Manager involvement in the clinical governance agenda and tended to spend time on a one to one basis with those who were making less progress. In this way, she tried to clarify what was required and even facilitate the process; however, her approach appeared to become increasingly more directive if action was not taken. This pattern is apparently not unique to the implementation of clinical governance but, as indicated earlier, there are similarities between this and the approach adopted in the implementation of clinical audit - devolved responsibility and the expectation of local interpretation in the first instance but becoming increasingly prescriptive and directive in the event of sub/non-delivery.

Generally, involvement does not just happen but requires some sort of vehicle for its

achievement. One of the key mechanisms is structural and the efforts of the Clinical Governance Lead have ensured that there are a number of new groups; some existing groups have an expanded membership and taken on a new role whilst others, such as the Trust Board, have new responsibilities. There is something new in each of these groupings whether it is membership or remit. However, prior to or during the fieldwork period, there did not appear to be any explicit investment in developing and increasing the effectiveness of these groups through attention to team building, training around the role and responsibility of the chair and of group members, exploring ways in which the group will function or how individual members will make a contribution. In fact, apart from the early 'brainstorming' in Clinical Governance Sub-committee, there does not appear to have been much in the way of 'time out' for these very significant groups (including the Trust Board) despite their varied and sometimes large membership. These are mostly high level groups, but if clinical governance is to be everyone's business, it is equally important for the development of structures lower down the hierarchy to enable front line staff to become involved other than through their individual clinical practice. Despite this, as we have already seen in one particular division, the main group forum for staff is the staff meeting and clinical governance has not featured consistently on these agendas.

The degree of involvement for some managers also appears to be a function of time and feelings of job security; both of which seem to be somewhat stretched:

> *'These people (managers) have also been very busy and are now not confident about what their jobs are going to be in a year's time.'*

In reality, areas where clinical audit, risk management activity, appraisal and so on are

not already taking place, undertaking them anew will naturally represent an addition to the existing workload. The issue of 'time' was recognised in the development of the Trust approach and one of the objectives in the Development Plan concerned an assessment of organisational capacity. Whilst initial scoping work was apparently undertaken, there does not appear to be evidence of a formal, systematic assessment of capacity having taken place across the Trust and, in the absence of an implementation plan, it is perhaps a question of 'time for what?' For instance, although there is a sense that people believe more time is needed to deliver clinical governance, this does not seem to take into consideration the time spent on activity which may be inappropriate as this manager observed:

> *'There (may) be practices going on which are ineffective and if staff spent some time looking at their practice then they wouldn't be spending their time doing ineffective things'.*

The lack of an explicit assessment of capacity has implications for the allocation of both human and financial resources for the delivery of the change agenda; however, there does not appear to have been any deliberate phasing of objectives in line with existing resources. Any phasing seems more in accordance with the energy of individual managers which is naturally susceptible to highs and lows.

Scheduling time for clinical governance-related activity appears problematic for some managers at all levels. Day to day activity with shorter deadlines appears to be displacing the development of clinical governance; with the pressure to deliver the routine work, clinical governance seems to be slowly sinking lower down the 'to-do' pile. When asked directly about this, one manager answered:

> *'Oh gosh, yes. Clinical governance was not performance managed... '.*

Low involvement does not appear to be a 'hearts and minds thing'; it is difficult to argue against spending time on quality per se but it seems a function, to some degree, of blockages around knowledge, uncertainty around future employment and the time factor.

7.8.2 Co-ordination

The discussion previously has touched on the facilitation role played by the Clinical Governance Lead but she has also served as the main mechanism of co-ordination of clinical governance activity across the Trust. As such, it is likely that she has the most comprehensive overview of the progress of clinical governance implementation within the organisation. The Terms of Reference of the Clinical Governance Sub-committee suggest, in part, a steering role for this group. However, without a comprehensive implementation plan against which progress of the process can be measured, and, given the lack of collective development in preparation for this remit, this steering function appears to serve as something of a challenge, as one Non-executive Director commented:

> *'We went to our first meeting (of the Clinical Governance Sub-committee) and none of us really knew what it was (clinical governance). I mean, in a sense, we are only just coming to the point where we can come and say something meaningful to you (Trust Board) - we are only just sorting it out ourselves'.*

Although some divisions received input from a member of the Clinical Governance Development Team early on, this has only recently been extended to all. In reality, much of the co-ordinating function seems to have relied on the energy of the Clinical Governance Lead. Although an Executive Director of the Trust, the Lead only has line management responsibility for some members of the Clinical Governance Development

Team and the library staff. Consequently, to move the initiative forward, she has relied on influencing skills rather than the line management process and, at times, this approach seems to have been rather circuitous.

The Clinical Governance Lead recognises the need to integrate the relevant systems both new and existing and is trying to move away from a reliance on making the connections through individual attendance at numerous meetings and move to a more systematic process of information exchange. A particular area in which progress has been made is risk management. The membership of the Risk Management Team now consists of the right people operating at the right managerial level to ensure that the information received is acted upon. A number of interviewees remarked that receiving risk management data which is both consolidated *and* disaggregated by unit has enabled members to recognise the trends and appreciate that other areas are experiencing similar difficulties. Consequently, there is a greater willingness to work together to find joint solutions and, indeed, an expectation that this should happen:

> *'We've noticed a few things at Risk Management - (x division) has the same sort of things (problems/incidents) as (y division) so again, it has been suggested that the two Divisional Managers get together to have a look at the incidents to compare and learn from each other'.*

However, this is not the case with all components of clinical governance and it is recognised that more needs to be done in order to integrate the work of areas such as the Complaints Committee into the mainstream clinical governance activity. There is also a need to address the way in which the reporting of clinical audit activity informs the clinical governance agenda as this does not appear to feed into the quarterly

reporting framework:

> *'Nobody takes a blind bit of notice (of the audit reports) - that's what (the Clinical Governance Lead) is trying to do - integrate it with all the other stuff that is going on and say we are not going to do a separate audit report - we are going to have a report on clinical governance which will include clinical audit activity from each of the divisions'.*

Although many individuals are contributing to clinical governance activity, the key co-ordination mechanism is in the person of the Clinical Governance Lead; unless and until the Clinical Governance Development Team becomes fully operational, this is likely to continue but, in the meantime, increasing operational involvement risks displacement of work on the 'bigger picture'.

7.8.3 Feedback

When the Clinical Governance Sub-committee did the early 'visioning' work which led to the 'Clinical Governance Report' and subsequently the 'Clinical Governance Development Plan', some of the Sub-committee members were by no means certain that what they had come up with was 'it'. This sort of uncertainty is not uncommon where policy is new and potentially so far-reaching but dealing with it is a key challenge for the management of change. One way of decreasing uncertainty is the establishment of multiple feedback mechanisms to gain as much information as possible from within the system.

One route to such feedback is through the formal reporting structure. A key, nationally-set objective was the establishment of a mechanism for regular clinical governance reporting to the Trust Board. The initial dataset constructed by the Trust consisted largely of data readily available from existing groups. The dataset has

gradually been expanded and is now considered by a number of internal audiences (Clinical Governance Sub-committee, clinical governance divisional fora) in addition to being received quarterly in the public part of the Trust Board meeting. The report consists of operational performance data, data from clinical governance-related groups and provides an update on progress against the Development Plan objectives; the report does not, however, reflect the implementation process per se. Thus it is perhaps not too surprising to find this Trust Board member apparently unaware of the fact that the Clinical Governance Development Team was not fully operational:

> *'I understand that the Trust has a clinical governance team who are responsible for proselytising to the rest of their team and they each have reps which then link in to your committee (Clinical Governance Sub-committee) ..... but their job is also to take the message out to the troops'.*

The dataset described above remained the basis of routine clinical governance reporting during the research period. Although an additional framework was subsequently developed to specifically address the components of clinical governance, this was for the purpose of the Trust annual clinical governance report. In addition to acting as a vehicle for the reporting of information upwards, this framework also gave a clear steer to Divisional Managers regarding the corporate conceptualisation of the components for clinical governance and the areas on which they should be focusing local attention. Whilst this did provide a useful end of year summary, it could also have served as an explicit tool for monitoring clinical governance activity on a regular basis in-year.

As in the case of the work around user involvement, some initiatives have not always included explicit arrangements for the provision of feedback on progress; yet, there is now a growing tendency within the Trust to incorporate this into the system and a good

example is the Significant Clinical Incident Review process. All divisions are expected to receive the final report, assess their area of responsibility against the learning points and confirm to the Clinical Governance Lead whether local action will be required or is not considered appropriate. A similar feedback mechanism has also been built into the new system for the dissemination of guidelines. Nevertheless, as earlier comments around incident reporting suggest, there is still a need to ensure feedback to staff on specifics such as incidents and so on but also more generally on the progress of clinical governance in the Trust.

Setting up feedback mechanisms is important but the ultimate test is how the information is used once received. Early feedback to the Trust after a routine review by the Regional Office was used to inform the Development Plan. Written and verbal feedback was provided by the researcher to the Chief Executive and Management Team after the rapid appraisal undertaken in the autumn of 2000. The recommendations of this first report centred largely on the need to develop an implementation plan and the need to clarify whether the Trust concept of clinical governance was based on an assurance or improvement model or both. This recommendation was based on an observation that systems were being implemented to address the assurance aspects of clinical governance but the notion of continuous improvement did not feature explicitly. An example of the latter was the lack of a mechanism at the local level to facilitate the involvement of front line staff in CQI. Neither of these issues were addressed directly by the Trust during the fieldwork period. The notion of models did not appear to sit comfortably with the culture of the organisation. Whilst acknowledging that the research report was much as the Trust expected, the minutes of

the Clinical Governance Sub-committee dated 19 January 2001 record the following comments:

> *'(The Clinical Governance Lead and the Chief Executive) would argue with respect to the 'quality models' and pointed out that they would be difficult to convince about adopting quality models'.*

This apparent conflict with the prevailing organisational culture is similar to the Trust response to the recommendation that it develop a comprehensive implementation plan. The stated reason for not developing this latter was that, with the Trust moving towards the creation of a PCT, the focus would be on consolidating what had already been achieved. However, the dissolution of the Trust was to take a further 15 months during which time the organisation was without a comprehensive implementation plan to guide the change process. The final research feedback was submitted in December 2001 and the Clinical Governance Lead confirmed that a number of the recommendations from the second research report would directly inform the plan for clinical governance within the new PCT.

In addition to the two formal written feedback points, verbal feedback was an ongoing feature of the action research process and was offered at corporate and divisional meetings. At times, the researcher was able to provide observations from the front line that challenged the corporate assumptions about the extent to which the clinical governance agenda had cascaded down into the organisation. Verbal feedback was also offered to interviewees during the fieldwork and will be discussed later in the section on 'support'.

7.8.4 Communication

The association between change and uncertainty has already been commented upon. The Emerald Trust is not only coping with the changes required by clinical governance and the wider modernisation agenda but is also facing the prospect of large-scale organisational change in the move towards PCT status. The role of feedback and education in reducing the level of uncertainty has been discussed earlier in this section; however, for greater impact, these elements should be incorporated into the wider system of communication operating within the Trust generally. The need for extensive communication in a period of change is appreciated by this interviewee:

> *'... ... it's a pretty important issue because it's lack of communication or poor communication that makes people make up their own minds on what's happening. And all sorts of rumours start to fling around then... ... with the changes taking place within the service, if you had someone with a communications lead ... you would say - right come up with views on how we are going to make staff appraised about what is going on and get day to day questions answered - then someone would (need to) come forward with a communication plan... ... no-one has been identified with the role (internal communications), ... so it is not seen as someone's responsibility'.*

Whilst the Trust has undertaken clinical governance road shows, several articles have appeared in the newsletter, and the Annual Clinical Governance Report has been produced, these constitute discrete initiatives. In contrast, there is no evidence of an on-going, multi-method communication campaign taking place to raise and maintain the profile of the clinical governance agenda within the Trust. In fact, there is no communication strategy to accompany the implementation process per se; indeed, neither is there a strategy for internal communications and there is a lack of clarity around where the responsibility for this particular activity lies. Thus, there was no formal launch of the Development Plan prior to the road shows which reached less than

10% of the workforce; of these, as indicated earlier, the majority of attendees were thought to be managers. Communication of the Development Plan appears to have relied on the cascade of information from corporate through divisional levels and on to those in the front line of service delivery. However, it is clear from research in the Primary Care Division that this approach has not been particularly effective in practice.

Although elements of the clinical governance agenda appear in the minutes of Management Team meetings, there does not appear to have been a regular discussion around clinical governance per se or its implementation in this arena. In some divisions, this situation has been replicated further down the hierarchy; for instance, some of the junior managers in the Primary Care Division had not seen the Significant Clinical Incident Reports or, in fact, the Development Plan until a meeting with the Clinical Governance Lead early in 2001. In addition, the feedback from the rapid appraisal in 2000 confirmed that the Development Plan was not a living document within the divisions generally although the Divisional Managers all knew of its existence. This senior manager expressed strong opinions on the communication issues with the Trust:

> *'People don't cascade information. The Management Team probably do but what happens after that..... Could be a power theory; could be that people do not have structures in place like team briefing to allow cascade. Another of this - oh it's something to do with staff therefore I haven't got time to do it - more important (things) to do like delivering services to clients - (they are) not making the connection between those two things. No, we don't have any structured way of cascading information'.*

And this was another senior manager's experience:

> *'My clinical governance forum - nothing cascades down. I'm giving them all this stuff but when I go out to the staff - they haven't heard*

about the information..... I don't know where the blockages are or why it's not being disseminated'.

The value of effective communication systems in establishing a common language and a common understanding around clinical governance did not appear to have been appreciated or these outcomes actively sought. The manager cited below was echoing the views of a number of senior colleagues with regard to the junior staff:

'(I) don't expect people to tell me what clinical governance is but I expect them to tell me how they use the evidence, how we can plan care, how we monitor (it)'.

Given the sentiment above, it was therefore something of a surprise to read that the issue of a manager briefing pack had been raised at Management Team two months after the approval of the Development Plan; however, this was not produced within the fieldwork period.

7.8.5 Support

The need to provide support for the divisions was recognised early on in the Trust's developing approach to clinical governance implementation. The Clinical Governance Development Team was established in principle in May 2000 but did not achieve its full complement of members for almost 18 months. In the meantime, one or two team members were able to form links with specific divisions; other than this, the main source of internal support was the Clinical Governance Lead who provided advice to the Divisional Managers on a one to one basis. Whilst some of the Trust Board members thought the Team was up and running, it seems that not all managers were clear of its remit some 18 months after the publication of the Development Plan:

'It's like the Clinical Governance Development Team - I've heard of it but what are they actually doing, who are they and it's only when you

start to sit down and think I don't know who these are, what are they actually doing that you actually get an answer; it is automatically assumed that everybody would actually know about it'.

External support was obtained through several routes. A small number of natural work teams (two for certain) have taken part in the national programme offered by the Clinical Governance Support Unit. The catalyst to the decision to put forward these teams was not clear - i.e. the team's own request/nominated by the Trust; however, this initiative does not appear to have been part of a deliberate corporate approach and there has been no move to send a large number of teams for this training.

One opportunity for obtaining peer support was through the formation of a county-wide network of clinical governance leads which was co-ordinated by the health authority. The Trust Clinical Governance Lead also became a member of the Clinical Governance Sub-committees of the local Primary Care Groups (PCGs) and, latterly, a representative from each of these groups has been invited to join the Trust Clinical Governance Sub-committee. In contrast, the Lead does not appear to have established direct links with other NHS Trusts providing the same/similar services as Emerald.

The action research process was also a source of external support for managers in particular. In addition to providing real-time feedback, the contact offered an opportunity for interviewees to explore some of the general issues around the implementation of this agenda and obtain an outsider perspective on action they might be considering.

Interviews generally followed a semi-structured format following a clear inquiry

framework. Interviewees commented that the questions would often serve as prompts to action; firstly causing them to think - *'why has she asked me this'* and secondly to consider whether they might need to take action on the issues being discussed. Many of these questions related to process; issues such as awareness raising with staff, whether clinical governance was a regular/standing agenda item at team meetings, how are incidents and complaints considered collectively, how does clinical audit happen locally (Appendix 8). Some found the interview process offered protected time and within this an opportunity to talk through the agenda. This helped some managers gain a greater clarity about the concept of clinical governance and the role of the interviewee with regard to this policy and its implementation.

As a result of the ongoing data collection, the researcher was also able to challenge some of the assumptions being made; examples of this include corporate-level perceptions around the level of actual knowledge amongst some of the managers and a belief that having a local PCG with an active Clinical Governance Sub-committee could act as a substitute to the establishment of a forum for clinical governance in the Division.

Although the Clinical Governance Lead has advised divisions on practical aspects of clinical governance, there appears to have been little provision of formalised support from an organisation development perspective. This was touched upon in the 'education and involvement' section with reference to building teams and investing in time-out for development. This type of deliberate intervention in team/group development does not seem to be a Trust norm. In practice, there appears to have been

a distinct lack of attention to the development needs of new and existing groups in relation to implementation of the Trust's clinical governance agenda. This does not appear to be confined to the clinical governance agenda as suggested by the following comments from these Non-executive Directors:

> *'I'm unhappy at the training that I had as a non-exec - or lack of training'.*
>
> *'When I first started here I was unhappy with the way I was inducted and felt that I didn't really have much info to work on and it took me a long time to work out for myself what my role was..... even now I probably haven't got it right but that's how I felt at the time'.*
>
> *'That is very typical of this Trust that it is presumed that we are going to pick it (clinical governance) up; fortunately we are pretty able I think'.*

In terms of the Non-executive Directors as a group, they do not meet separately from the whole Trust Board although some felt that would be beneficial:

> *'One of the things we never do as non-execs is come together to discuss something alone without the other directors there..... but even if it was once a year I feel the need for us to meet'.*
>
> *'We (the non-execs) don't have the equivalent of a group meeting'.*
>
> *'Never even discussed having a (separate) meeting'.*

Earlier in this chapter, there was a comment on the lack of questions at Trust Board on the quarterly clinical governance report; however, discussion with several Non-executive Directors revealed that papers for Trust Board did not generally arrive to give them the five days notice that was intended. At times, papers even arrived on the morning of the Trust Board meeting thus the Non-executives had little time to read, digest or make some investigation around the information with which they had been presented.

The lack of group development at the corporate level is reflected in the Primary Care Division and Locality under study and this will be discussed in the next chapter; however, the expectation that the collective will pick up what it needs to know along the way also seems to relate to the individual. The Trust does not appear to have made any explicit arrangements to address the variation that exists in the experience, knowledge and know-how of individual managers and staff, not only in terms of clinical governance but also in relation to the process of change management. Individuals within the Trust appear to be at different starting points regarding the above and there has been little to address this although a workshop is planned for January 2002 - two years after the release of the Development Plan. This lack of deliberate organisation development (OD) intervention is surprising given the centrality of learning in the Trust's conceptualisation of clinical governance.

7.9 CHAPTER SUMMARY

As in the previous chapter, it is clear that the Trust has made a positive start in terms of the implementation process. Each of the activity clusters have been addressed in some way although gaps are apparent which may, ultimately, have a negative impact on the likelihood of overall success of the clinical governance initiative. As with the Trust approach in terms of content, the significance of these process initiatives will be discussed in Chapter 9.

This chapter concludes the description of corporately-led clinical governance initiatives, the following chapter will now present an overview of clinical governance in one of the Emerald Trust divisions and a Locality within this.

CHAPTER 8

RESULTS - CLINICAL GOVERNANCE IMPLEMENTATION- A DIVISIONAL VIEW

8.1 INTRODUCTION

The previous chapter has described the work that has been taking place at the corporate level to take forward clinical governance within the Trust. One of the key aims of the Clinical Governance Lead was to ensure that the strategic objectives were translated into the operational reality of the clinical divisions. Thus, one of the research objectives has been to follow the translation process from the corporate level down towards the front line of service delivery.

The Primary Care Division and the Northern Locality have been selected as targets for further research and the rationale for this choice has been outlined in the earlier methodology chapter. The aim of this chapter is to present firstly an overview of the Division and Locality and then to describe the clinical governance initiatives that have taken place within these areas. As far as possible the Miles framework (1997) will be utilised to shape the presentation of these results.

8.2 PRIMARY CARE DIVISION - AN OVERVIEW

The Primary Care Division consists of three localities. Over a six month period, the researcher followed the progress of clinical governance arrangements at divisional and locality level - the latter focusing on the Northern Locality.

The Division provides Health Visiting, District Nursing and Child Health Services; health care for the older adult is provided in a Community Hospital. The Divisional management structure comprises the Divisional Manager; three Community Health Care Managers - each responsible for a Locality, and a Child Health Nursing Manager. Within each of the localities there is a Clinical Leader for Health Visiting and one for District Nursing; in Child Health, there is a Clinical Leader for School Health, the Paediatric Nursing Team, Hospital at Home and Child Development Centres.

Since early 2001, the Divisional Manager post has been an acting position and, in addition to the responsibilities as Acting Divisional Manager (ADM), the post holder has retained her role as Board member on the Northern PCG. The Community Health Care Manager post for the Northern Locality is also an acting post (the previous manager is acting up as Divisional Manager) which comprises 50% of the post holder's time. In the other 50%, the manager retains her responsibilities as Clinical Leader for Health Visiting in one of the other localities which is geographically distant from the Northern. The Clinical Leader posts were introduced in year 2000 to strengthen line management arrangements; apparently 80% of those in post are new to a formal operational management role.

Prior to the establishment of the Divisional Clinical Governance Forum, the key meeting for managers within the Division was 'Clinical Leaders'; this takes place on a monthly basis and is attended by all Clinical Leaders and Community Health Care Managers. It is chaired by a different Community Health Care Manager each month; access to minutes was highly problematic as there is no central generation of or

repository for the record of these meetings; a situation attributed to the monthly change of chair. This is meant to be an opportunity for top down - bottom up communication but in practice there is apparently little contribution to the agenda by the junior managers.

8.3 CLINICAL GOVERNANCE IMPLEMENTATION IN THE DIVISION - CONTENT

During the rapid appraisal of clinical governance within the Trust undertaken in year 2000, it was apparent that clinical governance, as an integrated system for continuous quality improvement (CQI), was yet to become established within the Division. This is a rather euphemistic way of highlighting the difficulty in identifying deliberate initiatives aimed at the implementation of the Trust 'Clinical Governance Development Plan'; although, it should be noted that individual initiatives to develop and improve Divisional services were taking place. The researcher's next contact with the Division was in April 2001, seven months after the rapid appraisal. In the intervening time, little progress had been made with this agenda other than the establishment of a Clinical Governance Forum - 13 months after the publication of the Trust Development Plan. When questioned on progress, the response from one of the managers summed it up as follows:

> *'This will be short and sweet because the brutal truth is - very little (has happened)'.*

The first meeting of the Forum took place in February 2001. At this initial meeting it was decided that the chair of the group should be nominated on a rotational basis to provide a development opportunity for Clinical Leaders; selection would take place by

drawing names out of a hat. This process duly took place and the first chair appointed for three months accordingly; however, this person was not present during the selection process and, therefore, did not have the opportunity to highlight the fact that she only worked part-time in the Clinical Leader role.

Membership of the Forum included the ADM, Community Health Care Managers and Clinical Leaders; latterly the newly appointed Clinical Governance Facilitator also joined. The overall aim of the group was the development of Divisional strategies for clinical governance; its Terms of Reference were to reflect the requirements of the Trust 'Clinical Governance Development Plan'. The Terms of Reference suggest a variety of roles for the group: assurance, steering and 'doing'; however, the integration of all three is likely to present a challenge to this newly formed group.

Meetings of the Forum were scheduled at monthly intervals and have taken place regularly. In general, agendas seem to have consisted of items cascaded by the ADM or those which the Chair considered to be of interest. Once the Chair of the Forum became the Divisional representative on the Trust Clinical Governance Sub-committee, there appeared to be a clearer frame of reference for the local clinical governance agenda.

The minutes of the meetings demonstrate that issues around specific components of clinical governance such as clinical audit, clinical supervision, incident reporting are discussed. The group has also been reviewing the progress of an initiative to re-introduce Clinical Rounds and Individual Performance Review (IPR). The need for

more work to raise staff awareness of clinical governance was recently recognised and discussion has taken place around mechanisms for achieving this. However, although a number of key actions were identified at the outset, these have not subsequently been translated into an action plan and there was no sense of a systematic approach to the implementation of clinical governance being considered. According to this member of the Forum, there was a lack of direction in these early days:

> *'I've not got any direction. I haven't been given any direction. I don't know what's expected. How can you drive anything forward if you haven't got the time and you don't know what it is you are supposed to be doing anyway'.*

From direct observation of two meetings, 'discussion' was the predominant albeit not exclusive activity with certain issues referred to the Clinical Leaders Group (despite the similarity in membership) for further discussion. Although issues were being highlighted, it was not always clear how and who would take these forward and there appeared to be a lack of clarity around the authority vested in the roles of the Chair and in the group as a whole. The arrival of the Clinical Governance Facilitator appears to have coincided with a change in the group approach - action points and the responsible individual(s) being clearly identified in the minutes and separate groups being set up with a remit to look specifically at the issue in question.

Latterly, the group has started to receive a copy of the same consolidated dataset as that submitted to the Trust Clinical Governance Sub-committee and also copies of the Significant Clinical Incident Review report summaries; both of which could provide an important focus for future discussion and action.

8.4 CLINICAL GOVERNANCE IMPLEMENTATION IN THE LOCALITY - CONTENT

The Northern Locality is a rural area with a population of approximately 60,000. There are seven GP practices which are based in the main towns and the larger villages. Health Visitors and District Nurse teams are attached to each of the seven practices; services are provided within the Locality and, where necessary, across county boundaries. The staffing profile as of September 2000 reported around 75 whole time equivalent District Nursing and Health Visiting staff employed within the Locality on Nursing Scales ranging from A to I grades. A Community Health Care Manager is responsible for each Locality and District Nursing and Health Visiting staff are line managed by a Clinical Leader.

Some evidence of clinical governance activity such as incident reporting, appraisal and so on can be identified in the Locality, however, as highlighted earlier in this chapter, clinical governance as *an integrated system* for quality improvement is yet to be established within the Division and this situation is also reflected in the Locality. At this point, it is important to recognise that, despite the fact that clinical governance is apparently in the very early stages of development, improvement work does take place locally. These initiatives may be enhancements to an existing service, may represent a new service for clients or may improve clinical practice in some way; examples include the Integrated Nursing Team pilot, the development of a wound care formulary, joint working around smoking cessation and the introduction of client-specific support groups such as 'Cradle Clubs' for first time mothers and Breast Feeding Support Groups.

8.4.1 Structures for Quality Improvement

Up until mid 1999, active standard setting groups existed for both Health Visiting and District Nursing but these seem to have disbanded over time apparently as group members moved on. This gradual decline also seems to have coincided with the change in corporate arrangements for the facilitation of clinical effectiveness and audit; that is the movement away from a central clinical audit function:

> *'Basically the standards group just fell apart; the person who was leading it left and it's never really got back together again because of pressure of time'.*

In the absence of the Standard Setting Groups, the main forum for discussing improvement opportunities appears to be the staff meetings. These take place on a regular basis, usually monthly, and tend to be uni-disciplinary although speakers from different specialties/professional groups/services are invited to attend and present on issues of interest. Minutes of these meetings suggest a very varied agenda which is largely around information exchange; this may relate to operational issues, details of training, national policy - the NSF for Older People, 'Improving Working Lives' and the NHS Plan all appear to have been discussed. In some areas, feedback is provided from staff development such as courses, conferences etc, and there is evidence of practical outcomes arising from efforts to bring the learning back into the organisation such as the development of a leaflet on eczema. Feedback is also provided from joint working groups on topics such as wound care.

Whilst 'clinical governance' does not appear as a regular, explicit item on the agenda of these meetings, components of this agenda appear to have been discussed such as clinical supervision, clinical audits for which the Locality has provided data,

information around the introduction of staff appraisal and the re-introduction of Clinical Rounds. However, there is a view that a more explicit focus on clinical governance per se is required:

> *'When we meet for unit meetings, I think as many people as possible should be informed about what clinical governance should mean in practice because I don't think people realise it enough. We have never had a unit meeting of all this area and said clinical governance is here and this is what it means'.*

Although one area has recently started to disseminate the summary reports of Significant Clinical Incident Reviews, there does not appear to be a mechanism, either as part of the staff meeting or through an alternative structure, to support regular, collective review and discussion of clinical/non-clinical incidents or complaints. This is despite the fact that routinely-collected data on these issues is available, albeit centrally collated:

> *'Feedback is really important but when you don't get any it's demoralising; we've done this, we've sent in this form and you get nothing back from it that's perhaps going to improve something - (that) this, this and this has been done - you get a bit cynical - you think what's changed?'*

> *'Things are pushed from one side - you've got to improve quality, you've got to do this, you've got to do that; when you do all that, nothing much comes back from it'.*

8.4.2 Clinical Supervision

There are groups within Health Visiting and District Nursing which meet regularly for clinical supervision. The groups were established at different intervals and therefore are at different stages of development. Some groups are perceived as working well whilst others are apparently experiencing some difficulties. Some of this difficulty appears to relate to the opportunity to meet as a group given operational demands

which can be unpredictable particularly during periods of staff sickness:

> *'It all comes down to time; the idea is very good but it's time. If you are busy and you've allocated an hour to do it, what goes is that because your visits or (something else will get in the way)'.*
>
> *'It's time..... when you have got a day when you put it down and think right we'll do that, you get staff taken off you to go to help somewhere else'.*
>
> *'The minute you get reasonably well staffed and you think - we can do this- they take them (staff) to another group'.*

The Clinical Leader for Health Visiting has recently proposed a review of the current arrangements for clinical supervision.

8.4.3 Appraisal and Personal Development

Appraisal and the formulation of Personal Development Plans is starting to take place and in 2001 there has apparently been a particular corporate emphasis on getting this process established. Clinical Leaders are appraising their senior staff and, as they in turn receive training, the senior staff will appraise their teams or in the case of Health Visiting, the Health Visiting Co-ordinator and the Clinical Leader will share this responsibility. Apparently there has been an increase in demand for training and the delay in getting places on courses is thought to be holding up the cascade of appraisal.

8.4.4 Clinical Audit

The Standard Setting Groups were perceived as the main locus for clinical audit work and, although staff may be involved in data collection for audit projects led by other disciplines, in the absence of the previous structures, little in the way of clinical audit

has been initiated recently by the Locality itself:

> *'It (clinical audit) doesn't happen very often. Since I have been in post I haven't done any audits. There is a real issue about getting meaningful data..... we do need to look at audit but sadly we lack the training and skills'.*

8.4.5 User Involvement

There was a perception amongst staff that user involvement tended to take the form of client/patient satisfaction surveys; these would more likely be undertaken with clearly defined groups which meet over a period of time. Involving individual clients/carers is more likely to be seen as part of the care planning process.

8.4.6 Clinical Governance - Knowledge and Skills

As highlighted earlier in this report, the Trust led a number of road shows in 1999 to raise awareness of clinical governance within the organisation. Most staff who took part in this research project, either in interviews or focus groups, were aware of the early initiatives but few had actually attended. Levels of awareness around the clinical governance agenda vary as the earlier quotes have demonstrated. Staff interviewed generally reported that their knowledge had been gained via external sources; for example: post graduate study, attendance at conferences or through professional publications or bodies. The level of knowledge around specific elements of clinical governance such as clinical audit and risk management was also variable and whilst front line staff might have taken part in audit or completed incident forms, there was less understanding of how these practices formed part of clinical effectiveness/risk management as quality improvement systems. Although a number of staff had attended the risk management workshop held in July 2001, few reported they had received any

specific training around clinical audit or risk management.

In terms of acquiring the detail around clinical governance, there is a sense that delivering the service to clients is taking up all the energy of some and clinical governance as a high level policy has not been effectively translated for those who are at the front line. The following comments from clinicians illustrate a number of these points:

> *'It's workload. ... ... Most of us are working to capacity in an environment that is constantly changing. Clinical governance is one of many names that is just hanging there and there is this mad panic - good God where's this one come from. It hasn't translated into action and it's one of many. We are fully occupied, we haven't got free time to make connections... ... too busy doing the job'.*
>
> *'It would be very nice if they (management) sent out or gave us the information as to what parts of the (clinical governance) umbrella have been addressed or completed'.*
>
> *'Staff are bogged down with delivering the service... just no time to think or to read... just hope that someone higher up will send directives'.*
>
> *'I feel lost in the vision of the NHS, never mind clinical governance; somebody must have sat around the table in Whitehall and said right this is the vision for the new NHS and this is how it is going to be. As the visionary has stayed at the top and they haven't found other visionaries to carry the baton on down here, I don't know my place in the vision; I don't even see a vision; I have nobody re-affirming that vision to me as a practitioner any of the time ... ... whereas when I was a newly trained nurse... you knew what she wanted (the matron) because she came down to the wards and told you... ... but it has become unseen, unseen down here - they have not got visionaries on the ground. There's nobody sitting around the table (at Trust HQ) who has caught the vision and can inspire people to carry it'.*
>
> *'It just seems to be if you appear to be getting on with the job then no-body has any involvement with us; as long as the boat is not rocked... you just get on with it to what you consider to be the best of your ability; giving the best service time allows to your clients; if nothing happens to tip the scales, that's just how it rolls on. No-one comes and tells you what's happening, what's changing, what's going to*

be expected of you in the future - just rolls on. If the wheel doesn't come off - then fine'.

The clinical governance agenda is also at risk of being displaced by the forthcoming organisational changes:

'So much change isn't there. We know come October they are going to PCT status, so everything else almost goes on the back burner'.

Or as one manager commented:

'There is a huge change and transitional agenda around at the moment in the NHS and staff at the moment may or may not have clinical governance and some of the components within it high on their personal agendas or on their professional agendas. But it is trying to ensure that they do understand that some of the most important things they do are part of the clinical governance agenda. But at the moment there will be a very strong focus on the dissolution of the Trust which affects everyone's terms and conditions of employment; -transition to PCT status, am I going to have a job at the end of this, what will it mean for me. I am aware that staff at the moment have a degree of vulnerability and uncertainty that may or may not affect the way they are prioritising other elements of the role they have to do'.

Others identify a clear priority for staff when there are competing demands on time:

'Clinical governance, clinical supervision, sharing good practice, research, audit, they will all have to take a side step if a patient has to be seen and that is difficult to marry up..... the bottom line is, the patients will always come first'.

The manager's assessment of clinical governance activity to date that was cited earlier in this chapter ('very little') was supported by research in the field. There appears to have been little in the way of deliberate attention to the implementation of this agenda until the senior management arrangements changed. The following section will highlight the process elements of implementation within both the Division and the Locality.

8.5 CLINICAL GOVERNANCE: THE IMPLEMENTATION PROCESS IN THE DIVISION AND LOCALITY

8.5.1 Clinical Governance Implementation - A Late Start

Although there is evidence to suggest that service improvement does take place within the Division, little in the way of deliberate activity to implement clinical governance was apparent at the start of the current research. This situation had been allowed to continue for 12 months after the publication of the Development Plan but, by the time the ADM came into post, it was clear that this agenda needed urgent attention:

> *'... ... this has been outstanding for some time, will someone please get a handle on it for primary care.'*

This urgency would have been difficult to ignore especially as it was emphasised in a meeting of senior managers, facilitated by the Clinical Governance Lead, to agree a local way forward. Shortly after this meeting, the Clinical Governance Forum was convened, the Terms of Reference of the group were made explicit and a number of action points identified.

8.5.2 An Action Plan for the Division

Around the same time as this initial work was taking place in the Forum, the ADM was required, for the purpose of the Trust Annual Clinical Governance Report, to provide an update on local progress around the clinical governance agenda using the framework promulgated by the Clinical Governance Lead. The resulting document gave examples of certain clinical governance related activity within the Division and highlighted a number of gaps. At an 'Away Day' in September 2001, the ADM, Community Health

care Managers, Clinical Leaders took 'time out' to map the key areas for action across the range of drivers which impact on the Division. The aim of this activity was to develop an action plan to address the issues identified above over the period 2001-2002.

Within the resulting action plan, a number of areas for attention have been identified under the banner of clinical governance such a appraisal, personal development plans, risk management, complaints. However, certain key elements such as clinical audit and National Service Frameworks (NSF), although highlighted for action, appear to be separate from clinical governance activity. Thus, amongst the Divisional objectives, clinical governance appears as a discrete element and, in this way, clinical governance seems to have been conceptualised as a separate entity to that of the modernisation agenda. Consequently, clinical governance is something which requires prioritisation along with everything else as this quote from a senior manager suggests:

> *'In order to do it (clinical governance) properly, you would need to have one clear day a week dedicated purely and simply to driving forward the clinical governance agenda - and that is not realistic in today's heath agenda because it's just not clinical governance - you have drivers from the modernisation agenda, from the national plan, from recruitment and development, from improving working lives etc etc etc. - not to mention the new National Service Frameworks; all of which are coming out with clearly defined governmental time targets on them and so however high a priority clinical governance may be both as an organisation and as a personal view, the reality is that it will have to be prioritised along with all the other drivers and if I was a full-time clinical governance project manager then and only then would you see massive changes within each area, each Division, each discipline'.*

This fragmentation is surprising given the divisional framework for the Trust Annual Report is inclusive and integrates a range of components, including the elements identified above, under the clinical governance umbrella.

Despite the Divisional activity described above which has seemingly culminated in three 'action' documents, there was no evidence during the six months of fieldwork that these had been brought together either to form an integrated clinical governance strategy or an implementation plan that would facilitate operationalisation within the Division. Also, although these different action sets seem to have been generated through discussion with managers, there has been no comprehensive assessment of the current coverage or effectiveness of existing systems for quality improvement such as clinical audit and risk management or, in fact, an evaluation of the clinical governance implementation process to date. Therefore, although the Division has action points to guide it towards a destination, these do not appear to have been formulated with a clear sense of the starting point. This approach may do little to either challenge the status quo or provide a solid foundation upon which to build new systems.

8.5.3 Organisation Development - A Missing Component

The lack of a deliberate OD programme at the corporate level is also reflected within the Division. At the collective level, the impression of the early Forum is of a group struggling to deliver an agenda but without any initial investment in its own development needs. Consequently, a number of gaps are apparent which are likely to have a fundamental impact on the group's ultimate effectiveness. There is a lack of clarity around the authority, role and responsibility of the group as both a collective and as individual members. There was also a lack of clarity around *what* is meant to be in place in clinical governance terms and *how* this should/could be achieved.

The minutes of these early meetings reflect the newness of the group. Although issues

were being discussed, closure which led to action points was less evident. Items were sometimes being passed to the Clinical Leaders' meeting for further discussion; same people but in a different forum. In this way, issues are essentially being passed 'over the wall' to another group rather than being taken forward in the present arena. From August 2001, there is a clear change in the style and tone of the minutes which coincides with the arrival of the Clinical Governance Facilitator; action points are clearly identified and responsibility assigned to a named individual; separate working groups are formed to address specific issues which need further action instead of these being passed on for further discussion elsewhere.

Although the Forum holds the specific clinical governance remit for the Division, there does not appear to have been a systematic process of translating the corporate clinical governance objectives into a comprehensive, local strategy. Although there is now a Divisional Development Plan which includes clinical governance objectives, the group does not have an integrated work plan that will enable it to fulfil its Terms of Reference in either the short or long term. As a group it had not defined its information needs or made explicit how it would relate to the Division as a whole or to the wider Trust/corporate clinical governance function. Neither has time been devoted to developing a clear sense of how the group will function in terms of internal dynamics or to making a considered assessment of the development/training needs either of the collective or of individual members.

Organisation development is not just about ensuring collective effectiveness but also that of individuals; this is important for all employees but particularly so where junior

staff are required to assume new responsibilities. The first Chair of the Forum was an H grade, part-time Clinical Leader who was not even present at the meeting when her name was drawn out of the hat. In adopting this approach, selection for this important role was based on a random act rather than careful consideration of the knowledge, skills and experience that would be required to discharge the responsibilities of the role, the time that would be needed and the administrative support required.

The initial plan to rotate the role of Chair at three monthly intervals was soon revised; it was decided that the present incumbent would remain but with the active support of the Division's newly appointed Clinical Governance Facilitator. Prior to this, there had been no provision for in-division support; the Chair did not meet on a one to one basis with the ADM and the routine meetings with her own line manager appeared to deal with the general business of the Locality rather than clinical governance per se.

Although the development needs of the Forum and its individual members is an important matter that needs to be addressed, this gap is consistent with the approach to a wider but connected issue of management development in general. Many of the Clinical Leaders were new to line management and yet there was no systematic assessment of their development needs which meant that, in some cases, junior staff were going on leadership courses before their managers. This was, for some, compounded by a sense of urgency to deliver which seemed to be reflected down the line. One manager reported that, on appointment, she was told she would need to *'hit the ground running'*. Another manager felt that her own inexperience was holding back progress in terms of delivering the service.

Within the Locality, the lack of deliberate action to implement clinical governance from the top of the Division is reflected closer to the front line services. Although the researcher did not come across anyone who had not heard the words 'clinical governance', it was difficult to determine how the corporate agenda was being operationalised at the professional-client interfaces. Given that there are no vehicles to deal explicitly with the translation of the clinical governance at the front line, there is a risk that any impact clinical governance may be having at the professional-client level is likely to be the result of individual rather than corporate or divisional initiatives.

8.6 CHAPTER SUMMARY

The purpose of this chapter has been to present a picture of clinical governance at the Divisional and local levels. It would appear that deliberate activity in relation to the implementation of this initiative has been a relatively recent occurrence despite the fact that corporately defined objectives for the Division have been in existence for some time. There appears to be considerable scope for further work around this agenda in the areas highlighted here and this has been recognised by key managers at the corporate level and also in the Division and Locality. It has proved rather difficult to use the Miles framework (1997) due to the lack of related activity in terms of both the 'what' and the 'how'. Instead, this chapter has tried to focus on the work around clinical governance that has actually taken place whilst, at the same time, identify some of the gaps. A full discussion of the results presented in all three chapters will now take place.

CHAPTER 9

DISCUSSION OF RESULTS

'The past is never dead. It's not even past'
(Faulkner, 1951)

9.1 INTRODUCTION

The aim of this case study was to describe in detail the experience of one NHS Trust as it implemented clinical governance. At the outset of fieldwork, clinical governance was still a relatively new concept; its emergence as a policy has been tracked in some detail in Chapter 1 of this thesis. Given this newness, the research design sought to capture what the Trust was doing to implement the concept rather than test this against some sort of blueprint. As a qualitative study, rich description is an essential component in the presentation of the findings and Chapters 6-8 have incorporated, as far as possible, direct quotations which bring the voice of the interviewee to the reader. Also, rather than merely relaying a sequence of actions, some degree of interpretation has been incorporated within the results to improve readability, an approach recommended by some authors on this subject (Patton, 2002).

In the absence of a blueprint for clinical governance, Trusts have been allowed to interpret this locally which is in sharp contrast to the NHS Plan (Department of Health, 2000) with its centrally-specified action sets and corresponding milestones. The Department of Health's approach to clinical governance seems more like the one adopted in an earlier experiment with Total Quality Management which took place at

the end of the 1980s - early 1990s. Although on that occasion a technical note was issued, during the course of the fieldwork it was apparent that the organisations had either not accessed this or chosen to disregard it because there was little evidence that it was being operationalised (Joss and Kogan, 1995).

Given the lack of clarity around the clinical governance concept, the Emerald Trust should be applauded for its courage in agreeing to take part in this research. The author was allowed unrestricted access and the Trust has not sought to edit or censor the write up. Consequently, the trial and error of clinical governance predicted by Lugon and Secker-Walker (1999) has been played out under the stark spotlight of an intensive and long-standing research process.

In the case of the previous NHS TQM experiment referred to above, just as with clinical governance, the Department of Health encouraged an eclectic approach to development in the hope that it would provide a rich source of initiatives for evaluation. This posed a particular challenge for those evaluating TQM as there was no definitive model depicting what needed to be implemented or how this should be achieved. Then, the researchers based their evaluation on a traditional model of TQM and also on the Trusts' own objectives. Faced with a similar situation, a similar approach has been adopted by this researcher. Although clinical governance is not explicitly depicted as Total Quality Management, the language and practice, where specified in the policy documentation, is redolent with that of TQM and implies total quality management or a whole system approach to quality if not explicitly named as such.

Owing to the lack of theoretical underpinning to the emerging clinical governance agenda, and despite the lack of a universally accepted theory of TQM, the TQM literature has proved a useful guide to what clinical governance might look like in terms of content or the 'what'. In light of the centrality of change to the notion of improvement, a variety of change management models have also been utilised to inform the 'how'; in particular Miles (1997), but also Kotter (1996), and Pendlebury and colleagues (Pendlebury, Grouard and Meston, 1998).

Given the rich description and the initial interpretation which have been included in the earlier results chapters, it has proved somewhat of a challenge to address this chapter and draw out significant issues without repeating large sections of that which has gone before. In addition, it has been important to remember that, due to the emergent understanding of the clinical governance concept, this study set out to be of a formative rather than summative nature and, in line with this, the researcher has played a helping role rather than that of arbiter of success or failure. Besides, the payback to the Trust for taking part was researcher input to the implementation process; the deal did not include judgement per se.

9.2 FACTORS WHICH PREDICT SIGNIFICANT MOVEMENT TOWARDS TOTAL QUALITY

In shaping this chapter, the author was strongly influenced by a sense of déjà vu given that clinical governance was not the first attempt to introduce a whole system approach to quality improvement into the NHS. Thus, in an effort to avoid succumbing to the *'collective amnesia'* described by Klein (1998), it seemed highly

appropriate to draw on the lessons learned from this past experience. As a result of this earlier experiment, Joss and Kogan (1995) offered 11 factors which they considered to be predictive of significant TQM movement (Table 9.1). These factors have been adapted and will be used as an umbrella framework to guide a discussion of some of the significant findings of this most recent case study concerning the implementation of clinical governance.

Table 9.1: Factors which predict significant movement towards total quality

1. Demonstrated senior management commitment and understanding ;
2. A well-developed and well-documented implementation strategy ;
3. Strong/persevering co-ordinator - board level appointment;
4. Structure overseeing implementation;
5. Comprehensive baseline assessment of service quality;
6. Early effort involvement of clinicians;
7. Sufficient funding for facilitators;
8. Standard setting only as part of strongly monitored CQI;
9. Comprehensive training;
10. Explicit strategy/resources for recognising and rewarding progress;
11. Organisational changes after evaluation.
Adapted from Joss and Kogan (1995; p151)

9.2.1 Demonstrated Senior Management Commitment and Understanding

Joss and Kogan (1995, p152) were of the view that demonstrated senior management commitment was *'of central importance'* to the successful implementation of TQM. This is echoed by others writing in relation to TQM implementation specifically (Saraph, Benson and Schroeder, 1989; Porter and Parker, 1993; Ahire, Golbar and Waller, 1996) and change in general (Kotter, 1996; Miles, 1997; Pendlebury, Grouard and Meston, 1998). Brown (1993) highlights the other side of this coin and comments that hardly any TQM failure is reported without the executive being

blamed in some way. He goes on to comment that although most are committed in their hearts, in practice, their employees will judge them by their behaviour and actions.

It is for the reasons stated above that Joss and Kogan (1995) emphasise 'demonstrated' commitment particularly as they found that management commitment to TQM at the pilot sites was rather less than impressive. The authors (ibid) speculated that the Department of Health's lack of any mandate to specify the leadership arrangements required for this experiment contributed to the situation regarding management commitment. In this matter, the Department's approach with the TQM pilot sites was in stark contrast to its current approach to clinical governance. Clinical governance is a *statutory duty* and the Department of Health has been explicit in the leadership and accountability arrangements surrounding this at the corporate level (1998). The consultation document (ibid) states that the Trust Board is accountable for the quality of services and that the chief executive is the accountable officer; the lead for clinical governance is to be a senior clinician. In this way there is no doubt where the ultimate accountability for clinical governance lies and, in addition, by stressing that clinical governance is the responsibility of all, the explicitness of ultimate accountability does not displace individual accountability within the clinical governance agenda.

The Emerald Trust clearly complied with the Department of Health requirements in terms of making the accountability arrangements explicit at the corporate level; however, it still faced the same challenge as all organisations currently

operationalising this agenda; namely how to *demonstrate* its commitment to clinical governance. Irrespective of individual commitment, it has been stated in a previous chapter that the minutes of the Trust Board meetings do not give a sense of any detailed debate around clinical governance generally or interrogation of the clinical governance reports in particular. Also, members not on the Clinical Governance Sub-committee seemed to take a pragmatic view that clinical governance was in the safe hands of their colleagues who served on this particular committee. Whilst this may indeed be so, it is surely the duty of the Trust Board to model the spirit of the consultation document in what has almost become a mantra - 'quality is everybody's business' - and consider explicit and tangible mechanisms by which the Trust Board as both a collective and as individual members may demonstrate its commitment. Otherwise, it risks sending a signal to the rest of the organisation that quality is only the business of some and can therefore be delegated.

The way in which clinical governance is operationalised locally will provide staff at the front line of service delivery with a view of how seriously the organisation is taking clinical governance generally and implementation in particular. At the time of the initial rapid appraisal in November 2000, five out of six divisions had established a local clinical governance forum; however, only two out of six had developed an action plan to take forward the Trust 'Clinical Governance Development Plan'. These early interviews with managers also suggested that little in the way of awareness raising (other than the Trust initiative) or specific clinical governance training had taken place in the divisions.

In effect, the Development Plan was not a living document within the organisation at that time. In the division which had not established a forum, it was acknowledged by senior managers that there had been little if any formal clinical governance activity in between the development of the Trust Plan and the formation of the local forum, a period of around 15 months. This supports the earlier findings of Joss and Kogan (1995) in that, where there was no local structure in support of TQM, little local progress with implementation was observed. In such circumstances, any perceived rhetoric-reality gap could erode confidence in the commitment of senior managers and lead swiftly to cynicism amongst front line staff; this and a sense of 'business as usual' was certainly evident from the focus groups undertaken as part of this latest research.

Joss and Kogan (1995) also argue that, before commitment can be demonstrated, there needs to be awareness and understanding. In many of the accounts of TQM implementation, this notion is clearly appreciated (Glover, 1993; Rand, 1994; Ghobadian and Gallear, 1994) and the most common approach to address this tends to be through workshops. The preferred sequence for education and training (Porter and Parker, 1993; Dale and Cooper, 1994) is to start with the senior executives of the organisation and then cascade this down towards the front line or what Mintzberg (1979) terms the operating core. The purpose of these workshops is generally to ensure that everyone has the same basic understanding of the initiative and also to provide an initial outline of the implications of clinical governance for participants.

There is some support in the literature for training to be carried out by managers from

one reporting level to the next and so on throughout the hierarchy in order to demonstrate commitment and translate understanding into action (Kanji and Barker, 1990). This is particularly important for those at the corporate level because executive behaviour sets the tone for the rest of the organisation and is even more desirable where there is a lack of clarity around the initiative which has been the case in both TQM and more recently clinical governance.

A workshop was scheduled for the Trust Board in the early days of implementation but this was subsequently cancelled. Unfortunately, it was to be a full two years after the publication of the Development Plan before this would be re-scheduled.

Such workshops as described above would have provided the Trust with a valuable opportunity to test the existing understanding of the Trust Board and provide the basic overview needed to bring all members to a similar level in terms of knowledge and understanding. This shared knowledge base should ideally have given the Board a clearer idea of what the new statutory duty of quality meant for them both as a collective and as individuals and, in doing so, provided an insight into the very significant and transformational nature of the change process that lay ahead. This in turn could have laid the foundations for the work to come namely the development of the strategic direction. It might have also allowed the Trust Board members to play a more active role in the shaping of the agenda, the commitment of resources in support of implementation, the identification of the information required to enable the effective execution of the statutory duty for clinical governance and ultimately ensured that the corporate body was in a position to challenge, if necessary, the nature

and rate of progress of this important initiative.

In reality, the role the Trust Board plays in relation to clinical governance is likely to reflect its role in terms of the Trust business generally and, in the case of the latter, some Trust Boards appear to operate as little more than 'rubber stamps' for the executive team (Carver, 1990). If Boards are to operate effectively, they need the knowledge and skills to do this and this requires *deliberate* attention to their development needs - induction in the first instance and ongoing development subsequently. The Non-executive Directors interviewed in this Trust were not satisfied by the arrangements for their induction although they had subsequently been on a number of training courses relating to their specific responsibilities. Also, as demonstrated above, as a corporate entity there had been no collective attention to the Trust Board's development needs in relation to clinical governance; this may have contributed to the fact that, as a collective, it did not challenge the implementation drift that was apparent during the research project.

An early assessment of the clinical governance knowledge base of the Management Team would have been eminently appropriate given the relative newness of this particular agenda and the complexity of implementing total quality per se (Kanji and Barker, 1990). It would appear that to assume a level of knowledge around quality management is risky; according to some (Dale and Cooper, 1994; Taylor, 1996; Yong and Wilkinson, 1999), many senior managers have merely a superficial understanding of TQM and that is often confined to the 'buzzwords'. According to Yong and Wilkinson (ibid), making such assumptions without a proper assessment of

development needs is unwise as they regard many of the 'roadblocks' to the successful implementation of total quality as having emanated from senior/middle managers - often because they feel threatened in some way by the initiative (Walsh, 1995).

The lack of a shadow quality structure to bridge the gap between the corporate level Clinical Governance Sub-committee and the divisional clinical governance fora inevitably meant that the Management Team needed to play a central role in the implementation of clinical governance for several reasons. Firstly, as Divisional Managers, they were essentially responsible for turning the corporate objectives into local objectives and subsequently ensuring the operationalisation of these within the divisions. Secondly, most of the Divisional Managers had a relatively high level of visibility within their area of responsibility and thus their response to the clinical governance agenda would ultimately set the tone for the staff. Given the value of behaviour over words in demonstrating commitment to the clinical governance agenda, it was, therefore, important that they model the appropriate response through local action (Brown, 1993; Katz, 1993; Shea and Howell, 1998). However, the degree to which Divisional Managers took forward the clinical governance agenda was extremely variable and, as indicated earlier, lack of deliberate action in one particular division seems to have signalled a 'business as usual' approach which cascaded down through the hierarchy to the front line. In reality, whilst some of the senior managers did indeed have a good understanding of the agenda, others were less fortunate but, despite this, the Management Team was expected to *'get on and do it'*.

The experience of this Trust appears to add weight to Joss and Kogan's earlier

assertion (1995) that an important precursor to commitment is an understanding of the principles of quality management and what is expected of the individuals involved. In addition, in order to avoid the cynicism which may arise from any perceived rhetoric-reality gap, the words need to be reflected in action. One vehicle for making explicit both the words and the action required for implementation is the strategy and this will now be considered.

9.2.2 A Well-Developed and Well-Documented Implementation Strategy

Corporate strategy is the main vehicle for making explicit the vision of the organisation, the objectives that will deliver this vision, the people and other resources required in its delivery and the time-scales by which the objectives are to be achieved. The way in which clinical governance is conceptualised within this vision will determine the scope and scale of the change involved in its implementation; for many organisations, this will/should represent a transformational, frame-breaking change rather than more of the same. Strategy in transformational change is vision-led (Miles, 1997). This is largely because the future state is either not clear or, perhaps because of the nature of the change, it is unknowable. In such circumstances, it is easier to understand why the implementation of total quality is often referred to as a journey rather than a destination (Dale, 1994). In this uncertain environment, the vision acts as a compass outlining the general direction whilst the strategy becomes a map of the route to be taken.

The Trust's vision does not suggest that clinical governance has been conceptualised as TQM; albeit TQM by another name. In fact, although the term 'quality' is

mentioned frequently, there is no explicit statement within the two key Trust documents of what constitutes 'quality'. As the literature review in Chapter 3 has demonstrated, the notion of quality is often contested; thus an insight into the Trust's conceptualisation of this core element of clinical governance might have served as a useful starting point. The recurring theme within the Trust approach is 'learning' - learning from problems that have arisen and learning from new knowledge that is generated from within or outside of the organisation. This is subsequently reflected in many of the 'what' elements of the Trust clinical governance implementation outlined in Chapter 6; examples include the introduction of the Significant Clinical Incident Review process and the development of the library and knowledge resources. The aim of the Trust is to generate and capture the learning with the intention that this will deliver improvement. However, the national experience of existing quality improvement systems such as clinical audit and risk management is that this knowledge does not always lead to a closure of the loop and the implementation of the change and improvement required (Berger, 1998; Walshe and Dineen, 1998). The Trust has recognised the potential for the lack of action described above and built into many of the new systems a review process to determine whether change is actually taking place.

The Significant Clinical Incident Review process is a particularly important example of the above and it also highlights an attempt by the organisation to signal a change in *'how we do things here'*. The Review process aims to get to the root causes of problems and take remedial action which addresses the whole system. The Trust regards this as a very positive advance as this did not tend to happen before, at least

not in such a systematic way; however, the Significant Clinical Incident Review process is yet to be incorporated within the wider risk management system. Valuable as such initiatives are in themselves, they are yet to be encompassed in an integrated framework for quality improvement; also a common problem for both the NHS TQM pilot sites (Joss, Kogan and Henkel, 1994; Joss and Kogan,1995) and the Norwegian sites (Øvretveit, 1999; Øvretveit and Aslaksen, 1999).

Whilst 'learning' is important, when trying to implement improvement it is essential that the learning process is regarded as a means to an end rather than the end in itself. For this reason, perhaps it would be more appropriate to focus on the goal of CQI and develop a vision which describes what this might look like in practical terms. In this, the guidance from the Department of Health (1999, p11) is informative, at least in relation to front line staff:

> *'It must be recognised, however, that the practice of clinical governance at service level - clinical teams analysing and assessing the quality of their services and seeking ways to improve them - will be a multi-disciplinary and often also a multi-agency activity'.*

The picture presented above captures a flavour of CQI at the operating core; groups focused on processes in an effort to improve them. What is also needed is a vision of CQI at the corporate and middle levels which brings the whole organisation at each level of the hierarchy into alignment and thus creates an environment so that the front line may, indeed, operate in the way described above. This notion of alignment is emphasised throughout the TQM and the change management literature and plays an important role in ensuring the consistency needed for a successful change process (Miles, 1997; Pendlebury, Grouard and Meston, 1998). For instance, in one division

of the Trust, the vehicle for quality improvement had historically been the standard setting process and there was a strong desire locally to re-establish the standard setting groups. However, this may not be an appropriate way forward in the absence of any other quality improvement structure at locality level. Joss and Kogan (1995) recommended that standard setting should only be part of a broader CQI approach. Their rationale is based on the observation that standards tend to be set but neither audited in terms of compliance or revisited/revised in a timely manner - hardly consistent with the dynamic nature of CQI.

The lack of a central blueprint for clinical governance has meant that Trusts have been left to interpret the concept for local application and the action set outlined in the Trust Development Plan reflects a vision of clinical governance derived in this manner. In its present form, the Development Plan is not explicitly geared to deliver a whole system approach to CQI and is therefore unlikely to achieve this with the present focus. What is evident from the case study is that some of the quality assurance elements are being put in place (reporting mechanisms etc); nevertheless, whilst a CQI model may yet emerge, this was not apparent during the fieldwork period.

Total Quality Management requires a strategic approach to quality management (Walsh, 1995); for TQM to be considered a priority and receive appropriate funding, CQI must be part of the corporate plan (Davis, 1997). Both of these statements might be considered equally applicable to the implementation of clinical governance. In addition, there needs to be a focus on the core processes which constitute the business

of health care and an ability to address both positive and negative quality. Positive quality is regarded as proactive and is about adding value in the absence of any identified problem. Negative quality is seen as reactive. It is usually a response to complaints, incidents etc, and in this way focuses on dealing with the cost of poor quality - that is putting right what should have been right first time (Zairi, 1994). The strategic approach to total quality must recognise and deliberately address both of these elements; unless there is a commitment to strive towards positive quality and CQI, an organisation may find itself trapped in a reactive spiral of fire-fighting and problem orientation.

Whilst the design and development of strategy is important, implementation is everything. Without the implementation process, plans stay as words on paper and it is often the process of getting them off the paper which is the most problematic (Glover, 1993). As Sproull and Hofmeister (1986) commented, implementation is not sexy, it is about the nuts and bolts of getting something in place. Although the Trust Development Plan outlined an ambitious action set of 39 objectives (36 of which were either ongoing or to be achieved in year one), it did not appear to be a living document within the divisions even 12 months after its publication. Indeed, only two out of six divisions had any form of local plan of action for clinical governance despite there being some very explicit objectives specifically for these areas of the Trust. Rather than a sense of dynamic goal deployment, there was evidence of a general implementation drift having occurred despite a number of important initiatives having been put in place (Chapters 6-8).

In reality, although milestones indicated a timescale for the achievement of the objectives, there was little in the way of an explicit emphasis on the main priorities. Although progress against the Development Plan was reported to the Clinical Governance Sub-committee, the implementation drift continued throughout the first 12 months at least. Also, despite the fact that many of the objectives had resource implications, the Plan was not explicitly costed.

In essence, despite the scale and scope of the implementation process, a project management approach was not adopted; in fact there was even a sense that this would be contrary to the prevailing culture. Although clinical governance is not a discrete project, there are elements of the implementation process that clearly are. Several TQM practitioners strongly advocate the adoption of a project management methodology (Dale and Cooper, 1994; Stamatis, 1994). Given the stress placed upon the active management of change and total quality (Oakland, 1995; Kotter, 1996), it could be argued that project management could also provide a valuable underlying structure for clinical governance implementation in that each aspect of the management process is emphasised.

A project management approach may have helped this Trust in a number of ways. In addition to identifying objectives, costing these would have likely forced explicit prioritisation; although, ultimately quality might be free (Crosby, 1979), it is recognised that the introduction of CQI involves set up costs (Porter and Parker, 1993; Joss and Kogan, 1995) which need to be resourced appropriately. The allocation or re-allocation of resources is considered to be a powerful signal of what

the organisation considers important (Miles, 1997). Whilst the Trust did invest in terms of the executive lead post, it failed to allocate specific resources at the outset for the Clinical Governance Development Team. This delayed its formation for almost two years despite the fact that it is generally advocated that the facilitation of large-scale change generally needs to commence at the outset and remain ongoing (Joss and Kogan, 1995; Miles, 1997; Pendlebury, Grouard and Meston, 1998).

The need to allocate resources could also have eased the process of identifying the 'critical few' in terms of objectives and thus facilitated a move to phasing implementation rather than having a large number of objectives to be achieved/commenced in year one - as Miles (1997, p48) comments *'the new internal context of the organisation does not emerge in a moment of cosmic creation'*. The Department of Health has also recognised that phased implementation would be required in accordance with the resources available (Department of Health, 1999); an approach which receives support from the wider TQM literature (Yusof and Aspinwall, 2000a). In this way, the Trust could have produced some tangible, early 'wins' which included *positive* quality (Miles, 1997; Pendlebury, Grouard and Meston, 1998); thereby emphasising the proactive aspects and reinforcing the belief that clinical governance is achievable rather than something so big as to almost induce the sort of management paralysis that can be associated with TQM (Dale, 1994). Also, the focusing of resources for delivery could also serve to emphasise the commitment of senior management to the clinical governance objectives. Contrast this approach with the reality of clinical supervision in the Primary Care Division where some staff reported problems attending because of clinical duties. Where situations such as

these remain unresolved, there is a risk that the organisation inadvertently sends a signal to staff that clinical supervision is not a high priority for the Trust despite its continued encouragement of staff to take part.

According to Yusof and Aspinwall (2000a), one of the most influential factors in the successful implementation of total quality is the development of a sound implementation plan before embarking on the change process. The potential benefits of utilising a model or framework to guide implementation have been discussed in the earlier chapters of this thesis. Motwani and colleagues (Motwani, Sower and Bashier, 1996) highlight the fact that much of the implementation of total quality in health care is not based on any specific implementation guidelines *'except for those in directives'*. The authors (ibid) consider the use of a model/framework to be a necessity if the effectiveness of the implementation effort is to be improved. The use of an overarching implementation framework such as the one developed by Miles (1997) could serve to make explicit the elements of both 'what' and 'how' and in this way force managers to address issues that might be avoided either deliberately or through oversight (Yusof and Aspinwall, 2000a). Certainly, utilisation of the Miles framework (1997) would have highlighted to the Trust the gaps in what Miles has termed the 'process architecture' (Appendix 2).

The elements which constitute the process architecture are apparently quite commonly overlooked; both the TQM and the change management literatures abound with examples of this. Unfortunately, these elements are considered to be the ones that will 'orchestrate' the transition from the present to the future state. A consistent

message amongst practitioners of change management is the need to take a holistic approach and omitting elements will have negative results (Kotter, 1996; Miles, 1997; Pendlebury, Grouard and Meston, 1998). This tends to support the argument for a well-formulated implementation framework albeit one that serves as a guide rather than a prescription.

9.2.3 Comprehensive Baseline Assessment of Service Quality

Joss and Kogan (1995) found that few of the TQM pilot sites had undertaken what they described as pre-implementation diagnostics; this led to a lack of clarity about the exact starting position of the organisations in relation to TQM. The lack of any clear view of the quality systems already in place obviously had implications for planning and, in particular, decisions about what needed to be reinforced/changed in order to implement the initiative. The subsequent measurement of progress was also impeded by this general failure to obtain an accurate picture of the pre-change position.

The omissions described above are apparently not uncommon and a number of authors have commented on the propensity for managers to either by-pass or only address superficially this important activity; alluding to a preference for action rather than careful diagnostics and planning (Dale and Cooper, 1994; Anderson and Ackerman-Anderson, 2001). Interestingly, the guidance on clinical governance issued by the Department of Health (1999) included the need for a baseline assessment in its 'must do' list. The guidance also provided a clear indication of the areas that Trusts need to address as part of this assessment: the effectiveness and

integration of existing systems for quality improvement (such as clinical audit), the quality of existing data for monitoring quality activity, the identification of problematic services, the degree to which existing strategies (HR, IM&T etc) support the clinical governance agenda. In addition, it was also made clear (Department of Health, 1999, p17) that the findings of the assessment should be shared within the organisation:

> *'The baseline assessment should let the whole organisation see what it is good at, what it is less good at, and the areas needing to be developed'.*

So, it seems from the above, not only is the baseline assessment required for planning purposes but the findings should also be communicated to a wider audience than those involved directly in the development process. Although it was reported that the Trust had undertaken a baseline assessment, it proved difficult to determine what had been included in this process, how it had been conducted and the findings in detail. Although the 'Clinical Governance Report' made a broad reference to a number of areas that needed attention, the findings were not presented in any detail in either of the two key Trust documents neither, according to the minutes of the meetings obtained by the researcher, does this appear to have been discussed in depth at the Trust Board. Thus, although the Trust Development Plan presents the objectives to be achieved, it is not possible to link these directly to the current state of the areas prescribed within the guidance (Department of Health, 1999).

This lack of detail does not just have implications for the planning and monitoring processes but is also likely to have implications for other aspects of implementation. Kotter (1996) describes the need to create a sense of urgency whilst Miles (1997)

talks instead about confronting reality. Each approach is intended to increase the ability of the organisation to create the energy needed to make the transition from the present to the desired future state. However, the absence of a detailed baseline assessment or any formal external benchmarking did not seem to affect the sense of urgency of the Clinical Governance Sub-committee, at least at the outset. Although the risk of paralysis when faced with the notion of implementing a whole system approach to quality improvement is well documented (Dale, 1994), the Sub-committee was very keen to make a start. Whether the level of baseline information available was sufficient for the Sub-committee to fully appreciate the reality of its starting position is perhaps an issue for the Trust to consider. Given a clearer picture of the effectiveness and coverage of existing systems such as clinical audit, risk management, appraisal, and perhaps knowledge of the work taking place in other Trusts, the strategy may have looked rather different. The Sub-committee may have decided to focus initial efforts on addressing gaps in the existing systems in an effort to provide a solid foundation for further development rather than setting up new processes within these systems as was generally the case.

In the earlier review of the clinical governance literature (Chapter 2), details of one Trust's devolved approach to baseline assessment was briefly outlined (Holland and Fennell, 2000). In this case, directorates across the Trust undertook a self-assessment against a selection of pre-determined criteria. This informed local clinical governance action plans and also the corporate plan. Locally, it focused attention on the issues to be addressed and, in the authors' view (ibid), this process fostered local ownership of the objectives. It is unclear how the divisions within the Emerald Trust

were involved in the baseline assessment but, almost 12 months after the appearance of the Development Plan, the rapid appraisal found that none had undertaken an assessment of the effectiveness of their existing systems. Although, when eventually produced, the Primary Care Division Plan included objectives relating to existing systems, these were still not based upon a systematic review and this omission may have contributed to the rather fragmented nature of the Divisional Plan.

Another important reason for undertaking the baselining work referred to here is the need to make a careful assessment of the existing organisational capacity to pursue the intended change. Miles (1997) argues that organisations that find themselves with a high level of resource *and* a high capacity for change are in the minority and those with low resources and low capacity should not embark on the change unless this situation can be successfully remedied. Spurgeon (1999) makes a similar point and observes that many health care organisations are not in a position to undertake transformational change and asks whether commercial organisations facing similar circumstances would embark on this; the author (ibid) concludes that they would not. However, in the case of clinical governance, its status as statutory duty essentially means that implementation is not optional and the establishment of the Commission for Health Improvement to review progress reinforces this message. Where capacity and resources are not high, Trusts will need to consider such issues carefully and take a deliberate decision regarding prioritisation and phasing in order to increase the likelihood of successful implementation. Related to this theme of 'first things first', one of the areas which normally receives early attention during organisational change in general (Kotter, 1996; Miles, 1997) and clinical governance in particular is

structure (Latham, Freeman Walshe et al, 2000) and this will now be considered.

9.2.4 A Structure to Oversee Implementation

Structure is defined by Miles (1997, p36) as: '*the formal structural arrangements of the organisation that delineate its basic units of authority and accountability*'. Expressed in another way, the structure provides a framework of order and command through which the process of management in terms of planning, organising, directing and controlling may be applied (Mullins, 1999). Thus, structure is regarded as an important design feature in the implementation of transformational change generally (Miles, 1997) and quality improvement specifically (Oakland, 1995). The TQM experiment demonstrated that, in Trusts with no structure below corporate level, implementation was observed to be poor (Joss and Kogan, 1995).

An important consideration in the implementation of total quality is whether the structural design should reflect a 'shadow' or 'line' structure. Neither choice is apparently without its problems. A shadow structure risks creating/reinforcing the perception of quality as the responsibility of the quality function; however, where the responsibility for implementation rests within the existing line management arrangements, there is a risk that the quality agenda will be displaced by day to day activities (Dale and Cooper, 1994). Joss and Kogan (1995) found that where implementation was left to the line managers, there tended to be less progress achieved. Consequently, the authors (ibid) recommend that a shadow structure should be established initially but with a view to integration within the line as the initiative becomes more established operationally. Irrespective of whether the

initiative starts with a shadow or line arrangement, there is support for the proposition that responsibility for the management of quality should rest within the line management remit (Brown, 1993; Davis, 1997).

Both of the issues raised above were apparent in the Emerald Trust. There was a perception that the Clinical Governance Lead was responsible for driving the agenda. The corollary of this seems to have been that several of the areas which did not receive her personal attention did not necessarily move forward at the same pace as others. Also, the lack of a forum in one division corresponded to a lack of specific clinical governance activity in this area. Although managers locally were aware of the clinical governance agenda, until the Forum was established, there did not appear to be a vehicle to take it forward. In the absence of a specific structure for clinical governance, there was no evidence that the existing line management arrangements naturally incorporated the requirement to implement this initiative.

One important gap that needs to be addressed by the Trust is the lack of a quality structure below the divisional fora. This may take the form of process improvement teams, quality improvement teams or quality circles (Oakland, 1995) and, given their absence at the case site, one must question how CQI is to be operationalised by clinical teams. Although, as discussed earlier, this is not evident in the Trust vision for clinical governance, it is an explicit feature of the Department of Health thinking and highlighted in the guidance (Department of Health, 1999). Without a vehicle for improvement, initiatives at the front line risk being piecemeal (Walsh, 1995) and/or do not reflect corporate objectives which may ultimately limit the chances of

resources being released to ensure success.

In reality, clinical governance structure at the Emerald Trust appears to be a mixture of shadow and line. There are explicit forums for clinical governance at the corporate level (the Clinical Governance Sub-committee) and at division level (the divisional fora); between these two levels, there is the line function in the form of the Management Team. Although it was implied in the Development Plan that Divisional Managers have a key role to play in the implementation of clinical governance, it was not explicitly stated that Management Team would be the main vehicle through which this agenda would be operationalised - it was merely assumed that this would take place. In reality, the extent to which the Management Team as individuals have taken the Development Plan forward has been variable. Although clinical governance issues are taken to Management Team by the Clinical Governance Lead, the minutes of these meetings do not reflect a collective operational responsibility for managing the change process associated with clinical governance. Thus, under the current arrangements, a lack of clarity around the lines of accountability and authority at divisional management level and below appears to have created something of an operational vacuum.

The structural gaps described above have implications for all aspects of the management process. The minutes of the Clinical Governance Sub-committee are not routinely circulated to the Management Team and, until the chairs of the divisional fora became members of the Sub-committee, the minutes were not routinely received by the divisional groups either. This gap has important implications for the

effectiveness of quality policy deployment and thus the likelihood of goal congruence and alignment (Krishnan, Shani Grant et al, 1993; Zairi, 1994).

In addition to the above, there is also the question of accountability and control, both of which are important core elements of clinical governance. Although the Clinical Governance Lead has a clear overview of the progress of clinical governance implementation throughout the Trust, this is not actively monitored by Management Team and consequently this function rests with the Clinical Governance Sub-committee and ultimately the Trust Board. However, both the Sub-committee and the Trust Board are presented with a mixture of detailed operational data and information relating to performance against the Development Plan which tends to be stated in broad terms reflecting the way in which the initial objectives were formulated.

To enable the Clinical Governance Sub-committee to perform this monitoring and control function and for the Trust Board to be assured that this is being carried out, it would seem that the form and content of the quarterly reports may benefit from further consideration in terms of appropriateness and usefulness. Information is an important determinant of the effectiveness of Trust Boards and finding the right balance of providing enough detail to enable members to take a proactive approach without 'drowning' them in data is recognised as an on-going challenge (Audit Commission, 1995).

Data as opposed to information can obscure rather than enhance the picture presented. The reporting mechanism currently in place does not seem to have led either the Trust

Board or the Clinical Governance Sub-committee to challenge the fact that one of the divisions had not established a forum until 15 months after the publication of the Development Plan or to question the presence of a general implementation drift. This may be partly accounted for by the quality of the information but there is also an issue of the nature of the control system in place to deal with any sub/non-implementation.

Where there was a lack of action, the Clinical Governance Lead approached this on a one to one basis and, in this way, corrective action appeared to rely on her influencing skills rather than any formal control mechanism. Given the centrality of accountability to the notion of clinical governance, this is an area which the Trust perhaps needs to address. Why this lack of a formal control function is allowed to continue is unclear. This is not just a feature of the executive level but relates to management at all levels within the hierarchy. As was the case in the earlier the TQM experiment (Joss, Kogan and Henkel, 1994; Joss and Kogan, 1995), the individual objectives for managers within the Emerald Trust did not contain specific objectives relating to the clinical governance agenda other than perhaps the need to undertake appraisal of subordinate staff.

Perhaps the above is a manifestation of the high trust culture operating within the senior management tiers. Trust is an important element in all organisations but it is especially so where there is a high level of professional judgement required which is often the case in health care. Davies and Mannion (1999) argue that the establishment of trust and control is not an either-or decision. Trust without a control function may lead to the creation/maintenance of a dependent relationship between

the organisation and those who will deliver the services. Instead, the authors (ibid) suggest that the challenge lies in *'finding the balance between checking and trusting'*. The advent of clinical governance and corporate accountability for quality means that *assuming* certain action is taking place is no longer enough; systems need to be in place that will not only demonstrate this is so but also that the appropriate remedial action has been taken where necessary.

Given the scale and scope of change which has accompanied the 1997 White Paper (Department of Health) and the NHS Plan (Department of Health, 2000), it is reassuring to see the emphasis that is being placed on effective leadership and the action being taken to make this available to the NHS. Whilst acknowledging the importance of leadership, there are those who are also cautioning that management must not be forgotten in the process (Spurgeon and Latham, 2003). Neither total quality or change will 'just happen', both must be actively managed (Oakland, 1995; Kotter, 1996). Kotter (ibid) suggests that the leadership/management notion is a both/and situation rather than either/or, having argued in an earlier publication that leadership and management are different conceptually and in practice (1990). Structure plays an important role in the effectiveness or otherwise of both leadership and management. Drucker (1989, p223) argues that a good structure does not guarantee a positive performance but a poor structure *'makes good performance impossible'* irrespective of how good individual managers may be.

Having considered the issues surrounding structure and clinical governance in the Emerald Trust, the next section will continue with a similar theme - namely the

establishment of a vehicle for co-ordination and facilitation.

9.2.5 Strong/Persevering Co-ordinator – Board-level Appointment

Joss and Kogan (1995) found that most of the Trusts in their study had appointed a manager or co-ordinator to take the total quality initiative forward but generally these posts were set too low within the hierarchy. In view of this, the authors (ibid) recommended that this post should be a board-level appointment - a recommendation which is clearly reflected in the Department of Health requirements for clinical governance (1998).

Earlier research (Latham, Freeman, Walshe et al, 2000) found that the post of clinical governance lead tended to be a jointly held appointment of the medical/nurse directors and that the majority had little or no dedicated time to carry out this role. In contrast to the above, the Emerald Trust created the executive post of Director of Clinical Governance which has meant that most of the Lead's responsibilities are concerned with the discharge of this wide-ranging remit. This particular director, in addition to a clinical background, has also played a strong operational management role within the Trust and seemed to be perceived as a credible lead throughout the organisation.

The appointment of an executive clinical governance lead was regarded at the corporate level as a powerful signal of its commitment to the clinical governance agenda; however, as in the case of TQM, this has not eased the process of translating corporate commitment into commitment and ownership locally. Although there was

no evidence of managers breathing *'a sigh of relief because there was no longer a need to worry about this quality stuff'* (Brown, 1993), there was certainly a variability in the proactiveness of their approach - and some evidence that this was due to the fact the Clinical Governance Lead seemed to be on top of the agenda. Whilst having provided a strategic lead in terms of clinical governance, the Lead was nevertheless becoming increasingly embroiled in operational detail. The lead took forward all of the Significant Clinical Incident Reviews and, as Chair of the Risk Management Team, was increasingly leading on risk management issues. A number of elements relating to the implementation process could be contributing to this increasing entanglement with the operational side of implementation and these will be now be considered.

Firstly, against each of the objectives outlined in the Development Plan there is a schedule of responsibility, however most of these are set against multiple 'key players'. Identifying each person/group with a responsibility is important but seems to have left the Clinical Governance Lead with the task of co-ordinating the activity involved in reaching each of these goals across all of the six divisions. Alternatively, in addition to each individual manager being assigned responsibility for the local implementation of each objective, a Divisional Manager could have been identified as co-ordinator for several objectives with the remit to take these forward across the divisions. The Clinical Governance Lead would then have been free to retain an overview and influence progress. At the same time, the Lead would be able to devolve some responsibility, directly engage the Divisional Managers and streamline the implementation and monitoring of the process.

Secondly, in the absence of an operational group to support the clinical governance implementation process, there was little opportunity for the Clinical Governance Lead to delegate. The issue of delegation related not only to the objectives discussed above but also to those activities that would normally be the remit of more junior staff such as the preparation of agendas, responsibility for minutes and the general servicing of the various committees. In addition, the lack of a comprehensive risk management function led to a situation where the Clinical Governance Lead increasingly assumed responsibility for operational aspects of risk management almost by default.

Thirdly, a related but rather different issue is that of line management. In the absence of a direct line of management to those tasked with the implementation of the Development Plan, the role of the Clinical Governance Lead was inevitably one of influencing rather than directly managing. This is consistent with the sort of 'shadow' arrangements that are evident in certain models of total quality (Oakland, 1995) and change management (Pendlebury, Grouard and Meston, 1998) initiatives; however, in the absence of strong monitoring and control mechanisms, this could, as perhaps in this case, contribute to a degree of implementation drift.

Finally, the provision of facilitation and support are important factors in the effective implementation of total quality (Glover, 1993; Rand, 1994; Oakland, 1995) and large-scale change generally (Miles, 1997; Pendlebury, Grouard and Meston, 1998). It is important that this is available throughout the initiative and particularly in the early stages when there is the risk of managerial paralysis (Whalen and Rhamin, 1994; Dale, 1994). This may be due to a limited understanding of the requirements of

quality management (Dale and Cooper, 1994; Yong and Wilkinson, 1999), or simply because of what some consider to be 'a fact of life' - that employees will give more attention to the activities for which they are actively called to account (Dale and Cooper, 1994). Whilst some managers were able to pick up the clinical governance agenda and start taking it forward, others found this more problematic and did not move forward until they had received assistance.

Pendlebury, and colleagues (Pendlebury, Grouard and Meston, 1998) suggest that facilitators may play a valuable role as catalysts and in the Emerald Trust they could probably have done much to clarify issues of local responsibility and accountability. Through the provision of content and process expertise, the Clinical Governance Development Team might also have helped in the translation and implementation of the corporate objectives into the divisional setting. Accompanied by stronger collective monitoring and control at the corporate level, the spotlight would thus have focused very clearly on the responsibility of the divisions for delivering the clinical governance agenda.

The Trust recognised, early on, that the divisions would need assistance - some more than others. However, it was to be almost two years before the Clinical Governance Development Team was fully established. During this time, some of the facilitators made positive contributions to the divisions; other part-time members found their role rather more difficult to discharge. In this, their experience was similar to that of others elsewhere (Joss and Kogan, 1995); trying to work for the Team part-time, members found that this activity was generally displaced by the demands of their

other role. This situation may have been avoided if, as suggested earlier, explicit priorities had been set at the outset and funding allocated to ensure that the facilitation had been available.

It is worth noting that the appointment of a facilitator to the Primary Care Division brought immediate, observable added value to the implementation process. Amongst other things, the Clinical Governance Facilitator ensured that the discussions within the local Forum resulted in clearly minuted action points with deadlines for completion and the identification of a member of the group as lead/manager responsible. In addition, there was the creation of working groups to explore issues outside of the meeting and a requirement to report back to the Forum at a later date. This approach meant that issues that could not be addressed immediately would remain within the remit of the Forum rather than 'going over the wall' to another group such as Clinical Leaders and risk falling into the 'white space' between the various groups.

The Trust's appointment of a Clinical Governance Lead to such a senior post is to be applauded; however, the Trust will need to address the current operational gap so that the Executive Director may continue to take a strategic view and play a leadership role. This will be essential in order to avoid the initiative degenerating into a *'list of confusing projects'* (Yong and Wilkinson, 1999) and/or the Executive Lead becoming submerged by operational and administrative issues that essentially could and should be delegated elsewhere.

9.2.6 Early Involvement of Clinicians

Over a decade ago, Berwick (1989) warned:

> *'Quality improvement has little chance of success in health organisations without the understanding, the participation, and in many cases the leadership of individual doctors'.*

Joss and Kogan (1995) remarked on what was considered to be a significant lack of involvement of consultant medical staff in the pilots which they described as a *'serious blow to the credibility of TQM'* (ibid, p107). In the Emerald Trust, the largest group of medics were employed in mental health and learning disabilities and both specialties were represented by a consultant on the Clinical Governance Sub-committee.

Although, some might see the medical consultant as *the* key stakeholder in terms of the clinical governance agenda in an acute unit (Hackett and Spurgeon, 1999), the sheer diversity of the clinical workforce in a combined trust such as Emerald perhaps challenges this notion in this context. It is interesting that, apart from the work on consultant appraisal that was being taken forward by the Medical Director, the initiatives highlighted in Chapters 6 and 7 do not reflect any significant corporate engagement with the medics as a specific target group. Whether this has had any impact on the progress of the mental health and learning disability divisions was not explored explicitly as the focus shifted to the Primary Care Division which employs few medics.

A review of the implementation activity outlined in earlier chapters suggests that apart from the early awareness raising sessions and the risk management workshop

much later in the process, there was little in the way of formal initiatives undertaken to engage clinicians in the clinical governance agenda. Whilst new approaches such as Significant Clinical Incident Review had been introduced, a number of managers felt that staff did not see this as part of the Trust clinical governance approach per se. In fact, some of the managers did not see that the recommendations arising from these reviews could have any relevance in areas other than where the incident actually occurred; this was not necessarily the case.

Interestingly, the conflict between business and clinical approaches to quality described by Pollit (1996) was not apparent; perhaps this is not surprising because, as suggested earlier, the Trust vision of clinical governance had not been conceptualised as TQM and CQI. Instead, the main tools for its operationalisation related to clinical audit, risk management and so on rather than cross-departmental/divisional quality improvement teams using specific process improvement methodologies. Certainly, in the Primary Care Division, there did not appear to be any vehicle to take forward CQI in a systematic manner and, unfortunately, although improvements to services were taking place, this did not appear to be the result of a systematic approach to quality improvement but often the outcome of individual interest and effort - a situation also found at many of the TQM pilot sites (Joss, Kogan and Henkel, 1994; Joss and Kogan, 1995). In fact, there was a sense of 'business as usual' amongst interviewees at the front line of service delivery.

Yong and Wilson (1999) found that confusion over what TQM meant in practical terms was an important barrier to implementation. Any assumption that the Trust's

clinical governance Development Plan was diffusing naturally towards the front line staff seems to have been unfounded. In reality, although some of the clinical staff interviewed had a good grasp of clinical governance in principle, others demonstrated the sort of confusion found by the authors above (ibid). In the absence of an organisation-wide training initiative, it is difficult to see how significant commitment and involvement will be secured from front line staff.

9.2.7 Comprehensive Training

According to Oakland (1995, p26), the message for implementation is '*train, train, train, train and train again*' and the importance of education and training to the effectiveness of implementation is echoed by others. Although there appears to be some consensus that wholesale awareness raising is an important first step (Davis, 1997), more specific training in terms of both knowledge and skills needs to be targeted at teams that will work together to solve real quality problems (Mann and Kehoe 1995). In the absence of this 'just in time' approach, there is a risk that training and education will take place in a vacuum; the knowledge gained quickly dissipating unless employees are able to utilise this directly and become involved in quality improvement activity (Dale and Cooper, 1994).

Joss and Kogan (1995) recommend a mixture of classroom education and workplace application and this is now the approach adopted by the recently formed national Clinical Governance Support Unit. The TQM experiment (ibid), highlighted a significant difference between the amount of training provided at NHS and commercial sites. The experience of the latter demonstrated that the provision of

adequate training required a serious commitment in terms of funding so that appropriate trainers could be engaged and also so that staff may be released from daily responsibilities. In practice, few of the pilot Trusts progressed beyond awareness raising; apart from the opportunistic, localised contacts of members of the Clinical Governance Development Team and the work around appraisal, this was also the case at the Emerald Trust.

The provision of the necessary knowledge and skills to deliver the clinical governance agenda is essential. The complexity of the change means that a wide range of issues need to be addressed from the principles of clinical governance through to the tools to deliver this agenda. This latter includes both the theoretical and technical aspects of existing systems such as clinical audit and risk management through to change management, team dynamics and interpersonal skills. Any programme should be based on a thorough assessment of the education and training needs of staff. As Firth-Cozens (1999) discovered, these requirements will inevitably vary; it is, therefore, not prudent to assume that even senior clinicians in management will have the same skills as senior managers without a clinical background - they have inevitably followed a different route to the top.

Neither should it be assumed that, because systems such as risk management and clinical audit are not new to the NHS, clinicians have the skills to undertake this activity. This current study has highlighted this as a gap in certain areas of the Trust; however, it has been interesting to note how the increased attention being given to clinical audit by the clinical governance agenda has led to calls for training from front

line clinicians in the Trust. Similarly the increased corporate focus on appraisal has meant that managers must now appraise all staff and this requirement has been incorporated into their individual objectives. However, the managers must demonstrate that they have attended training before undertaking this activity which has led to a considerable increase in demand for training in this area - so much so that it is proving difficult for the Trust to meet the demand in a timely manner. In contrast, courses in clinical incident reporting, not part of the IPR, are being cancelled because of lack of uptake. This seems to add some weight to the adage 'what gets measured gets attention' and highlights the need for training and development to be linked to a robust system of individual performance review; this is yet to become established on a Trust-wide basis.

The earlier discussion around structural issues touched on the importance of information flows to the effectiveness of teams/groups but, as alluded to above, issues around knowledge and skills, team dynamics and so on also play an important role. In reality, effective teams/groups do not 'just happen' and deliberate effort needs to be directed at facilitating this process (Dale and Cooper, 1994). Members of committees do not automatically have the experience and/or skills to add value in these arenas (Katz, 1993). Despite this, there is a perception amongst some interviewees that they have been left 'to get on with it' and this seems borne out by the fact that no formal development work has taken place with new or existing groups either as collectives or with individual members. This is something that the Trust needs to reconsider given the number of new groups associated with clinical governance, the existing groups such as the Trust Board and Management Team which have, in theory, taken on new

responsibilities, and the fact that many of the junior managers in the Primary Care Division are new to management per se.

From Trust Board through to divisional fora there appears to be a lack of clarity around a variety of key issues such as roles, responsibilities, accountability and authority in relation to the clinical governance agenda. This may have serious implications for the effectiveness of these groups. For instance, it has been suggested earlier in this thesis that the Trust Board minutes do not provide evidence of a robust discussion of the reports. In addition, the reports received are largely based on routinely available data rather than the Trust Board having taken time out to decide what information is needed to discharge its statutory duty. Until the appointment of the facilitator to the Primary Care Division, its Forum appeared to lack direction. Although the group had developed Terms of Reference, these did not address the sort of issues just described. Broad based objectives had been outlined and yet the group did not go on to develop a work programme to ensure delivery. Neither did the Forum identify the current information systems that should report into the group or clarify arrangements for reporting to others (upwards, downwards or laterally within the organisational hierarchy) on a regular basis.

Essentially, it did not appear that any of the groups discussed here took time out to work through the elements that need to be addressed deliberately to ensure effectiveness - whether this occurred in the other five divisional groups has not been explored. This is an important activity for all levels of the clinical governance hierarchy: the Trust Board is ultimately accountable for quality, the Clinical

Governance Sub-committee is responsible for steering the initiative and also for fulfilling an assurance function; the Management Team is meant to be translating the corporate objectives into local objectives and the purpose of the divisional fora is to operationalise the clinical governance agenda at the front line of service delivery. When one considers the education and training needed to lay the foundations of effectiveness for each of these groups, this provides some indication of the likely commitment that is needed from the organisation and challenges the notion that clinical governance is likely to be cost neutral. It also highlights the fact that any education and training programme needs to be carefully developed and planned, based on needs assessment, phased and adequately resourced both financially and in terms of appropriately experienced personnel.

The need for training was recognised in the Development Plan as was the need for the Training and Development Group to develop a corporate training strategy in support of the clinical governance agenda. Unfortunately, neither objective was achieved during the research period although the Trust's experience in this respect appears to echo that of the TQM pilot sites (Joss, Kogan and Henkel, 1994; Joss and Kogan, 1995) and also the findings of others (Katz, 1993; Davis, 1997). Awareness and understanding are important foundations for building commitment and involvement within the organisation. Unless the Trust takes a proactive approach to the education and training of employees, it may find itself having to go *'back to the drawing board'* (Kanji and Barker, 1990) at a future point in time just to ensure people have even the basic knowledge and skills. If these elements are essential ingredients for successful implementation, it would seem appropriate for the necessary investment in staff to be

made sooner rather than later.

9.2.8 Explicit Strategy/Resources for Recognising and Rewarding Progress

The development of mechanisms to ensure the recognition and reward of initiatives that demonstrate both the application of total quality principles and the improvements achieved through this process are a central feature of the TQM literature; albeit one to which Deming (1986) does not appear to subscribe. On one level, recognition and reward may serve as an important mechanism for rewarding achievement; at another level, rewarding certain behaviour over others is a powerful signal of what the organisation regards as valuable (Miles, 1997).

In practice, this is a rather complex area if one differentiates between negative and positive quality. The former is improvement through the correction of problems, errors, service failures and the latter is improvement which constitutes added value (Zairi, 1994). Initiatives such as the Significant Clinical Incident Reviews are aimed at addressing negative quality which has very different connotations and how this is recognised needs to be handled with care. As interviews with front line staff have suggested, it should not be assumed that the openness at the corporate level which surrounds Significant Clinical Incidents or complaints is as evident as one goes further down the hierarchy and closer to those individuals and groups directly associated with the incidents themselves. Some report that there is still a desire to keep such occurrences in-house and even within the group as opposed to any wider dissemination within the division. The Trust is approaching this issue by trying to emphasise the learning that has arisen from investigation of the incident but it

inevitably remains a process that puts poor quality and sometimes individuals under the spotlight which challenges somewhat the notions of recognition and reward.

9.2.9 Organisational Changes after Evaluation

Although certain sites developed metrics in terms of TQM activity, Joss and Kogan (1995) found that few of the TQM pilot sites had undertaken any formal evaluation of the implementation process itself. The Emerald Trust received a written quarterly report of progress against specific Development Plan objectives. This seemed to provide a comforting sense of progress which one could argue was, in part, the result of the lack of a clear appreciation of the starting point by some senior managers which, in turn, seems to have almost obscured the true scale and scope of the task that lay before them. Apart from the two formal feedback points which had been deliberately incorporated into the research process, there were no other formal collective evaluation points scheduled to enable a review of the implementation process as a whole. Inclusion of an internal formal evaluation might have allowed organisational members to identify for themselves gaps in vital areas such as organisation and individual development, the lack of a project management approach and so on. Alternatively, without the benefit of external facilitation, it is possible that the prevailing culture might have supported the status quo rather than promote the adoption of approaches which may have seemed different to the way implementation is traditionally addressed by this particular organisation.

Written feedback from the research process was first provided in December 2000; the second and final feedback was delivered in December 2001. The first report was

short and succinct and a large proportion of the recommendations focused on the need for an implementation plan to guide the process. The second report echoed this but also highlighted specific issues relating to the whole system that might benefit from further attention. The recommendations of each report are included in this thesis as Appendix 6 and 7 respectively.

Although the first report was presented to the Clinical Governance Sub-committee and the Management Team, there did not appear to be any subsequent in-depth discussion of the findings and neither was an action plan developed to address its recommendations. According to Hart and Bond (1995), this is not uncommon; but, at least in this case, the research was allowed to continue. In contrast to the first report, the second was almost a formality in that the issues raised had already been fed back to key individuals and groups over the preceding period. In this way, there was little, if anything, in the final document that had not previously been brought to the attention of the Trust prior to publication. Most of the recommendations reflected the gaps highlighted in this and the previous three results chapters; many were subsequently addressed in the clinical governance plan which was a central feature of the Trust application for PCT status.

It is difficult to say whether what appeared to be a greater acceptance of the feedback second time round was because the message was presented in a manner more in keeping with the Trust culture, whether the content was more acceptable or whether the Trust had just got used to the messenger - perhaps it was a combination of all three elements. However, irrespective of notions of the message and messenger etc,

one message to the Trust was clear - change needs to be actively managed - even more so in the face of the massive structural change that was about to take place as the organisation moved towards PCT status.

9.3 KEY MESSAGES FROM THE EXPERIENCE OF EMERALD NHS TRUST

Patton (2002) warns qualitative researchers against the temptation of making excessive claims as to the generalisability of their results arguing that, in the past, this has fuelled the arguments of those intent on criticising qualitative methodologies. I have also taken note of Spurgeon (1999) who emphasised the fact that transformational change is highly context-specific; Lane (1987) who warns that recipes for successful implementation can seem deceptively simple and thus enticing to the unwary and Øvretveit (1999) who suggests that it is the principles that are more likely to be transferable rather than specific programmes of quality improvement. Given the insights cited above, it is with extreme caution that I approach the task of identifying 'lessons' from this case study. My aim has been to provide enough 'rich description' of one Trust's clinical governance journey to enable the reader to compare Emerald with their own experience or the experience of other authors and/or to make their own evaluation if minded to do so. Nevertheless, I would like to offer a number of observations arising from this case study that will certainly inform my own future work in the area of change management in general and clinical governance in particular.

9.3.1 Learning from the Past

The research completed almost a decade ago into the implementation of TQM in the NHS (Joss and Kogan and Henkel, 1994; Joss and Kogan, 1995) and in Norway (Øvretveit, 1999; Øvretveit and Aslaksen, 1999) has provided valuable information about the challenges faced by complex health care organisations as they attempt to introduce a whole systems approach to quality management and improvement. It is positive to see that certain key recommendations arising out of the earlier work in the UK is reflected in the more recent thinking around clinical governance (Department of Health, 1998; 1999). In addition, insights from of these earlier research projects have also informed this most recent case study into the implementation of clinical governance.

The factors outlined in Joss and Kogan's framework (1995) (Table 9.1) have served as a useful heuristic for shaping the discussion contained within this chapter. This framework has been used as an organising mechanism which has enabled me to highlight and discuss not only the positive work undertaken by the Trust but also to present what I consider to have been gaps in the implementation effort, both end state and process. Deciding whether the Trust approach has been a success or failure is beyond the scope of this research as the design was essentially formative rather than summative. However, there is evidence of sub-implementation and even non-implementation; the former in that the Trust did not deliver against some of its own objectives for clinical governance implementation (training and development as an example). An example of non-implementation was the prolonged lack of deliberate activity around the implementation of clinical governance in one of the divisions.

Perhaps a fair assessment of the Trust approach would be to say that it has made an important start but still has a long way to go; in that respect, the organisation probably has much in common with other NHS Trusts.

The action research process provided the Emerald Trust with a series of recommendations for addressing the gaps highlighted in this and previous chapters (Appendix 6 and Appendix 7). What should perhaps be of a more wider concern is that many of the issues that seemed to get in the way of this Trust's progress have much in common with the numerous pitfalls identified in the general literature review on TQM (Chapter 3) and also in the UK and Norwegian experiments (Joss and Kogan, 1995; Øvretviet, 1999). Thus, although clinical governance might be a newer concept, many of the challenges to successful implementation are not. With regard to TQM, these unresolved challenges have apparently led to partial implementation (Kolesar, 1995; Yong and Wilkinson, 1999). Consequently, the concern is that that the manner of introduction may ultimately detract from what could be achieved through full implementation of the concept and philosophy (ibid, 1999). These concerns are expressed in relation to TQM but it is easy to see how they may also be applicable to the implementation of clinical governance.

Thus, it seems the NHS has much to learn from the past if it is not to succumb to the *'collective amnesia'* described by Klein (1998) and risk repeating the same mistakes as others; behaviour which some aspects of the Emerald Trust experience appear to demonstrate only too well.

9.3.2 A Study of Implementation – A Study Of Change

Jenkins (1978, p203) states unequivocally that *'a study of implementation is a study of change'* and it would seem important that this notion is kept to the fore of any implementation effort. Whole system change is extremely complex and there is a risk that the central theme of change may become lost in the subsequent activity. In the case of clinical governance, the nature of the change required for implementation is essentially transformational in nature as, for most organisations, it is a frame-breaking concept; nevertheless, this does not exclude incremental improvement within this transformational framework. This realisation is important so that the scale and scope of the change effort likely to be involved may be appreciated and the energy, resources and the timescale needed to move from the present to the future state accurately assessed.

The effective leadership of transformational change is undoubtedly important but arguably not enough in itself. The creation of the vision, the shaping of values and beliefs are essential for mobilising and sustaining the workforce but change and quality also need to be managed, neither will just happen (Oakland, 1995; Kotter, 1996). If the objectives within the clinical governance agenda are to be achieved, the organisation must pay attention to each element of the management process and managers at all levels need to have the knowledge and skills (as well as the other resources) to deliver their objectives. The demands of delivering total quality and transformational change quickly highlight the development needs of organisations, teams and individuals. Given the scale of the intervention required to implement clinical governance, it would also seem that the discipline of a project management

methodology could serve as a considerable source of added value.

9.3.3 Clarifying the 'What' of Implementation

It would seem, from the early policy documentation (Department of Health, 1997, 1998, 1999), that clinical governance was not fully formed as a concept when it was first presented to the NHS. As indicated previously, this is not uncommon and the detail often emerges during the implementation process (Klein, 1998). However, as Wolman (1981) has indicated, the likelihood of successful implementation is not merely a function of the implementation process but is also influenced by factors that originate further 'upstream' during the policy formulation process itself. Whilst it is important to recognise the role of local context (Spurgeon, 1999), it is perhaps worthwhile questioning whether, in the case of clinical governance, conceptual development upstream could have been taken further before its presentation to the NHS.

Although clinical governance resonates with the language of TQM and the goal of the initiative is CQI, the policy documentation somehow stops short of making the link totally explicit. Although TQM might be implied, the lack of clarity around clinical governance as a concept leaves space for local interpretation of the concept itself rather than limiting the scope of this interpretation to decisions relating to the customisation of the principles. As is evident from TQM, interpretations may range from a philosophy for running the business to a particular quality programme (Witcher, 1995); these constitute very different ends of a spectrum which would require very different approaches to implementation.

The Emerald Trust has conceptualised clinical governance as a vehicle for learning; however, this is not automatically synonymous with either quality improvement per se or the delivery of a comprehensive, integrated framework for CQI. The efforts of the Trust during the period of the research seem to reinforce this; although the initiatives introduced were positive steps, attempts to integrate the individual approaches were far more problematic. This seems largely due to the Trust's conceptualisation of clinical governance which led to a design which aimed to deliver a vision of learning rather than CQI. In addition, designing a whole system approach to CQI is challenging; as the earlier literature review in Chapter 3 has demonstrated, TQM and CQI are not underpinned by a uniform set of principles nor are they accompanied by tried and tested recipes for implementation. Thus it is unwise to assume that managers have an in depth knowledge of TQM or CQI by virtue of their position in management. I am able to confirm this through my own experience - it is one thing talking about TQM and CQI at a conceptual level, it is quite another to get past the 'buzzwords' and translate the concept into something tangible that can be operationalised in the real world.

9.3.4 Implementation Frameworks to Deliver the 'What' and the 'How' of the Change Process

Motwani and colleagues (Motwani, Sower and Bashier, 1996) have drawn attention to the general lack of adoption of formal frameworks to guide the implementation of total quality in health care. Thus it appears that the Emerald Trust is not unusual as there was no evidence that such an approach was adopted by this organisation either. Each of the three results chapters and the previous sections of this current chapter

have highlighted a number of significant gaps in both the 'what' or end state objectives and also the 'how' or process objectives in the Trust approach to implementation. Thus, in keeping with Yusof and Aspinwall's (2000a) argument that implementation frameworks force managers to take a comprehensive rather than selective approach to all elements, it is the contention of this writer that the implementation efforts of the Trust could have been augmented significantly if frameworks to guide both the 'what' and the 'how' of clinical governance had been utilised. It is also acknowledged here that a single framework is unlikely to provide all of the answers (Elmore, 1978; Lane, 1987) which points towards the use of more than one as the following discussion will demonstrate.

Although it is appreciated that clinical governance has not been explicitly defined as TQM in the Department of Health documentation (1997; 1998; 1999), the author found sufficient similarity to use Oakland's work on total quality (1995) as a tentative guide to possible design elements of a whole system approach to quality improvement under a clinical governance umbrella. Even recognising that some of the tools and techniques may vary if the Trust had utilised such a framework, the principles of TQM and CQI might have been more apparent and the implementation design more appropriate for the delivery of an integrated whole system approach to continuous quality improvement. In order to realise this goal there needed to be a greater emphasis on the improvement of key processes, clear initiatives to engage the users of the service, structures and a supporting infrastructure from the corporate level through to the operating core to provide the vehicles for quality and clinical governance to take place in practice. Instead, there is the situation where, although important

quality improvement initiatives have been introduced, there is a risk that they will remain as individual initiatives rather than elements within the integrated whole.

A framework for the 'how' of implementation was based largely although not exclusively on the Miles framework (1997). This framework served as a very useful guide to the management of change; part of its attraction lay in its conceptual clarity and also in the successful integration yet differentiation of the dual aspects of implementation - end state and process. It has been seen from the discussions in Chapters 2 and 3 that differentiation between the two is not always made explicit in the literature and from the evidence of this case study, neither does this necessarily happen in practice.

Just as the 'what' elements need to be made explicit, so do the 'how' elements. A lack of clarity around the implementation process, particularly in terms of the scope and scale of change required to establish clinical governance, may lead to insufficient emphasis being given to significant elements or even to them being overlooked completely as happened in some areas of the case study. An important theme within each of the change management frameworks that have informed this inquiry has been the notion of wholeness and its relationship with the success or otherwise of the change initiative; omissions are likely lead to failure (Kotter, 1996; Miles, 1997; Pendlebury, Grouard and Meston, 1998). Adoption of a framework such as the one proposed by Miles (1997) could have alerted the Trust to a number of important gaps: the lack of a communication strategy to support the implementation process, an over-reliance on the Clinical Governance Lead to provide support, facilitation and co-

ordination of the entire process across the whole organisation, the lack of an organisation development programme and so on.

The notion of wholeness referred to above does not mean that everything should happen at once but emphasises the need for deliberate phasing of activity. Phasing in turn does not imply a piecemeal approach but instead a deliberate and dynamic orchestration of all components to achieve internal alignment; the scope of this will vary depending on the resources available (Miles, 1997). A lack of deliberate intervention in the system such as that just described is one of the factors that leads to the sort of piecemeal introduction of initiatives observed by Kolesar (1993) and Yong and Wilkinson (1999) and there is also evidence of this in the approach of this case study site.

Finally, frameworks should not be regarded as a recipe for success; as Lane (1987) has warned, they can seem deceptively simple to the unwary. Successful application requires knowledge and skills in relation to change and change management. According to the literature and from the findings of this case study, it seems unwise to assume that either will be found automatically in every level of the management hierarchy. Frameworks should not be seen as a way of providing *the answer* to implementation but instead as a mechanism for *organising the questions*. Careful utilisation may ensure that any omissions are the result of a considered phasing decision rather than a design element that has been overlooked.

9.3.5 Culture Matters

The reader may, at this point, be wondering why, given this was an action research project, these frameworks were not proposed by the researcher. Essentially, the key recommendations of the first report drew attention to the need for a CQI model and an implementation plan but the response from the Trust was clear:

> *'(The Clinical Governance Lead and the Chief Executive) would argue with respect to the 'quality models' and pointed out that they would be difficult to convince about adopting quality models'.*
>
> *'We don't go big on implementation plans and documentation. That's not how we do things here and you (the researcher) won't change us'.*

The above was interpreted as 'that's not the way we do things here'. Instead of trying to impose a preferred approach, the researcher worked around this issue and used the frameworks to guide her own work which then led to recommendations for future action based on the areas illuminated by the frameworks selected. So, although the frameworks were not used explicitly by the Trust, they have indirectly contributed to its implementation approach.

This reluctance to use frameworks and models highlights an interesting aspect of culture. The need for culture change in relation to clinical governance is expressed so often it has almost become a mantra; however, this seems to be expressed most often with reference to clinicians, for example, the need to adopt evidence-based practice. Yet the notion of culture change also applies to managers who, it seems, need to be as wary as their clinical colleagues of the neutralising force that the prevailing culture may exert on new initiatives (Bate, 1994). This may be particularly evident in successful organisations which continue to apply tried and tested formulae to

innovations such as clinical governance which may actually require very different ways of managing the business.

The clinical governance agenda brings a more explicit emphasis on openness, probity and accountability not only to the clinical quality of services but, in a broader sense which is partly the governance element, it also includes the quality of business management. Thus, in this sense, frameworks that offer what Anderson and Ackerman-Anderson (2001) describe as an organising vehicle for decision-making rather than a prescription for action could allow an organisation to demonstrate not only that a systematic approach to implementation is being adopted but also the rationale for the design of both the 'what' and the 'how' of the initiative. With the advent of corporate and clinical governance, managers may also need to look at their practice and make changes accordingly in pursuit of increased effectiveness - irrespective of whether this represents a departure from previous ways of managing.

9.4 LIMITATIONS

This was an ambitious study for a new researcher in a number of ways. It focuses initially on the corporate and then divisional level and therefore includes breadth as well as depth. An action research approach posed additional challenges given the lack of clarity around the policy at the centre of the research process. Also, from past experience (Latham, 1996), I was well aware that the use of qualitative methods may precipitate the 'real research' debate. Despite these challenges, it is proposed that this study makes a significant empirical contribution to the slowly emerging research into clinical governance and its implementation. However, there are a number of

limitations which will now be considered.

As highlighted in Chapter 5, action research may be regarded as something of a continuum with a consultancy-type model at one end and a democratic, co-researcher-type model at the other; this work sits nearer the consultancy end of the continuum. Consequently, there is a flavour of the research having been '*done to*' rather than *'done with'* the organisation. This was a conscious design decision in light of an important constraint - the time available to the researcher; hence, intervention in the organisation was generally confined to the provision of feedback. Whilst the Trust considered this to have been beneficial, a more facilitative approach might have made a greater impact in terms of moving the implementation process forward. A co-research approach in which the host played a more active part in the research process might have secured greater ownership of the feedback which appeared to be something of an issue at the outset.

The focus of the study initially rested on the corporate level and, whilst still keeping the corporate level in view, attention was extended to one of the divisions. The intention was to gain an overview of clinical governance as it was being operationalised further down the hierarchy and nearer to the front line of service delivery. Whilst this was achieved, it threw a spotlight on non-implementation which was of value to the research process but, as the other divisions were not also studied as closely, there is a risk that this is perceived as indicative of the state of clinical governance implementation at divisional level across the Trust as a whole. The initial rapid appraisal suggests that this was not the case although it was true that the other

five divisions were at different stages of implementation. Unfortunately the research design did not permit any subsequent work of any detail with divisions other than Primary Care.

Joss and Kogan (1995) recommend that studies of this kind should be conducted over as long a period as possible given the nature of a total quality initiative itself and the scale of change required for implementation to take hold. Although this study took place over a period of 18 months, the focus only specifically incorporated the Division for the last six months. This was rather unfortunate as, during this period, the local Forum was really still in the forming stage and rather lacking in direction until the arrival of the facilitator whose early interventions appeared to promise progress. Unfortunately, it had not been anticipated that there would be such a delay in the setting up of this Forum so the research process ran out of time before it could really capture movement at the local level.

Finally, a single case design may be regarded by some as a limitation in itself; however, that surely must depend on how it is used subsequently. It has not been the intention here to provide a universal prescription for others to follow given that the implementation of clinical governance is likely to be of such a highly context-specific nature. Instead a rich description is offered; this highlights the issues facing a real organisation as it attempts to implement a concept whose inherent complexity is increased by what might be perceived as a lack of conceptual development on the part of the Department of Health. The rich picture in terms of the 'what' and the 'how' will allow practitioners to uncover similarities with their own efforts and the

recommendations from the reports to the Trust indicate how gaps may be addressed (Appendix 6, Appendix, 7). This study also provides a comprehensive account of method and results which may help others intending to undertake similar research within this arena.

9.5 FURTHER RESEARCH

The earlier view of the clinical governance literature presented in Chapter 2 highlights the fact that empirical work in this field is emerging slowly. Thus there seems to be immense scope for further research into what is essentially 'new territory'. In considering a possible focus for further work, it is worth noting the comments of those who have been involved in researching TQM. Joss and Kogan (1995) and Yong and Wilkinson (1999) make similar points in that, because of the different ways in which TQM is interpreted, it is difficult to know what is actually being implemented even though organisations may say (or think) they are implementing TQM. In light of this, Black and Porter (1996) suggest that instead of trying to capture convenient taxonomies what is required are more case studies which focus on the practical experiences of organisations.

The observations above could also be applied to further research into clinical governance. Clinical governance is a complex construct; there is no universal blueprint either in terms of content or implementation and the Department of Health approach has encouraged local interpretation. Dewar (1999) has described clinical governance as being 'under construction', but it is perhaps more accurate to think of this as being 'under local construction'. For this reason, there is a real need to

understand how clinical governance is being conceptualised by NHS Trusts (the 'what') and also to identify the processes by which the policy is being implemented (the 'how'). This would seem to suggest that additional descriptive case studies such as that of the Emerald Trust would be desirable. Given the current absence of an evidence base to support the notion that clinical governance will actually deliver quality improvement (Goodman, 2002; Thomas, 2002), in depth case studies might also be seen as an essential precursor to future attempts to establish the effectiveness of clinical governance as policy.

The apparent emphasis on the whole system which the above discussion implies does not preclude research into the various component parts which make up this complex agenda. There is likely to be value in following research themes across organisations such as the strategies, structures, systems and processes introduced; the roles of key actors and in particular clinical governance leads, Trust boards and so on. However, it should be remembered that at the core of clinical governance is the language and rhetoric of a whole system approach to continuous quality improvement which is a goal that requires the strategic alignment of all components and not merely the summation of its parts. To capture this, one surely needs the kind of rich picture provided by the case study.

9.6 CHAPTER SUMMARY

The focus of this chapter has centred on providing a review of the results arising from the research process. Once again, faced with a rich picture from the field, a framework has been utilised to shape the subsequent discussion. This time it is a framework

derived from the evaluation of an experiment to implement TQM in the NHS over a decade ago. Using this as a vehicle it has been possible to highlight areas of progress in relation to clinical governance at the Emerald Trust and also gaps in both the content and the process of implementation. Arising from this discussion, a number of key messages are offered for the consideration of practitioners and researchers alike. The limitations to the study are presented; and finally, suggestions for further research proposed. Concluding comments are reserved for the final chapter which now follows.

CHAPTER 10

CONCLUSION

'Those that cannot remember the past are condemned to repeat it'
(Santayana, 1905)

This thesis has been based on an action research project which has followed the experience of one NHS Trust as it attempted to implement clinical governance. Implementation may be conceptualised as both a change process and an end state; to capture this duality, two broad research questions have been posed namely: what constitutes the local clinical governance agenda (content) and how has clinical governance been implemented (process). Given that the main purpose of these research questions is to explore and describe, an overarching qualitative framework has been adopted to guide this study. Data collected using a range of qualitative methods has been presented in three earlier chapters: 6, 7 and 8. In these chapters, the readers may find a rich picture of Trust progress in relation to the clinical governance agenda which has been clearly differentiated in terms of both the what/content and the how/process of implementation.

There are some who would say that the implementation of TQM is the most complex activity an organisation can undertake (Kanji and Barker, 1990) and those tasked with the implementation of clinical governance may say the same about this recent initiative. The research evidence suggests that the Trust has succeeded in moving the clinical governance agenda forward in terms of both content and process on a number of fronts; sometimes these efforts have been constrained by the existing corporate culture and

other initiatives have been introduced which have signalled a definite change in 'the way we do things here'. Significant gaps in the Trust approach have also been identified during the course of the research process which have related to implementation once again in terms of both content and process issues. However, the organisation has addressed a number of these both in real-time during the life of the project and has also incorporated many of the research recommendations into the clinical governance plan for the new Primary Care Trust.

It has been argued earlier in this thesis that the effectiveness of policy implementation is influenced by factors originating both upstream during formulation and downstream during implementation; apparently deficiencies in the former are least likely to be acknowledged (Hogwood and Gunn, 1984). Gaps in the implementation process have been referred to above and elsewhere within this thesis. Whilst it is seemingly not uncommon for the detail of a new policy to emerge during the implementation process, this approach seems to have contributed to a lack of clarity in the field; the early clinical governance literature attests to this with contributors trying to make sense of the concept. It would appear that leaving the field to interpret the concept is very different from leaving space for local interpretation of the design elements. The risk is, as in the case of the Emerald Trust, that it will not be interpreted as CQI and alternative conceptualisations will bring different goals and organisational designs. For instance, the Trust focus on learning is different from a CQI focus; the former has brought, amongst other things, an emphasis on negative quality and seen the creation of more library facilities; the latter is intended to deliver an approach which results in the whole organisation being aligned in support of natural work teams addressing both the

positive and negative aspects of quality.

Implementation is the most difficult aspect of change. Klein (1998) warns against allowing the challenge of new policy to divert attention from the fact that there are lessons to be learned from the decades worth of difficulties governments have experienced with the quality agenda. To reinforce this view, it is worth noting that most, if not all, of the gaps identified in the Emerald Trust's approach to implementation have been seen before as the chapters reviewing the literature on total quality management and change demonstrate quite clearly. On a more positive note, the Emerald Trust has learned from its experience and sought to address the earlier gaps in the implementation process. There is also evidence that the recommendations from previous research (Joss, Kogan and Henkel, 1994) seem to have been heeded and are reflected in the upstream formulation of clinical governance as policy.

Whilst clinical governance might be a new concept, the underlying principle of CQI most definitely is not. In fact, one could be forgiven for thinking that clinical governance was TQM by another name; an 'old wine in a new bottle' (Asubonteng, McCleary and Munchus, 1996) or perhaps, more appropriately given the context, an old medicine with a new prescription. It has been argued that business approaches to quality are hard for the NHS to swallow (Pollitt, 1996) and so it will be fascinating to watch whether the new prescription (clinical governance) proves easier to tolerate. The Chief Medical Officer (Donaldson, 1998) is in no doubt that this remedy is needed as

the following reference to the 'Bristol Case' demonstrates:

> *'The spectre of bereaved parents picketing the General Medical Council with cardboard children's coffins was a harrowing sight. Through clinical governance the NHS has the opportunity to make a major leap forward in the prevention of such catastrophes so that history is never seen to repeat itself and public confidence is sustained'.*

Clinical governance is described as the *'linchpin'* of the quality strategy for the NHS (Department of Health, 1999; p4); whether it will successfully deliver the proposed agenda, it is perhaps too early to say. What seems clear in the meantime is that unless NHS Trusts recognise the *magnitude* of the change involved in implementing clinical governance, unless these organisations understand exactly *what* it is they are meant to be taking forward and unless the *knowledge and skills* around total quality and change management are actually present in these organisations, the odds may be more in favour of Goodman's assessment of clinical governance as *'empty phrases'* (1998) rather than that of Scally and Donaldson (1998) who paint a more positive picture *'of the big idea that has shown that it can inspire and enthuse'.*

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APPENDIX 1: IMPLEMENTATION TYPOLOGIES

Appendix 1a: Implementation typologies

Five steps to implementation (Glover, 1993)				
1. Awareness • Leadership • Review of options • Seminars, books • Planning session • Selection of change agent • Readiness survey • Involvement of union	2. Education • Leaders • Middle managers • Supervisors • Employees • Facilitators • QT leaders	3. Structural change • TQM design • Steering committee • Quality teams • Revised information system • Facilitation process	4. Necessary activities • Empowerment • Participation • Consensus • Harmony • Measurement • Fact-based problem solving • Continuous improvement	5. Expected improvements • Employee ownership • Productivity and quality • Consumer satisfaction • Market share and demand • Improved goals and financial performance

Seven steps with project management (Stamatis, 1994)	**Implementation framework for SME - 10 steps (Ghobadian, Gallear, 1997)**	**Stages of implementation (Kanji and Barker, 19900**
1. Energise the organisation 2. Change the culture of the organisation 3. Define the scope of your commitment 4. Identify key process and product variables 5. Implement SPC 6. Incorporate process improvement activities in the organisation 7. Assess the quality improvement in the organisation	1. Recognition of the need for the introduction of TQM 2. Developing understanding among management and supervisors 3. Establishing goals and objectives of the quality improvement process 4. Plan the TQM implementation 5. Educate and train all employees 6. Create a systematic procedure 7. Align organisation 8. Implement the TQM concepts 9. Monitor the implementation of TQM concepts 10. Engage in continuous improvement by going back to step 3	1. Identification and preparation 2. Management understanding and commitment 3. Scheme for improvement 4. Critical analysis

Appendix 1b: Implementation typologies

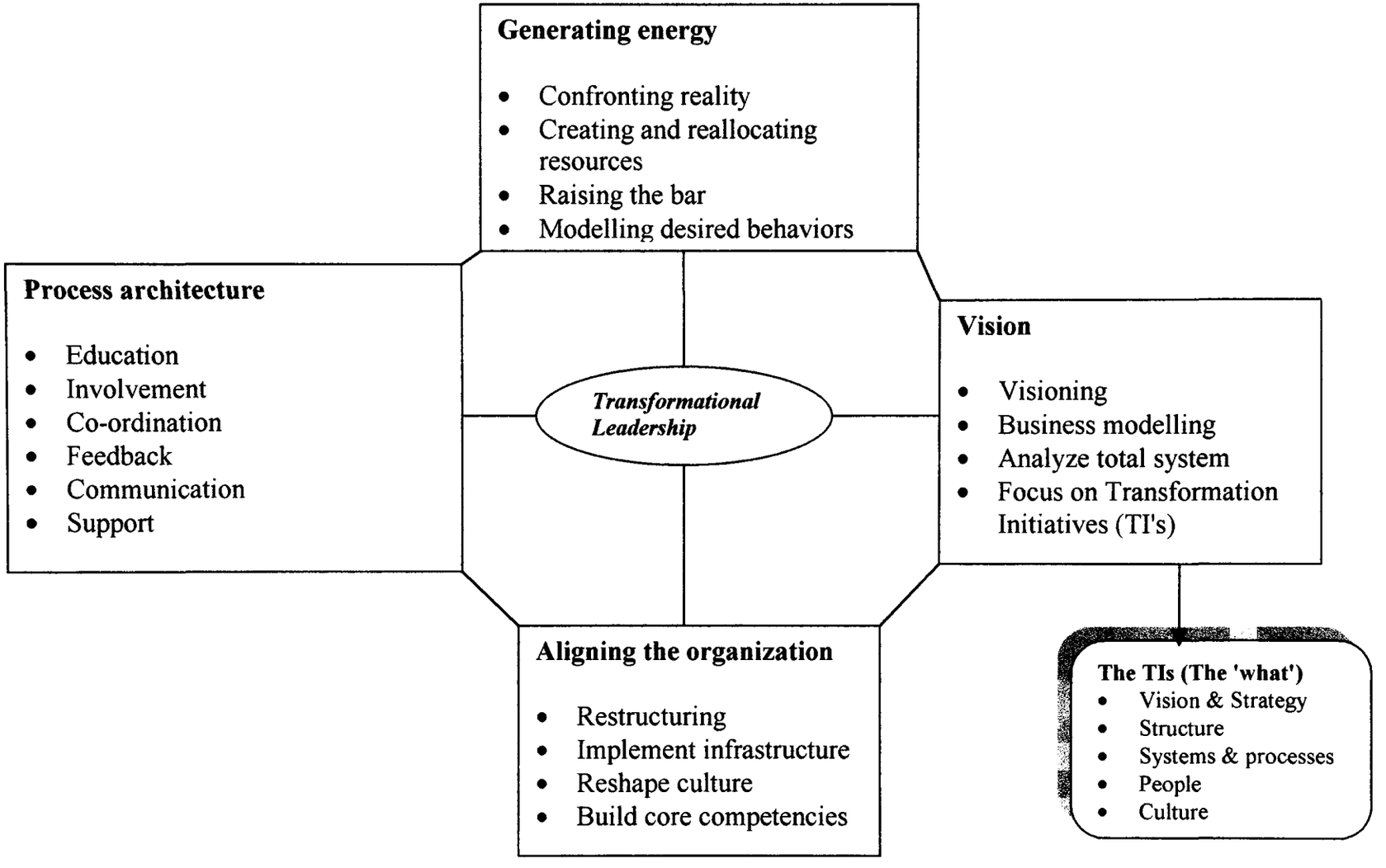
Process for designing and implementing a CQI strategy (Rand, 1994)	**TQM implementation (Oakland, 1995)**
Three key phases: 1. Exploration and design • Review mission, values and culture • Review theories, models and techniques • Select a framework • Gap analysis • Develop model: principles, process, support strategies • Design organizational accountabilities 2. Implementation • Establish goals and plans • Communicate • Educate • Implement model • Measure • Reward and recognise 3. Sustain • Measure and celebrate • Revise model • Revise organizational accountabilities • Revise reward system	Initial steps following one day seminar for top management (*links in with commitment, communication, culture - see text):* • Formation of quality council (top management team) • TQM attitude survey - profile of organization - quality costs - strengths/weaknesses • 2 day strategic planning workshop (quality council) - charter - mission statement - quality policy - CSFs - Critical processes - Implementation action plan • Formation of process quality teams and/or site steering committees • Teamwork seminar for quality council (may precede strategic planning workshop) • Identify team facilitators • Run specific training and team-forming workshops • Company-wide awareness training on customer/supplier interfaces • Implementation/improvement projects for quality deployment - quality costing - customer/supplier framework - DPA - Systems - Techniques • Feedback/follow-up workshops throughout implementation

Appendix 1c: Implementation typologies

Dale and Boaden 1994

Organizing	Tools and techniques	Measurement & feedback	Culture change
Long term strategy for quality improvement formulated and integrated with other strategies; Quality improvement plans developed	Identification of applicable tools and techniques at each stage of QI	Key internal and external performance measures identified, defined and developed	Assess the current status of organizational culture before developing plans for change
Definition of quality, TQM, and QI developed and agreed	Training in the use of tools and techniques, for the right people at the right time	On-going discussion with customers about expected performance	Recognise the ongoing nature of culture change and the need to outline specific culture changes
Identification of sources of advice	Use of a formal quality system	Benchmarking once QI is under way	Plan change consistently and incrementally
Choice of approach to TQM	Identification of other systems and standards that may be required by customers or legislation	Means for celebration and communication of success and teamwork developed	Recognize the role of people as an asset
Stages of improvement activity identified, taking the starting point into account	Identification of key business processes and improvement based on these processes	Consideration of the link between results from QI and rewards	Consider the inter-relationships of all activities within the organization in order to minimize conflict
Vision and mission statements developed and communicated to all members of the org		Means of assessing the progress towards world-class performance; eg EQA, MBNQA	Consider the national and local culture
Formal programme of education and training for al members of the organization			
Organizational infrastructure established to facilitate local ownership of QI			
Teamwork established as a way of working and part of the infrastructure			

APPENDIX 2: FRAMEWORK FOR TRANSFORMATIONAL CHANGE
(Adapted from Miles [1997, p6])



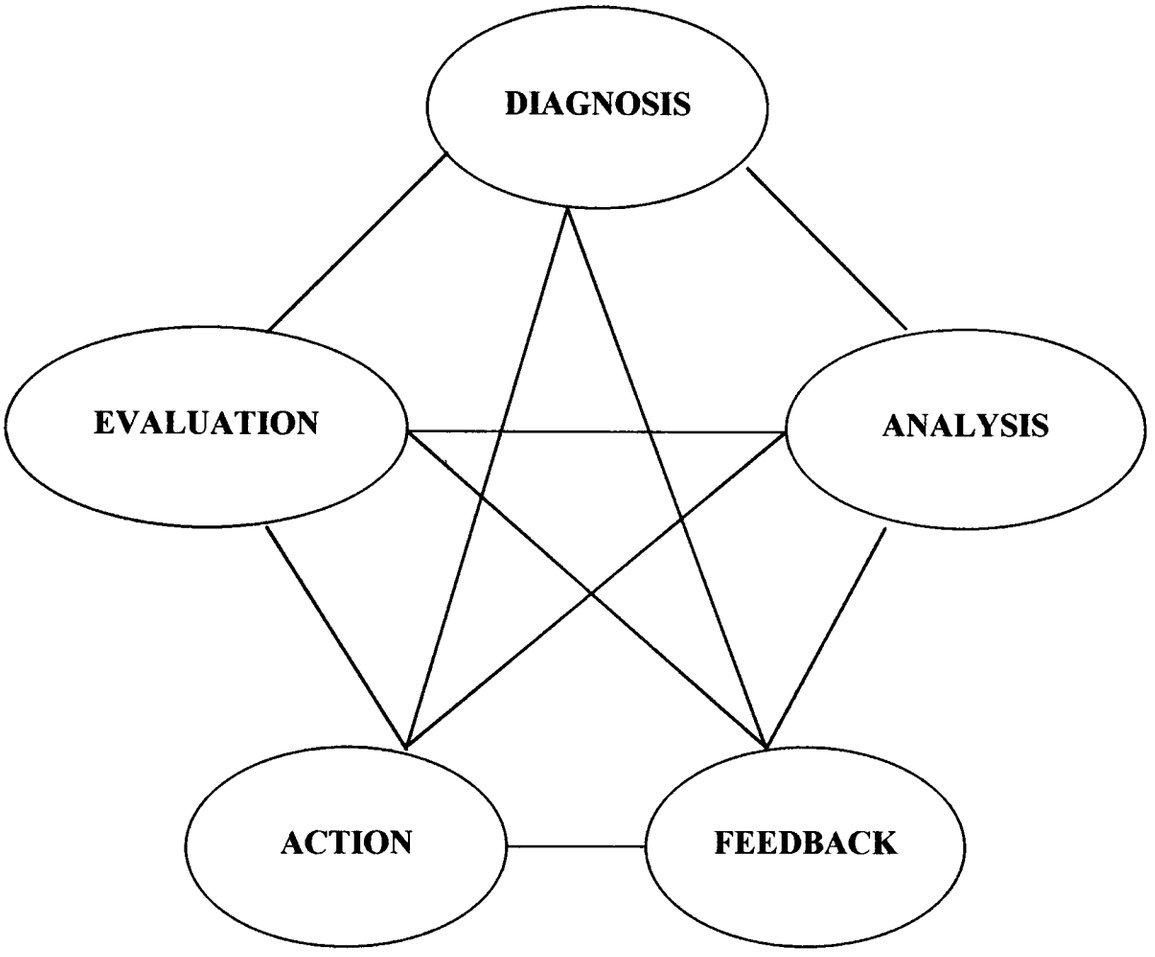
APPENDIX 3: EIGHT STAGE PROCESS FOR CHANGE
(Adapted from Kotter, 1996)

1. Establish a sense of urgency
2. Create the guiding coalition
3. Develop a vision and a strategy
4. Communicate the change vision
5. Empower employees for action
6. Generate short-term wins
7. Consolidate gains and produce more change
8. Anchor new approaches in the culture

APPENDIX 4: TEN KEYS TO EFFECTIVE CHANGE MANAGEMENT (Pendlebury, Grouard, Meston, 1995)

1. Defining the vision
2. Mobilising
3. Catalysing
4. Steering
5. Delivering
6. Obtaining participation
7. Handling the emotional dimension
8. Handling the power issues
9. Training and coaching
10. Communicating actively

APPENDIX 5: ACTION RESEARCH - A MODEL FOR PRACTICE (Adapted from Bate, 2000)



APPENDIX 6: RECOMMENDATIONS - ACTION SET 1

FIRST REPORT & FEEDBACK TO THE TRUST
December 2000

The trust is asked to consider the following action points:

1. Clarify and make explicit the model(s) of quality (QA/CQI) underpinning the trust approach to clinical governance and ensure that the trust clinical governance framework is congruent.

2. Distil the trust's vision for clinical governance into a short, concise paragraph that is meaningful, likely to engage the organisation at all levels (clinical and non-clinical staff) and convey clearly the trust aspirations. This should then be communicated in a comprehensive and sustained manner internally and externally and modelled at every opportunity.

3. The current clinical governance development plan offers a valuable outline of the Trust's short term objectives for clinical governance. As it is now almost 12 months since the plan was published, a review is recommended in light of the progress already made by the Trust and the comments contained in this paper. The Trust's house style is recognised and it is acknowledged that the Trust will need to strike an appropriate balance between central direction, prescription vs letting the trust find its own way, local freedom. However, for the purpose of Trust-wide implementation, given the size and nature of the agenda and the varied and developing experience within MT, we believe that it is important that the plan should serve as a map which addresses the following:

   - clear aims and objectives with short and long term milestones;
   - structures in place throughout the organisation accompanied by clear terms of reference;
   - supporting infrastructure;
   - clear roles, authority and responsibilities, accountability, co-ordination arrangements;
   - individual, team (corporate, MT, clinical, improvement teams) and organisational training and development needs specific to the quality management/leadership and innovation agendas;
   - sources of support and facilitation (internal and external);
   - communication strategy;
   - resource implications of plan.

4. Re-launch clinical governance highlighting recent quality improvement initiatives (large and small scale) that will illustrate clinical governance in action eg: ?lung cancer pathway, hospital at home, SCI, other.

APPENDIX 7: RECOMMENDATIONS - ACTION SET 2
SECOND REPORT & FEEDBACK TO THE TRUST
December 2001

1) It is recommended that the Clinical Governance Sub-committee gives consideration to the development of an implementation plan that will not only make explicit but also integrate all aspects of the implementation process.

2) It is recommended that the current Terms of Reference of the Clinical Governance Sub-committee are reviewed, the focus of its monitoring remit (strategic/and or operational) made explicit.

3) It is recommended that the present clinical governance framework is reviewed in terms of content and coverage to ensure that it reflects the monitoring remit of the Clinical Governance Sub-committee.

4) It is recommended that the collective development needs of the Clinical Governance Sub-committee are identified and addressed accordingly.

5) It is recommended that the role and membership of the Best Practice Development Team are reviewed .

6) It is recommended that the collective development needs of the Best Practice Development Team are reviewed and met accordingly.

7) It is recommended that the focus of the Risk Management Team's monitoring remit is made explicit and that the current data set is reviewed in terms of content and coverage.

8) It is recommended that consideration is given to the merits of appointing to an operational risk management role in support of the Clinical Governance Lead, the Risk Management Team and also to provide specialist support to the directorates/divisions.

9) It is recommended that consideration is given to the development of a dataset to facilitate regular, collective monitoring of existing training and development initiatives.

10) It is recommended that consideration is given to the 'cultural' aspects of accessing library resources and to overcoming 'cultural' barriers to access in particular.

11) It is recommended that the collective and individual development needs of the Trust Board are identified and met accordingly.

12) It is recommended that a review of both internal and external communications is undertaken and the development of an integrated communication strategy considered.

13) It is recommended that an explicit and on-going communication plan is developed to support the Trust-wide implementation of clinical governance .

14) It is recommended that current arrangements for training provision in relation to risk management and its components are reviewed - in the short term to address the issue of attendance and in the longer term to inform the development of the Trust training and development strategy.

15) It is recommended that a formal response to Significant Clinical Incident Review reports from each of the Trust divisions is incorporated as a feature of the post review audit process.

16) It is recommended that the Significant Clinical Incident Review process is integrated within the wider risk management process of the Trust.

17) It is recommended that the current mechanisms for reporting clinical effectiveness and audit activity are reviewed and this information is incorporated into the regular clinical governance reporting framework.

18) It is recommended that an explicit Trust clinical audit programme is developed which makes explicit both corporate and divisional priorities and serves as a framework against which progress may be monitored and opportunities for synergy identified.

19) It is recommended that consideration is given to the inclusion of a representative of the IM&T function to the membership of the Clinical Governance Sub-committee.

20) It is recommended that information on progress against clinical governance-related aspects of the IM&T action plan is incorporated into the regular clinical governance reporting framework.

21) It is recommended that consideration is given to the incorporation of the management and reporting arrangements for user involvement into the mainstream management arrangements of the Trust.

22) It is recommended that information on the progress of user involvement initiatives is incorporated into the regular clinical governance reporting arrangements.

23) It is recommended that the current arrangements through which the Human Resource issues inform the clinical governance agenda are reviewed and action taken to achieve greater integration.

APPENDIX 8: A SELECTION OF INTERVIEW SCHEDULES / GUIDES

APPENDIX 8a: INTERVIEW CHIEF EXECUTIVE - OCT 2000

1. What do you see as the main objective of clinical governance
2. What changes do you expect to see in the way that the trust works when clinical governance is embedded
3. If a junior member of staff wanted to know what the trusts vision for clinical governance is; where would they look it up
4. Accountable officer - what does this mean in practice
5. How did the development plan come into being (involvement)
6. How does the development plan relate to the business plan
7. What is the mechanism for implementation of the development plan (co-ordination, leadership)
8. How is the implementation process being monitored
9. What systems are in place to deliver clinical governance
10. How is the clinical governance agenda communicated to the trust
11. Have the directorate managers had any specific training in relation to clinical governance
12. Culture change - specific initiatives aimed at this
13. Quality circles
14. What does the trust do particularly well/What could be improved
15. What helps deliver the service/What gets in the way
16. What needs to happen next

APPENDIX 8b: INTERVIEW TRUST CHAIR

1. What do you see are the main objectives of clinical governance
2. Key elements of clinical governance
3. Newness
4. Your role as Chair
5. Role of trust board
6. Clinical governance - statutory duty for quality - has that made a difference to the way the board operates, business of the board, thinks about its role and responsibility (SCI reviews - quality issues explicit)
7. Preparation and training for members; assessment of awareness/understanding of the implications for them - particularly non-execs
8. Key priorities for the trust in relation to clinical governance
9. How were these determined; role of the trust board in relation to this
10. Systems in place to deliver the clinical governance agenda; systems needed
11. What information tells you that these systems are working effectively
12. Role of clinical governance sub committee
13. Challenges facing the trust in the implementation of clinical governance

APPENDIX 8c: INTERVIEW CLINICAL GOVERNANCE LEAD - OCT 2000

1. Tell me a bit more about your role in relation to clinical governance
2. Has this changed over time, how
3. Cultural emphasis in the trust; what interventions have been directly aimed at changing culture
4. Development plan; implementation and monitoring processes
5. Strategic role of clinical governance committee; how is the operational function discharged
6. Rationale for elements in the clinical governance reporting framework
7. Progress of the Serious Clinical Incident Investigations
8. Overall progress in implementing clinical governance agenda
9. Next steps

APPENDIX 8d: INTERVIEW DIRECTOR OF FINANCE - OCT 2000

1. Please tell me about your responsibilities within the trust
2. What do you see as the main objective of clinical governance
3. How is clinical governance different to other quality initiatives
4. What's happened so far around clinical governance in the trust
5. What has been your role in that
6. Where is the trust up to with its development plan
7. Links with business plan
8. Financial implications of clinical governance
9. Implications of clinical governance for managers
10. Rhetoric of policy - raise profile of quality over activity and finance
11. Is this feasible - how could it be achieved
12. Links with controls assurance
13. What needs to happen next

APPENDIX 8e: INTERVIEW NON-EXEC DIRECTORS - OCT 2000

1. Can you tell me what you see are the main objectives of clinical governance

2. What differences do you expect to see in the way the trust works when clinical governance gets to be part of the way things happen

3. Can you think back over the last 18 months and describe what the trust has done to take the agenda forward

4. If you were asked by a D grade nurse to explain the Trust's vision of clinical governance what would you say; where would s/he find this written down

5. How do you see your role in relation to clinical governance

6. How has this come about

7. What structures are in place

8. What systems are in place

9. What are the key indicators that tell you that these systems are working

10. Key examples of improvement (not capital developments); what was the catalyst (part of CQI/problem initiated)

11. Development plan; how did this come about

12. What is the mechanism for implementing this

13. If you asked a front line clinician to describe what the trust was doing about clinical governance and what their responsibility as a clinician is; what sort of response do you think you would get

14. What do you think the organisation does particularly well

15. What could it do better

16. What helps deliver the service

17. What gets in the way

APPENDIX 8f: INTERVIEW DIVISIONAL MANAGERS - SEP 2000

Could you start be telling me about the work of the directorate

- What sort of services do you provide; To whom
- By whom - professional groups, wte, management hierarchy, other agencies
- How is the service delivered / Where – location / When
- How long have you been here - what changes have you seen
- What helps you deliver the service you want to give your clients
- Is there anything that gets in the way of delivering the sort of service you want to deliver

Directorate

- Strategy and vision - business plan, resources, outputs, environment, technology
- Structure - hierarchy. Main decision/co-ordinating group, other decision groups
- Infrastructure - communications, HR (appraisal, CPD), reporting
- Infrastructure - quality: quality group, quality strategy, quality monitoring, key quality indicators, reporting
- Infrastructure - clinical audit, risk management, incident reporting, significant clinical incidents
- People (see service)
- Competencies - and what could be done better
- Culture

Quality improvement

- What initiatives over last 3 years / When did these happen
- What/who was the catalyst for the change. Who was involved - design, implementation,
- How was the impact evaluated / What was the outcome
- Is there a programme for improvement

Clinical governance

- What do you see as the main objectives of clinical governance - QI, QA, control
- What has the directorate done so far to implement clinical governance
    - What is the aim - how developed
    - Action plan - key interventions, how developed, how, who, when will these be implemented - links to business plan and resources
    - Action plan interventions - inclusion of education and involvement, co-ordination mechanisms (directorate/corporate/clinical governance subcommittee), feedback and communication, support, leadership
    - Baseline assessment of ? what, ?existing quality systems such as clinical audit, CRM, CPD, knowledge management complaints

- What has been the response of clinicians - assessed
- Changes in the way the directorate works
- Significant clinical incident investigations

APPENDIX 8g: FOCUS GROUP NON-EXECUTIVE DIRECTORS - SEP 2001

General role

- How do you see your role as non-execs

- Strategy/policy - formulation/monitoring
  - what stage involved in strategy/policy development process
  - away days to focus on strategy

- Each have a lead focus/ Written objectives

- What sort of preparation and training have you had specifically for your role as non-exec - anything on-going

Clinical governance

- Preparation for role in relation to clinical governance agenda - education, training; briefings

- What impact has clinical governance had on your role as non-exec
  - corporate accountability for quality - what has this meant in practice
  - how does the statutory duty for quality impact on your role
  - what tells you that you are discharging that duty

- What specific information do you get to enable you to discharge your responsibilities in relation to clinical governance - how were info needs identified

- Do you feel able to challenge the executive team around this agenda

- Where do you think the trust is currently with clinical governance - structures, processes. What tells you that clinical governance is going forward

- What information tells you that systems are in place and working
  - risk register/risks managed
  - clinical audit - closing the loop
  - programme of QI activity
  - appraisal / CPD

- What's new about clinical governance

- Has there been any team building as a board development - new executive team

APPENDIX 8h: INTERVIEW PRIMARY CARE DIVISION MANAGERS

Role of manager

- How long in this post
- Key areas of responsibility
- To whom are you accountable; how is this discharged (? Div manager)

Department

- Strategy - business plan, objectives for this year, quality strategy - objectives
- Structure - decision making group, hierarchy, quality group
- Infrastructure:
  - Decision making
  - Problem solving
  - Communications, regular meetings, mechanisms for feedback up and down
  - Appraisal, training, PDPs
  - Clinical audit, risk management, incident reporting
  - Complaints
  - R&D
  - Access to evidence (library, hardware, skills in EBP)
  - NICE guidance, NSF; how is this introduced if relevant
  - User involvement
- People - see service
- Culture

  Recent improvements (eg: ICPs,)

Quality improvement

- Key quality indicators
- What initiatives over last 3 years
- When did these happen
- What/who was the catalyst for the change
- Who was involved - design, implementation, evaluation, (multi-disciplinary)
- How was the impact evaluated
- What was the outcome
- Sustained after initiative
- Is there a programme for improvement

Clinical governance

- **Vision:**

➢ What do you see as the main objectives of clinical governance (QI, QA, control);
➢ What do you see as the key elements of clinical governance
➢ Do you see clinical governance as something new
➢ What sort of differences in the service do you expect to see when clinical governance becomes a way of life
➢ What is your role as a manager in relation to clinical governance
➢ Specific lead (eg: clinical governance committee)

- **What has the department done so far to implement clinical governance**

Strategy

- Is there a written plan
- What are the key objectives 01/02 and beyond
- How were these identified
- Who was involved in development, how
- How does this link with the business plan,
- Are there timescales for action,
- How will these be monitored
- What are the critical success factors
- Have resources been allocated
- Reporting mechanisms; feedback to staff, feedback up the hierarchy
- Was there a baseline assessment of existing quality systems?

Structure:

Clinical governance lead; co-ordinating group; clinical governance action plan (key objectives)

Infrastructure:

- Leadership arrangements
- Accountability
- Reporting mechanisms
- Co-ordination mechanisms (clinical audit, complaints, risk management
- Awareness raising
- Training for clinical governance, CQI
- Education - CPD
- Involvement; identification of issues, development, implementation, monitoring,
- Communication and feedback
- Appraisal
- Improvement
- Support
- Multidisciplinary approaches

People:

What have been the response of clinicians to clinical governance - has this been assessed

Competencies -

Key competencies for clinical governance - existing/to be developed

Culture -

Involvement, multidisciplinary working, CQI, customer focus

What helps you deliver the service / What gets in the way

APPENDIX 8i: FOCUS GROUPS DISTRICT NURSES/HEALTH VISITORS

1. Please write down what clinical governance means to you
2. What's been happening in the trust to take clinical governance forward
3. Early road shows; what since
4. Anything more locally
5. If not attended road shows, how have you heard about clinical governance
6. What changes have you noticed in the way you work as a result of clinical governance
7. What elements get most attention/least attention
8. How does clinical audit happen; what feedback do you get from incident reports; how are complaints handled - are these discussed in the staff meetings
9. What do you think you think needs to be done differently/happen to make clinical governance a reality

APPENDIX 8j: INTERVIEW ACTING DIVISIONAL MANAGER - MAY 01

Division/Locality

- Strategy - business plan, objectives for this year, quality strategy - objectives
- Structure - decision making group, hierarchy, quality group
- *Structure - other groups apart from PCG nurses and PAMS*
- Infrastructure:
  - Decision making; problem solving
  - Communications, regular meetings, mechanisms for feedback up and down
  - Appraisal, training, PDPs
  - Clinical audit, risk management, incident reporting, complaints (and integration system)
  - R&D
  - Access to evidence (library, hardware, skills in EBP)
  - NICE guidance, NSF; how is this introduced if relevant
  - User involvement
- People - see service
- Culture: Recent improvements (eg: ICPs,) and CQI, multidisciplinary working, customer focus

Quality improvement

- Key quality indicators
- What initiatives over last 3 years
- When did these happen
- What/who was the catalyst for the change
- Who was involved - design, implementation, evaluation, (multi-disciplinary)
- How was the impact evaluated
- What was the outcome
- Sustained after initiative
- Is there a programme for improvement

Clinical governance

- **Vision:**
  - What do you see as the main objectives of clinical governance (QI, QA, control);
  - What do you see as the key elements of clinical governance
  - Do you see clinical governance as something new
  - What sort of differences in the service do you expect to see when clinical governance becomes a way of life
  - What was your role as community manager in relation to clinical governance
  - Specific lead

- **What has the locality done so far to implement clinical governance**

Strategy

- Is there a written plan
- What are the key objectives 01/02 and beyond
- How were these identified
- Who was involved in development, how
- How does this link with the business plan,

- Are there timescales for action,
- How will these be monitored
- What are the critical success factors
- Have resources been allocated
- Reporting mechanisms; feedback to staff, feedback up the hierarchy
- Was there a baseline assessment of existing quality systems?

Structure:

- Locality group
- Locality lead

Infrastructure:

- Leadership arrangements
- Accountability
- Reporting mechanisms
- Co-ordination mechanisms (clinical audit, complaints, risk management
- Awareness raising
- Training for clinical governance, CQI
- Education - CPD
- Involvement; identification of issues, development, implementation, monitoring,
- Communication and feedback
- Appraisal
- Improvement
- Support
- Multidisciplinary approaches

People:

What have been the response of clinicians to clinical governance - has this been assessed

Competencies -

Key competencies for clinical governance - existing/to be developed

Culture -

Involvement, multidisciplinary working, CQI, customer focus
What helps you deliver the service
What gets in the way
What has got in the way of taking clinical governance forward

Divisional clinical governance forum

- Clinical governance lead for division
- Co-ordinating group; TOR
- Key objectives
- Translated into action plan
- Role of group chair - preparation; training
- Role of members - preparation; training
- How will the agenda be formulated
- Reporting mechanisms

- Link/integrate with other structures internally and externally (trust corporate and divisional; PCG)

Serious clinical incidents

- How do you get to hear that incidents have occurred and are being investigated
- How do you get the information around action sets arising from the review
- How is this actionned locally
- Have you had any SCI on your patch
- Tell me about the incident; how are the recommendations being implemented

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